DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

Sent Via Email

December 31, 2019

Catherine Monahan
American Oversight
1030 15th Street NW, Suite B255
Washington, District of Columbia 20005
Email: foia@americanoversight.org

Dear Ms. Monahan:

This letter is regarding to your Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry (CDC/ATSDR) Freedom of Information Act (FOIA) request of October 9, 2019, assigned #20-00057-FOIA, for:

> "All email communications (including email messages, email attachments, calendar invitations, and calendar invitation attachments) between (1) the specified CDC officials and (2) external parties, listed below, regarding the prevention, treatment, and control of infectious diseases at immigrant detention or holding facilities.
>
> **CDC Officials:**
> a. Dr. Mitch Wolfe, Chief Medical Officer
> b. Dr. Jay C. Butler, Deputy Director for Infectious Diseases
> c. Sarah Wiley, Senior Advisor to the Deputy Director for Infectious Diseases
> d. Dr. Nancy Messonnier, Director, National Center for Immunization and Respiratory Diseases (NCIRD)
> e. Allen Craig, Deputy Director, NCIRD
> f. Melinda Wharton, Director, Immunization Services Division, NCIRD
> g. Mark Pallansch, Director, Division of Viral Diseases, NCIRD
> h. Barbara Mahon, Director, Division of Bacterial Diseases, NCIRD
> i. Dr. Dan Jernigan, Director, Influenza Division, NCIRD
> j. Dr. Jonathan Mermin, Director, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP)
> k. Dr. Hazel Dean, Deputy Director, NCHHSTP
> l. Michael Melneck, Deputy Director, NCHHSTP
> m. Dr. Stephen Redd, Deputy Director for Public Health Service and Implementation Science
> Josh Bornstein, Acting Director, Center for Preparedness and Response (CPR)
> o. Michael Gerber, Acting Deputy Director, CPR
> p. M. Kathleen Glynn, Acting Deputy Director and Chief Medical Officer, CPR
> q. Lovisa Romanoff, Acting Deputy Director and Senior Advisor for Management and Operations, CPR
> r. Deb Lubar, Acting Director, Division of Emergency Operations, CPR
> s. Christine Kosmos, Director, Division of State and Local Readiness, CPR
> t. Joanna M. Prasher, Senior Advisor for Medical Countermeasures, Office of Public Health Preparedness and Response (PHPR).
>
> **External Parties:**

i. Employees of the U.S. Administration for Children and Families, including anyone communicating with an email address ending in @acf.hhs.gov.
ii. Employees of U.S. Customs and Border Patrol, including anyone communicating with an email address ending in @cbp.dhs.gov.
iii. Employees of U.S. Immigration and Customs Enforcement, including anyone communicating with an email address ending in @ice.dhs.gov.
iv. Employees of Texas Department of State Health Services, including anyone communicating with an email address ending in @dshs.texas.gov.
v. Employees of Correct Care Solutions, including anyone communicating with an email address ending in @correctcaresolutions.com.
vi. Employees of Wellpath, including anyone communicating with an email address ending in @wellpath.us.
vii. Employees of H.I.G. Capital, including anyone communicating with an email address ending in @higcapital.com.
viii. Employees of Correctional Medical Group Companies, Inc., including anyone communicating with an email address ending in @cmgcos.com.
ix. Employees of Armor Correctional Health Services, including anyone communicating with an email address ending in @armorcorrectional.com.
x. Employees of Corizon Correctional Healthcare, including anyone communicating with an email address ending in @corizonhealth.com.
xi. Employees of Wexford Health Sources, including anyone communicating with an email address ending in @wexfordhealth.com.
xii. Employees of NaphCare, Inc., including anyone communicating with an email address ending in @naphcare.com.
xiii. Employees of Centene Corporation, including anyone communicating with an email address ending in @centene.com.
Please provide all responsive records from September 1, 2018, through the date of the search."

We located 140 pages of responsive records (33 pages released in full, 6 pages released in part; 101 pages referred to other agencies). After a careful review of these pages, some information was withheld from release pursuant to 5 U.S.C. §552 Exemption (b)(5).

EXEMPTION 5

Exemption 5 protects inter-agency or intra-agency memorandums or letters which would not be available by law to a party other than an agency in litigation with the agency. Exemption 5 therefore incorporates the privileges that protect materials from discovery in litigation, including the deliberative process, attorney work-product, and attorney-client privileges. Information withheld under this exemption was protected under the deliberative process privilege. The deliberative process privilege protects the decision-making process of government agencies. The deliberative process privilege protects materials that are both predecisional and deliberative. The materials that have been withheld under the deliberative process privilege of Exemption 5 are both predecisional and deliberative, and do not contain or represent formal or informal agency policies or decisions. Examples of information withheld include meeting agenda and other preliminary material in draft form.

In addition, the search of CDC files produced records (two pages) that originated with the Department of Health and Human Services (HHS), and 99 pages that originated with the U.S. Department of Homeland Security (USDHS). These documents were referred to HHS and DHS for review and direct response to you. Contact information for the agencies is provided below:

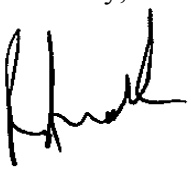
Michael Marquis, HHS FOIA Officer
FOIA Requester Service Center
FOI/PA Division, ASPA, OS
Room 221, Mary E. Switzer Building
330 C. Street, S.W.
Washington, DC 20201
Email: FOIARequest@hhs.gov

Jimmy Wolfrey
Acting Senior Director/FOIA Operations
U.S. Department of Homeland Security
The Privacy Office
245 Murray Lane SW
STOP-0655
Washington, D.C. 20528-0655
Email: foia@hq.dhs.gov

You may contact our FOIA Public Liaison at 770-488-6277 for any further assistance and to discuss any aspect of your request. Additionally, you may contact the Office of Government Information Services (OGIS) at the National Archives and Records Administration to inquire about the FOIA mediation services they offer. The contact information for OGIS is as follows: Office of Government Information Services, National Archives and Records Administration, 8601 Adelphi Road-OGIS, College Park, Maryland 20740-6001, e-mail at ogis@nara.gov; telephone at 202-741-5770; toll free at 1-877-684-6448; or facsimile at 202-741-5769.

If you are not satisfied with the response to this request, you may administratively appeal by writing to the Deputy Agency Chief FOIA Officer, Office of the Assistant Secretary for Public Affairs, U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, Suite 729H, Washington, D.C. 20201.You may also transmit your appeal via email to FOIARequest@psc.hhs.gov. Please mark both your appeal letter and envelope "FOIA Appeal." Your appeal must be postmarked or electronically transmitted by March 30, 2020.

Sincerely,



Roger Andoh
CDC/ATSDR FOIA Officer
Office of the Chief Operating Officer
Phone: (770) 488-6399
Fax: (404) 235-1852

Enclosures

#20-00057-FOIA

From: Messonnier, Nancy (CDC/DDID/NCIRD/OD)
Sent: 28 Dec 2018 10:16:47 -0500
To: Jernigan, Daniel B. (CDC/DDID/NCIRD/ID);Nordlund, Kristen (CDC/DDID/NCIRD/OD)
Subject: FW: Friday TODAY'S NEWS

Says flu b
CNN.com
Friday, December 28, 2018

Guatemalan boy who died in US custody had the flu, medical examiner says

By Carma Hassan and Ray Sanchez, CNN

(CNN)The 8-year-old Guatemalan migrant who died this week in the custody of US Customs and Border Protection had the flu, according to the New Mexico Office of the Medical Investigator.

An official cause of death for Felipe Gomez Alonzo has not yet been determined.

The boy, who was detained with his father, died shortly before midnight Christmas Eve at Gerald Champion Regional Medical Center in Alamogordo, New Mexico, about 90 miles north of the border crossing in El Paso, Texas.

An autopsy on the boy shows he tested positive for Influenza B, the medical examiner's office said Friday.

Influenza B is among the viruses that cause seasonal epidemics most winters in the United States, according to the US Centers for Disease Control and Prevention.

Felipe was taken to the hospital Monday after a border agent noticed signs of illness, and the medical staff first diagnosed him with a common cold and later detected a fever.

"The child was held for an additional 90 minutes for observation and then released from the hospital mid-afternoon on December 24 with prescriptions for amoxicillin and Ibuprofen," CBP said in a statement. Amoxicillin is a commonly prescribed antibiotic.

On Monday evening, the boy began vomiting and was taken back to the hospital for evaluation. He died hours later, the CBP said.

Felipe was the second Guatemalan child to die in US border patrol custody this month.

On December 8, Jakelin Caal Maquin, 7, died in a hospital two days after she was taken to a Border Patrol station.

CNN's Jamie Gumbrecht contributed to this report

-----Original Message-----
From: Mike Cooper <mcooper@panix.com>

Sent: Friday, December 28, 2018 9:23 AM
To: cdc@panix.com
Subject: Friday TODAY'S NEWS

TODAY'S NEWS

FRIDAY, DECEMBER 28, 2018

Health Care-Associated C Diff Rates Similar in 2011 and 2015, ContagionLive.com

Missed Opportunities to Prescribe PrEP Highlight the Need to Ask the Right Questions, ContagionLive.com

Guatemalan boy who died in US custody had the flu, medical examiner says; CNN.com

Man brought son, who died, to aid entry into U.S.; Washington Post

Two children have died in US border custody this month. Before that, none in a decade. Why now?; USAToday.com

Border Patrol beefs up medical checks on children, Albuquerque Journal

CDC: Marburg virus found in West Africa for first time; Healio.com

Effects of federal shutdown hit Triad, Greensboro News & Record

State reports activity of influenza widespread, Boston Globe

3rd case of polio-like disease confirmed in Massachusetts, more suspected; MassLive.com

Salmonella outbreak in turkey `might be widespread' in Canada and the U.S., officials warn; Global News

9/11-related cancers killed 15 police officers in 2018, CBSNews.com

U.S. turns to military, medical research to solve diplomats' 'health attacks'; NBCNews.com

People to Watch: 'Iowa's doctor' will offer calm guidance when pestilence is on the prowl; Des Moines Register

Fentanyl leaves a lethal mess that's costly and complicated to clean up, WashingtonTimes.com

A Worrying Rise in Gun Suicides, Bloomberg

ContagionLive.com
Thursday, December 27, 2018

Health Care-Associated C Diff Rates Similar in 2011 and 2015

RACHEL LUTZ

Health care-associated infection rates were lower in 2015 than 2011, though Clostridium difficile (C diff) infections remained relatively stable, according to recent findings published in The New England

Journal of Medicine.

Investigators from the US Centers for Disease Control and Prevention updated their original 2011 study in order to assess changes in the prevalence of these health care-associated infections. They noted there was national attention on these types of infections then and now. Back in 2011, their analysis showed that 4% of hospitalized patients had a health care-associated infection.

This time, the study authors recruited as many as 25 hospitals in Emerging Infections Program sites in 10 states. They prioritized locales that participated in the 2011 study. The hospitals chose 1 day that a selection of patients would be identified for their assessment and on that day, staff reviewed medical records using the 2011 definitions of infections.

There were 12,299 patients at 199 hospitals included in the 2015 investigation, compared to 11,282 patients from 183 hospitals in 2011. Primarily, the investigators found that fewer patients had health care-associated infections in 2015 than 2011: 394 patients in 2015 compared to 452 in 2011.

"It was interesting to see that the reduction in the prevalence of health care-associated infections between the 2011 and 2015 surveys appeared to have been due largely to reductions in urinary tract infections and surgical site infections, whereas we did not see significant changes in the prevalence of pneumonia or C diff infections," the study's first author Shelley S. Magill, MD, PhD, told MD Magazine(R).

The most common health care-associated infections the researchers observed were pneumonia and gastrointestinal infections; the majority of GI infections were due to C diff, the study authors wrote.

C diff accounted for 61 infections in 61 patients in the 2011 study, while it made up 66 infections in 66 patients in 2015, which the investigators reported and called "stable." C diff was also the top pathogen in 2015, the researchers learned. Some of the other health care associated pathogens included Staphylococcus aureus, Escherichia coli, Streptococcus species, which each represented 10% or more of all health care associated infections.

They did note, however, that they used the same definition for the infection in the 2011 and 2015 studies and did not take into account changes in testing and/or diagnosis.

"Regardless of whether changes in testing have inflated our estimate of the burden of C diff infection in hospitals, there is room for improvement," they wrote.

They also said that in order to make progress in prevention of pneumonia, C diff, and any other health care-associated infections, strategies should be augmented.

"There was no significant reduction in the prevalence of pneumonia or C diff infection, nor in the percentage of patients with health

care-associated infection who died during their hospitalization, which suggests that more work is needed to prevent these infection types and reduce mortality among patients with health care associated infections," the study authors wrote.

A patient's risk for acquiring a health care-related infection dropped by 16% in 2015 compared to 2011, the analysis showed after being adjusted for age, presence of devices, days from admission to time of survey, and status of being in a large hospital setting.

"These findings are important for physicians because they suggest that prevention efforts for certain infection types in hospitals may be working, and they also suggest areas where more attention is needed," Magill continued. "We are seeing improvements, but there is much work to be done. For example, physicians can help prevent C diff infections in hospital patients through infection control measures to prevent transmission and also through antimicrobial stewardship."

An earlier version of this article, "Health Care-Associated C Difficile Rates Similar in 2011 and 2015," was published on MD Magazine.com.

ContagionLive.com
Thursday, December 27, 2018

Missed Opportunities to Prescribe PrEP Highlight the Need to Ask the Right Questions

LAURIE SALOMAN, MS

Pre-exposure prophylaxis, or PrEP, is a revolutionary development that has proven quite effective in reducing HIV transmission rates in vulnerable populations. However, PrEP only works if it's prescribed and taken as directed. A recent study out of South Carolina highlights numerous missed opportunities for clinicians to connect patients with PrEP.

A team at the US Centers for Disease Control and Prevention and the University of South Carolina School of Medicine in Columbia examined data on 885 patients in South Carolina who were diagnosed with HIV from 2013 through 2016. Only patients with CD4 T cell counts of at least 500 were included in the study, and all were at least 13 years old. Most were African-American (73%), male (72%), and between ages 13 and 29 (51%). More than half (56%) were men who had sex with men.

An analysis of the study participants revealed that 586 of them, or 66%, had seen a doctor, nurse, or other health care practitioner at least once before their HIV diagnosis. In fact, the average participant had made 6.9 health care visits before then. Most (84%) were trips to the emergency room, where 61% of participants spoke to a provider trained in emergency medicine. Just 1 out of 10 visits were to primary care providers. More than 4 in 10 participants (42%) had no insurance or paid out of pocket, while 36% had government-provided insurance. Just 18% had commercial insurance.

The participants' health complaints during these medical visits ranged from tobacco and nicotine dependence and hypertension to headache, anxiety, and depression, among other maladies. A significant percentage (29%) were found to have gonorrhea, syphilis, or chlamydia at one of these visits. Having a sexually transmitted disease is a known risk factor for acquiring HIV. Yet it appears that providers often failed to suggest PrEP to these patients, according to a retrospective analysis of the study's participants and their subsequent HIV diagnoses.

The factors most associated with missed opportunities for PrEP were patients being female, black, and younger than 30 years old; however, investigators caution against drawing too many conclusions from the demographics of these patients. The reason that young, black, and female patients were disproportionately represented in this group is that they were more likely than other participants to visit health care providers in the first place, Sharon Weissman, MD, an infectious disease specialist and clinical professor of medicine at the University of South Carolina School of Medicine, and an author of the study, told Contagion(R). Because health complaints at these visits reflected a wide range of conditions, it was not always apparent that participants were at risk of contracting HIV. Dr. Weissman feels that health care providers should have dug a little deeper: "[I]f we don't ask the right questions, we don't get the right answers."

South Carolina, like some of its neighbors in the south, lags behind states in other parts of the country when it comes to progress made on the HIV front. "[Residents] certainly have lower rates of use of PrEP and higher rates of HIV," Dr. Weissman said. "The problem with the HIV rates in South Carolina probably speak to lower rates of insurance in South Carolina. We have not had Medicaid expansion. We have fewer providers per [capita]." Dr. Weissman also mentioned homophobia, the role of religion, wealth disparities, and the long history of racism in the area as contributing to the problem.

The good news is that several public health interventions have been implemented since this study that are creating more awareness around PrEP, according to Dr. Weissman. Now, she and other HIV experts would like to see PrEP publicized and funded in the same way the Ryan White HIV/AIDS Program offers primary care and support for people in the United States who are already living with these diseases. "We have a huge population of at-risk [HIV] negative [people]," she concluded.

CNN.com
Friday, December 28, 2018

Guatemalan boy who died in US custody had the flu, medical examiner says

By Carma Hassan and Ray Sanchez, CNN

(CNN)The 8-year-old Guatemalan migrant who died this week in the custody of US Customs and Border Protection had the flu, according to the New Mexico Office of the Medical Investigator.

An official cause of death for Felipe Gomez Alonzo has not yet been

determined.

The boy, who was detained with his father, died shortly before midnight Christmas Eve at Gerald Champion Regional Medical Center in Alamogordo, New Mexico, about 90 miles north of the border crossing in El Paso, Texas.

An autopsy on the boy shows he tested positive for Influenza B, the medical examiner's office said Friday.

Influenza B is among the viruses that cause seasonal epidemics most winters in the United States, according to the US Centers for Disease Control and Prevention.

Felipe was taken to the hospital Monday after a border agent noticed signs of illness, and the medical staff first diagnosed him with a common cold and later detected a fever.

"The child was held for an additional 90 minutes for observation and then released from the hospital mid-afternoon on December 24 with prescriptions for amoxicillin and Ibuprofen," CBP said in a statement. Amoxicillin is a commonly prescribed antibiotic.

On Monday evening, the boy began vomiting and was taken back to the hospital for evaluation. He died hours later, the CBP said.

Felipe was the second Guatemalan child to die in US border patrol custody this month.

On December 8, Jakelin Caal Maquin, 7, died in a hospital two days after she was taken to a Border Patrol station.

CNN's Jamie Gumbrecht contributed to this report

Washington Post
Friday, December 28, 2018, page A2

Man brought son, who died, to aid entry into U.S.

Critics say immigration policies are endangering migrant children

By Maria Sacchetti

Word spread through the impoverished village in the western highlands of Guatemala: Migrants traveling with a child are likely to make it past the Border Patrol and into the United States.

Agustin Gomez Perez was 47 and in debt, and that path would only deepen his obligations. But like others in the rural farming village of Yalambojoch, he decided that traveling with a child was the only way out.

He and his wife chose 8-year-old Felipe Gomez Alonzo for the journey because he was one of three sons, and the couple had only one daughter

together.

Felipe was eager to go, an older stepsister who also lived with them said in a phone interview Thursday. He was excited to attend school, find a new home and buy clothes for his siblings. He also wanted a new bicycle, like a boy in the village purchased with money sent after his father went to work in the United States.

"It was his dream," said the sister, Catarina Gomez Lucas, 21.

Father and son ended up in a holding cell in Alamogordo, N.M., on Christmas Eve after days of being shuttled from one Border Patrol facility to another. They expected that the U.S. government was about to release them to await a deportation hearing, just as the smugglers had promised.

Instead, the little boy vomited and spiked a fever. He died at a New Mexico hospital, the second child fatality in U.S. immigration custody in under a month.

The deaths have triggered finger-pointing between the White House and Democrats over border security, and allegations that the Trump administration is endangering migrant children by detaining them for days in cells meant as way stations for adults.

Federal officials say they must screen migrants before releasing them, and have been overwhelmed by a record surge of adults crossing with children.

The Department of Homeland Security has launched investigations of the deaths of Felipe and 7-year-old Jakelin Caal, expanded health screenings for detained children and asked the Centers for Disease Control and Prevention to examine why more migrants appear to be getting sick.

Homeland Security Secretary Kirstjen Nielsen will travel to El Paso and Yuma on Friday and Saturday to inspect border stations.

Late Thursday, leading House Democrats called on DHS to preserve "all evidence" related to the deaths, and vowed to conduct hearings after Democrats take control of the House next week.

Smugglers often charge less than half the price if a child goes along, knowing that migrants can turn themselves in to border agents and will soon be released.

In villages such as Felipe's, the price can be hard to resist.

The boy lived in a one-room house in a rural farming area with Gomez Perez and his second wife, Catarina Alonzo, 32, who speaks only the Mayan language Chuj.

Felipe was a smart and inquisitive boy who loved to read, count, and play soccer, his sister said. His father was a farmworker who earned less than $5 a day. Felipe sometimes pulled on his rubber boots and

joined him in the fields planting corn and beans.

Gomez Perez was in debt from a long-unpaid electric bill and other expenses. Add in the smuggler's fee, and he owed more than $6,500. He expected that he'd pay it off after working in the United States.

He left Guatemala with Felipe about two weeks ago and reported that they were fine on the journey through Mexico, Gomez Lucas said. Homeland Security officials also said Felipe initially appeared to be well. But on the sixth day in custody, he fell ill.

His sister said her father told her in phone calls from immigration custody that Felipe had been playing that morning when he said his tummy hurt.

"Don't get sick on me," she said her father told him gently. "We have just a few days left."

"I'm not going to die, papa," she said Felipe told him.

"My father doesn't know what happened," Gomez Lucas said. "He was well. He was happy. He was playing."

Border Patrol officials took Felipe to the hospital. His fever was 103 degrees. Doctors placed him under observation for 90 minutes, gave him ibuprofen and the antibiotic amoxicillin, and sent him back to federal custody.

They'd been held twice the amount of time the agency's detention standards recommended.

About 7 p.m., while they were being held at a highway checkpoint on Route 70, Felipe vomited, officials said. U.S. officials said his father declined medical assistance because the child had been feeling better.

Gomez Lucas said her father told her Felipe had vomited blood and it trickled out of his nose, which DHS wouldn't confirm. She said their father barely has a grade school education and speaks Chuj better than Spanish.

At 10 p.m., Homeland Security officials said, Felipe appeared lethargic and nauseated, so the agents took him back to the hospital.

Gomez Lucas said her father told her Felipe suddenly worsened. His "stomach hurt, that he couldn't breathe."

"My father started to cry," she said, recalling his words. "It can't be. Don't abandon me here. We have a dream to fulfill."

He was not allowed to inform the family of the boy's death until Dec. 26, Gomez Lucas said. DHS denied that account.

She said the family would ask the U.S. government for two things: Return Felipe's body so that they can bury him in Guatemala, and let his father work in the United States so that "my brother's death won't

be in vain."

"All we want are those things," she said. "We have nothing."

USAToday.com
Thursday, December 27, 2018

Two children have died in US border custody this month. Before that, none in a decade. Why now?

Doug Stanglin
USA TODAY

On Christmas Eve, an 8-year-old Guatemalan boy who suffered a cough, vomiting and fever died in U.S. custody at a New Mexico hospital. The boy, identified by Guatemalan officials as Felipe Gomez Alonzo, was the second child in three weeks to die while being detained near the U.S.-Mexico border by U.S. authorities.

Jakelin Caal, 7, also Guatemalan, died Dec. 8. at an El Paso children's hospital after being detained with her father and while preparing to travel by bus to a Border Patrol station in New Mexico.

The back-to-back deaths prompted an outcry from immigration activists, politicians and human rights groups and raised questions about the Trump administration policies that have separated children and parents and filled detention centers.

How did they die?

Felipe, along with his father, had been detained for a week after trying to cross the border illegally near El Paso on Dec. 18. Because of "capacity levels" in El Paso, they were moved to the Border Patrol station at Alamogordo, New Mexico, two days later, the CBP said. The next day, Felipe was sent to a hospital after a border agent noticed Felipe was coughing and had "glossy eyes," the CBP said.

After being diagnosed with a cold and a fever, Felipe was prescribed amoxicillin and Ibuprofen. The CBP said he was held 90 minutes for observation and released Monday afternoon. That evening, he was sent back to the hospital with nausea and vomiting and died hours later.

Jakelin died two days after a grueling trip through the desert with her father along with 161 other migrants who had crossed the New Mexico border illegally. They were initially taken to a base in rural New Mexico that did not have running water, according to Democrats who visited it after the girl's death.

Jakelin and her father were scheduled to travel by bus to a Border Patrol station in New Mexico when her father, Nery Gilberto Caal, told Border Patrol agents she was sick. She was taken to a children's hospital in El Paso where she died.

Are such deaths in U.S. custody common?

Kevin McAleenan, commissioner of Customs and Border Protection, tells "CBS This Morning" that the latest death is a "tragic loss" but also a "rare occurrence."

"It's been more than a decade that we've had a child pass away anywhere in a CBP process so this is just devastating for us," he says. "We've got over 1,500 emergency medical technicians that have been co-trained as law enforcement officers. They work every day to protect people that come into our custody."

Secretary of Homeland Security Kirstjen Nielsen said six people have died while in Border Patrol custody during Fiscal Year 2018, which ended in September, but that none were children.

Nielsen's statistics were provided five days after her testimony before the House Judiciary Committee in which she was unable to say how many people had died in Department of Homeland Security custody.

"I don't have an exact figure for you," Nielsen replied to a question by Rep. David Cicilline, D-R.I.

Pressed again whether she had even a rough idea of many people had died in her department's custody, she said, "I will get back to you with the number."

Why are there suddenly two deaths this month?

Rep. Joaquin Castro, of Texas, said many questions remain unanswered regarding the deaths, but noted the "lack of adequate medical supplies, equipment and resources" at CBP detention facilities to treat migrants and the agents working there.

Castro also suggested that many more migrants were taking more dangerous paths into the country because of the Trump administration's policy of turning asylum-seekers away from legal ports of entry. This policy, he said, was "putting families and children in great danger."

Nielsen, in a statement on Tuesday, blamed an immigration system that has been "pushed to the breaking point by those who seek open borders," including smugglers, traffickers "and their own parents who put these minors at risk by embarking on the dangerous and arduous journey north."

She said the Border Patrol has detailed 139,817 migrants on the Southwest border in the past two months, compared to 74,946 for the same period last year. These include 68,510 family units and 13,981 unaccompanied children.

"Given the remote locations of their illegal crossing and the lack of resources, it is even more difficult for our personnel to be first responders," Nielsen said.

McAleenan, the CBP commissioner, says Border Patrol stations "are not built for that group that's crossing today."

"They were built 30 to 40 years ago for single adult males, and we need a different approach," he tells CBS. "We need help from Congress. We need to budget for medical care and mental health care for children in our facilities."

Children who arrive unaccompanied by a parent are supposed to go to longer-term facilities operated by the U.S. Department of Health and Human Services. But HHS' system is also strained. The Associated Press reported this month that 14,300 children were being detained by HHS, most in facilities with more than 100 kids.

Homeland Security's inspector general examined nine CBP holding facilities earlier this year. In a September report, the IG said that the facilities complied with CBP standards and that people had access to food and water, toilets and sinks, and hygiene items - with "the exception of inconsistent cleanliness of the hold rooms."

Just three of the nine facilities had "trained medical staff to conduct medical screening and provide basic medical care," the report said. Showers were available for unaccompanied children at only four facilities.

How has the administration responded to the latest deaths?

Nielsen ordered that all children in Border Patrol custody undergo a thorough, secondary medical screening and that in the future "all children will receive a more thorough hands on assessment at the earliest possible time post apprehension - whether or not the accompanying adult has asked for one."

She said she has asked the Centers for Disease Control and Prevention to send experts to investigate the rise in sick children crossing the borders and to identify additional steps hospitals along the border should take to prepare for and to treat them.

In addition, Nielsen said she has asked the U.S. Coast Guard Medical Corps to assess CBP's medical programs and recommend appropriate improvements. She also sought assistance from the Department of Defense, the Federal Emergency Management Agency and the Department of Health and Human Services.

Customs and Border Protection, which did not notify Congress about Jakelin's death for days, said it would follow new procedures when someone dies in its custody. The procedures include notifying lawmakers within 24 hours of any death.

Contributing: Lindsay Schnell and Kevin McCoy, USA TODAY; The Associated Press

Albuquerque (N.M.) Journal
Thursday, December 27, 2018, page A1

Border Patrol beefs up medical checks on children

Centers for Disease Control to probe rise in sick young migrants

BY ANGELA KOCHERGA
JOURNAL STAFF WRITER

EL PASO -- The Border Patrol is performing medical checks on all children in custody, with an emphasis on those younger than 10 years old after the death of a second migrant child in New Mexico.

Secretary of Homeland Security Kirstjen Nielsen announced the new measures in "response to the unprecedented surge in children in our custody" in a statement released Wednesday.

"I have personally engaged with the Centers for Disease Control to request that their experts investigate the uptick in sick children crossing our borders and identify additional steps hospitals along the border should be undertaking to prepare for and to treat these children," Nielsen said.

Additionally, she said the U.S. Coast Guard Medical Corps will provide an assessment of Customs and Border Protection's medical programs and make appropriate recommendations for improvements.

The new measures were put in place after the death of an 8-year-old boy in Alamogordo on Christmas Eve.

Felipe Alonzo Gomez and his father were in temporary holding cells at the Border Patrol U.S. 70 checkpoint in Alamogordo when the boy became deathly ill on Christmas Eve.

"The child and his father were transferred because of capacity levels at the El Paso Station," according to a timeline provided by CBP.

The timeline also lists numerous "welfare checks" by Border Patrol agents, which are defined as an "agent directly observes all detainees are safe and secure, and attends to any issues observed or relayed by those detained," according to CBP.

There were multiple welfare checks from Dec. 18, when the father and son were taken into custody in El Paso, to Christmas Eve, when the child received treatment, reportedly for a cold, at the Gerald Champion Regional Medical Center.

The hospital released the boy back to the holding facility with a fever of 103 degrees that evening, prescribing an antibiotic and ibuprofen.

At 7 p.m., according to CBP, the child appeared to be nauseated and vomited. Agents helped clean up the vomit, and his father declined further medical assistance.

But when the boy's condition deteriorated in the holding facility, Border Patrol agents took the child back to the hospital, where he died.

The Office of the Medical Investigator in Albuquerque will perform an autopsy.

"These detention facilities are no place for children," said Cynthia Pompa, advocacy manager for the ACLU Border Rights Center. "The fact remains that there is no way to humanely detain children; the agency should seek proven alternatives to detention models to minimize the time any child remains in their custody," Pompa said in a statement released Wednesday.

Congresswoman and New Mexico Gov.-elect Michelle Lujan Grisham said Wednesday that she is examining how the state can help protect families and children arriving at the border and taken into custody.

"States are going to have to step up," she told reporters in Albuquerque. "People need to be held accountable."

Lujan Grisham, a Democrat who takes office as governor on Tuesday, said she is looking into the state's licensing and oversight authority. "We must protect these children," she said.

Federal agents, she said, are failing to adequately assess the health care needs of people they take into custody.

"Those individual agents should be held personally liable for these kids," Lujan Grisham said.

The boy's father remained at the Alamogordo station pending transfer to Immigration and Customs Enforcement. The man and his young son had turned themselves in to Border Patrol agents a week before Christmas after crossing the border illegally in El Paso about three miles west of the Paso del Norte international bridge.

Officials did not say whether the father and son were seeking asylum, like the vast majority of Central Americans showing up at the border.

"The Administration's policy of turning people away from legal ports of entry, otherwise known as metering, is putting families and children in great danger. We learned this firsthand last week during our Congressional oversight trip to Lordsburg Station," said U.S. Rep. Joaquin Castro, D-Texas, said in a statement released after the boy's death.

Castro, chairman-elect of the Congressional Hispanic Caucus, led a delegation that toured Border Patrol facilities in New Mexico after the death of Jakelin Caal Maquin, a 7-year-old Guatemalan girl who died in Border Patrol custody Dec. 8.

After the second child's death, CBP said it was considering "options for surge medical assistance from interagency partners" including the Coast Guard, the Department of Defense, the Federal Emergency Management Agency and Health and Human Services. CBP is also "reviewing all available custody options to relieve capacity issues at Border Patrol stations and checkpoints in the El Paso sector," which includes all of New Mexico, according to CBP.

Migrant shelters on both sides of the border are coping with an influx of asylum seekers. This week, ICE released hundreds of families onto

the streets of El Paso near the Greyhound bus station.

Most migrants stay on the border briefly until relatives elsewhere in the country send them bus tickets. Adult asylum seekers are usually set free wearing ankle tracking devices with orders to appear for court hearings.

Annunciation House, which works to provide temporary shelter for migrants and refugees with help from churches in El Paso and Las Cruces, is struggling to find space for Central American parents and kids as temperatures drop and rain is forecast in the region.

The Trump administration said last week that it reached an agreement with Mexico for Central American asylum applicants to "remain in Mexico" until they appear before an immigration judge who decides their case.

Across the border in Ciudad Juarez, Casa del Migrante has stopped accepting new arrivals. The migrant shelter affiliated with the Catholic Diocese of Ciudad Juarez can house up to 1,500 but is "struggling to feed" the 400 who remain at the facility, Rosa Maria Parra, a shelter worker, said Wednesday.

Healio.com
Thursday, December 27, 2018

CDC: Marburg virus found in West Africa for first time

Live Marburg virus was discovered in fruit bats in Sierra Leone, the first time the deadly Ebola-like virus has been found in West Africa, the CDC reported.

According to the agency, five Egyptian rousette fruit bats -- the natural reservoir for Marburg -- tested positive for active infection. The bats were discovered through two projects that were started in 2016 following the Ebola epidemic in West Africa, including one led by the CDC. They came from the health districts of Moyamba, Koinaduga, and Kono.

"We have known for a long time that rousette bats, which carry Marburg virus in other parts of Africa, also live in West Africa. So it's not surprising that we'd find the virus in bats there," CDC ecologist Jonathan Towner, PhD, said in a news release.

Samples from the bats showed multiple genetically diverse strains, suggesting that the virus has been present in Sierra Leone bat colonies

for years, the CDC said. Although no human cases have been reported in Sierra Leone, the virus' presence in bats means people are at risk. People can be exposed through bites or by eating fruit that is contaminated by bat feces, urine, or saliva.

"This discovery is an excellent example of how our work can identify a threat and help us warn people of the risk before they get sick,"

Towner said.

At present, there is no vaccine for the Marburg virus but some are being tested, including a phase 1 trial of a vaccine candidate at the Walter Reed Army Institute of Research.

Marburg, like Ebola, can cause severe hemorrhagic fever. Outbreaks have resulted in case fatality rates between 24% and 88%, according to WHO. - by Erin Michael

Greensboro (N.C.) News & Record
Friday, December 28, 2018, page 1A

Effects of federal shutdown hit Triad

By Richard Craver
BH Media

The local ripple effect from the partial federal government shutdown is following a similar path as the last major shutdown, which lasted 16 days, in October 2013.

Nutrition programs and housing are bearing most of the weight at this point.

Gov. Roy Cooper has expressed concerns about the shutdown's effect on federal child nutrition programs administered by the U.S. Department of Agriculture. CNN reported that 95 percent of the department's staff was on furlough as of Wednesday.

That directly affects the USDA's Office of Food and Nutrition Services, which oversees child nutrition programs; Supplemental Nutrition Assistance Program, formerly known as food stamps; and the Special Supplemental Nutrition Program for Women, Infants and Children.

Eligible households would receive monthly SNAP benefits for January. Child nutrition programs, including those for public school breakfast and lunch, have enough funding to continue through February.

However, for potential homeowners applying for a USDA home loan - typically those wanting or needing 100 percent financing - there's likely to be no movement until the shutdown ends. The department is required to directly underwrite mortgages before a loan can be closed through its rural housing programs.

Purchasing a home is again proving to be a bumpy but navigable ride for most potential buyers, though demand may be diminished because of recent increases in interest and mortgage rates.

The U.S. Department of Housing and Urban Development is maintaining certain functions, such as fulfilling payment and contract obligations associated with project-based rental assistance programs. HUD's regional office directors are operating on an "as needed" basis.

As for the for the Housing Authority of Winston-Salem, which receives HUD money, "HAWS is currently unaffected, but we will, of course, be monitoring the shutdown closely to see how the situation progresses and taking appropriate action as needed," said Gwen Burston, the local agency's public relations director.

Loans made through the Federal Housing Administration, U.S. Department of Veterans Affairs, Fannie Mae and Freddie Mac can move forward despite the shutdown.

However, the loans may not be completed because the IRS, where about 52,000 staffers are on furlough, cannot provide key tax return transcripts and income verification information. Although the FHA and VA do not require the transcripts, relying on W-2 and 1099 forms and pay stubs, more lenders are requiring the forms as part of tighter application standards.

The U.S. Small Business Administration can continue to back existing loans in its portfolio, but it cannot initiate new loan guarantees. The U.S. State Department is not able to process passport requests.

On the health care side, the U.S. Food and Drug Administration also is operating on an as-needed basis, particularly "activities necessary to address imminent threats to the safety of human life and activities funded by carryover user fee funds."

However, about 41 percent of FDA staff was furloughed as of Wednesday, as was 65 percent of the staff of the U.S. Centers for Disease Control and Prevention, according to CNN.

For most of its parks, the National Park Service won't provide any visitor services, such as restrooms, trash collection or maintenance. In Greensboro, Guilford Courthouse National Military Park is closed, according to the park's website.

Portions of the Blue Ridge Parkway have visitor facilities closed or being operated by concessionaires. To find out what is open or closed, go to the parkway's "Road and Facilities" webpage at www.nps.gov/blri.

Local Veterans Administration operations, including at the hospitals in Kernersville and Salisbury, are unaffected by the shutdown because the VA has already been fully funded for fiscal 2018-19.

Several federal lawsuits and court cases have either been stayed or suspended because of the shutdown.

For example, the Equal Employment Opportunity Commission has filed a motion for a stay in its lawsuit against an affiliate of Ashley Furniture Industries involving its Advance distribution operations.

The EEOC sued in April on behalf of Farrell Welch, who claims he was turned down for a truck driver position at the Advance plant "because the company regarded him as disabled."

The EEOC seeks back pay, compensatory damages and punitive damages, as well as injunctive relief. The agency said it filed the lawsuit after

failing to reach a settlement with the company.

Ashley has filed a motion for dismissal of the lawsuit.

Richard Craver is a reporter for the Winston-Salem Journal. Contact him at rcraver@wsjournal.com or 336-727-7376.

Boston Globe
Friday, December 28, 2018, page B5

State reports activity of influenza widespread

By Andres Picon
Globe Correspondent

Massachusetts was one of six states that by mid-December reported "widespread" influenza activity, which is the highest level of flu activity designated by the Centers for Disease Control and Prevention.

But cases of influenza-like illness don't seem to be above normal this year, according to Paul Sax, clinical director of the Division of Infectious Diseases at Brigham and Women's Hospital.

"We always see some region-to-region variation, but typically they'll catch up with each other," said Larry Madoff, director of the Division of Epidemiology and Immunization at the state's Department of Public Health. "We're tracking pretty much on par with other seasons."

The beginning of the holiday season tends to be the start of flu season, state health officials said, adding that it's not too late to get a flu shot.

"The flu season is underway," said Madoff. "We are seeing the flu, and we expect it to get worse, as it usually does."

The contagious respiratory illness, known for its debilitating body aches, fever, and cold symptoms, is more likely to affect people with weakened immune systems, such as young children and the elderly, according to the CDC.

Another common wintertime illness is a respiratory syncytial virus, or RSV, which, until recently, was often mistaken for the flu. Known for causing congestion, coughing, and fever, RSV affects mainly infants and can lead to more severe infections, such as bronchiolitis, according to the CDC.

There is no vaccine or effective treatment yet for RSV, but scientists are working on developing one, Sax said.

The strain of flu virus that circulates varies from year to year. The predominant strain this year seems to be H1N1, and the vaccine is expected to be effective, Madoff said.

Public health officials are urging everyone to get vaccinated in an

attempt to limit the spread of the virus, which has already killed seven children in the United States this season, according to the CDC.

"The flu vaccine is much safer than getting the flu," Madoff said.

Many people don't get vaccinated because they think the vaccine can give them the flu, but that's not the case, Sax said. The vaccine is made with an inactivated strain of the virus.

There are no flu vaccine shortages this year as there are for the shingles vaccine, and flu season doesn't usually peak until late January or early February, Madoff said.

MassLive.com
Thursday, December 27, 2018

3rd case of polio-like disease confirmed in Massachusetts, more suspected

By Anne-Gerard Flynn
agflynn413@gmail.com
Special to The Republican

The number of confirmed cases of acute flaccid myelitis, a rare polio-like disease, has increased by one in Massachusetts while cases under investigation have increased by two.

According to the Massachusetts Department of Public Health, there are now "3 confirmed, 1 probable and 5 suspect cases of AFM in Massachusetts."

The Centers for Disease Control and Prevention weekly report on the emerging disease indicates there are currently 182 confirmed cases of AFM in 38 states as well as in New York City to date this year among a total of 336 reports that the CDC has received of patients under investigation for AFM as of Dec. 21.

States reporting their first confirmed cases as of Dec. 21 include Florida and South Dakota. States with no confirmed cases to date this year include Alaska, Connecticut, Delaware, Hawaii, Idaho, Maine, New Hampshire, Oregon, Tennessee, Utah, Vermont and West Virginia as well as the District of Columbia.

Although a rare condition, the CDC began to release weekly reports in October of patients under investigation for AFM after noting an increase starting in August as certain seasonal viruses begin to circulate.

At that time, Massachusetts had two confirmed cases and four suspected cases, with the CDC reporting 62 confirmed cases in 22 states as of Oct. 17.

There is no specific clinical management for the disease that involves the expertise of both infectious disease specialists and neurologists, and it can take the CDC a few weeks to classify and confirm suspected

cases sent by state health departments.

AFM is defined by the Council of State and Territorial Epidemiologists as a "rare and very serious condition that affects the nervous system causing weakness in the arms or legs and is, in some instances, also associated with long-term disability."

The disease, which is seen mainly in children, has been compared to poliomyelitis because its symptoms can include limb paralysis, though the CDC has said no confirmed cases have yet to test positive for the polio virus.

It can be diagnosed through spinal cord fluid and an MRI, but no single pathogen or specific inflammatory process has been identified yet as the cause of AFM. Evidence of a virus, the CDC has said, has been more often found in respiratory and stool samples than in spinal fluid.

The CDC has detected coxsackievirus A16, EV-A71 and EV-D68 in the spinal fluid of four of 508 confirmed cases of AFM since 2014, when it began tracking the disease. For all other patients, the CDC has said, no pathogen has been detected in their spinal fluid to confirm a cause.

The onset of AFM sometimes presents first as a respiratory condition and then progresses to muscle weakness, including facial droop or weakness. Parents are urged to contact their health care provider if they notice such symptoms.

Global News (Canada)
Thursday, December 27, 2018

Salmonella outbreak in turkey `might be widespread' in Canada and the U.S., officials warn

By Josh K. Elliott National Online Journalist, International Global News

Health officials in Canada and the U.S. are looking into an ongoing and potentially wide-ranging outbreak of salmonella affecting raw turkey and chicken products.

The bacteria can infect individuals who handle raw meat or eat undercooked turkey or chicken.

The Public Health Agency of Canada (PHAC) says one person has died and another 21 have been infected by one strain of salmonella bacteria since April 2017. Nine of the cases occurred in October, around Canadian Thanksgiving.

The U.S. Centers for Disease Control and Prevention (CDC) says the salmonella in Canada has the "same DNA fingerprint" as a strain that has affected at least 216 individuals in 38 U.S. states. One American has died so far.

The CDC says the salmonella bacteria is resistant to multiple

antibiotics, although not ones normally used to treat the infection.

"The resistance likely will not affect the choice of antibiotic used to treat most people," a CDC spokesperson told Global News.

Patients reported eating different types and brands of turkey, the CDC said in a public notice on Dec. 21. No single source of the salmonella-infected turkey has been identified.

The Canadian Food Inspection Agency (CFIA) has not issued any recalls but continues to investigate the situation.

The U.S. Department of Agriculture has recalled approximately 116,000 kilograms of Jennie-O-brand turkey since Nov. 15 in connection with the outbreak. However, the CDC says the Jennie-O turkeys do not account for the whole outbreak.

"Based on the investigation findings to date, exposure to raw turkey and raw chicken products has been identified as the likely source of the outbreak," the PHAC said in a public notice issued Dec. 21.

The PHAC says the recalled American turkey products were not imported into Canada. The agency has also vowed to issue food recall warnings whenever an infected Canadian product is identified.

Most of the Canadian cases have occurred out west, with nine cases confirmed in British Columbia, seven in Alberta and five in Manitoba. One case was also identified in New Brunswick.

Salmonella can infect anyone, but it is particularly dangerous for the very young or old. Symptoms typically occur within six to 72 hours and include fever, chills, diarrhea, nausea, headaches and vomiting. These symptoms usually last four to seven days, according to the PHAC.

The infection usually clears up without treatment, but more severe cases might require antibiotics.

The PHAC says cooking a whole turkey or chicken to an internal temperature of 82 C will kill off any potentially harmful bacteria. Leftovers, burgers and ground meat should be cooked to an internal temperature of 74 C to avoid contamination.

Individuals should wash their hands with soap and water before and after handling raw turkey or chicken.

"This outbreak is a reminder that raw turkey products can have germs that spread around food preparation areas and can make you sick," the CDC says.

CBSNews.com
Thursday, December 27, 2018

9/11-related cancers killed 15 police officers in 2018

By Kate Smith

Fifteen police officers died in 2018 from cancers related to the terrorist attack on the World Trade Center on September 11, 2001, according to a new report. The 9/11-related deaths were part of an overall uptick in fatalities among law enforcement officers this year.

Police officer deaths nationwide increased by 12 percent this year, climbing to 144 fatalities as of December 27, up from 129 in 2017, according to the National Law Enforcement Officers Memorial's annual fatalities report. Firearms were the leading cause of death in the line of duty, claiming the lives of 52 officers, a 13 percent increase from 2017, according to the report. The most recent addition to that list, Cpl. Ronil Singh of Newman, Calif., was shot and killed at a traffic stop Wednesday.

Another 50 officers were killed in traffic-related incidents in the line of duty.

The report also detailed the growing toll of cancer-causing toxins present during the search and recovery effort at Ground Zero after the 9/11 attacks. These illnesses were responsible for 15 police officer deaths in 2018, a four-fold increase from the year before, according to the report. Nearly 10,000 people have suffered from similarly caused cancers, according to data from the World Trade Center Health Program, an arm of the Centers for Disease Control and Prevention that provides health care for first responders and lower Manhattan residents impacted by the 9/11 attacks.

More than 580 people, including first responders, survivors and Manhattan residents, have died from 9/11-related cancers as of September 30 of this year, according to the CDC.

"[The 9/11 first responders] are a fraternity that's shrinking," said John Feal, an advocate for World Trade Center first responders. "9/11 hasn't ended, it's the longest day in the history of days."

Feal lost half his foot to an injury during a search and rescue mission at Ground Zero in the days following the attack. Now, he works as an advocate the WTC Health Program, encouraging those who volunteered at the time to receive screenings and care. The organization has over 90,000 members including survivors and first responders, according to its quarterly report.

The 9/11 Memorial and Museum will soon be opening a new section to honor the first responders and local residents who have passed away due to World Trade Center-related toxins and cancers, according to a museum official.

NBCNews.com
Thursday, December 27, 2018

U.S. turns to military, medical research to solve diplomats' 'health attacks'

The source of attacks on U.S. diplomats remain a mystery, but medical researchers have confirmed that the attacks have done real damage.

By Josh Lederman

WASHINGTON -- In the waning days of summer, Deputy Secretary of State John Sullivan was quietly dispatched to a Pennsylvania brain clinic to investigate for himself what government doctors had described: American diplomats and spies suffering from a mysterious set of ailments.

For two years, the U.S. intelligence community and FBI investigators had tried and failed to solve an astonishing international mystery about who or what is attacking its diplomats overseas.

What researchers presented to Sullivan in late August didn't answer that question. But over four hours and a working lunch, neurologists and researchers showed Sullivan how they were tracking water molecules traveling through the central nervous system to create computerized maps that confirm that the damage to the U.S. workers' brains is real.

Medical experts in four states and officials from at least seven U.S. federal agencies are now actively on the case, including the Navy, the National Institutes of Health and the Centers for Disease Control and Prevention. They join other officials from the CIA, the State Department and allied governments who have been hunting for a culprit since U.S. diplomats and spies serving in Cuba and later in China started hearing strange sounds and falling ill in late 2016.

Now that the government is deploying its military and medical research arms, costs for research and treatment have run into the tens of millions of dollars, U.S. officials tell NBC News.

The mystery has weighed heavily on the patients, unsure if and when they'll fully recover and how their health might be affected long term. Some still spend much of their time shuttling between doctors and rehab appointments as they struggle with visual, hearing and cognitive problems. Others have tried to move on with their lives or started new posts overseas, even while they demand information and accountability from the U.S.

The lack of answers has also had a profound effect on U.S. ties to Cuba, which were just starting to mend in 2016 after half a century of estrangement, and has put the U.S. on high alert for similar attacks elsewhere.

With the U.S. Embassy in Havana operating at only partial capacity, the CIA has had to shut down its station there, officials said, depriving the U.S. of a key source of information just as the island is in the throes of a historic change in leadership.

And half a world away, in China, about 70 U.S. diplomats and their families serving in China have undergone testing in the last few months amid concerns they could have been affected by health attacks, too, State Department officials said.

They join another 300 who were tested in China earlier this year after

the U.S. disclosed that one of its workers in Guangzhou was "medically confirmed" to have the same symptoms as the Cuba cases.

In additional countries where U.S. diplomats serve, a few dozen more have also been tested. They've been given the Acquired Brain Injury Test, or ABIT, developed by the U.S. to test for health attacks. But officials wouldn't name those countries or say what prompted the concerns.

"To date, each report has been carefully evaluated and there have been no new incidents that are cause for concern," the State Department said. "Medical screening is available around the world for embassy personnel who may raise a concern."

Since the incidents started in 2016 in Cuba, 26 U.S. workers who served there and about a dozen Canadians have been confirmed to have been affected by what the U.S. calls "targeted health attacks" from an unknown source. Cuba adamantly denies any knowledge or involvement in the attacks. One U.S. diplomat in China who reported strange sounds and sensations was confirmed in 2018 to have the same symptoms. The incidents caused hearing, balance and cognitive changes along with mild traumatic brain injury.

With the FBI investigation making little progress, the Trump administration has turned to the Defense Department to try to recreate the technology that harmed the Americans. The Office of Naval Research's "Code 34" Warfighter Performance Department has been researching how different energy sources affect the human body and specifically the head.

"There's several research projects ongoing at the military," Dr. Michael Hoffer, a former military physician who first evaluated the Cuba patients, said in an interview. "This research is going to lead us to a solution, but we really have to support that research."

Hoffer and his colleagues, including at the University of Pittsburgh, have briefed Pentagon officials about their findings and are supporting the Navy's research. In connection with that research, federal spending records show that the Navy also awarded $363,000 this year in grants to the University of Pittsburgh to study how electromagnetic or sound waves interact with the cranium, including how changes to liquid in the head can form bubble-like waves of pressure that could affect various parts of the brain.

The Office of Naval Research declined to comment.

Meanwhile, at the National Institutes of Health in Bethesda, Maryland, government doctors and scientists are developing an in-depth clinical research study to try to understand what's happened to the diplomats' bodies and how long the symptoms will last. Patients are undergoing five full days of testing on various bodily systems to learn more how they interact with the brain. The study is expected to include control groups and is awaiting Institutional Review Board approval.

A separate program is underway at the CDC, which is studying the incidents as a public health risk. The agency is working to create a

formal "case definition" for the illness, including risk factors and a full list of common symptoms, to be used to better track its spread. CDC's epidemiologists traveled to China this year to gather data from U.S. workers and relatives who complained of neurological symptoms, officials said.

And at the University of Pennsylvania, where the U.S. is sending its patients for treatment, doctors have proposed to the U.S. government that they be allowed to create a Comprehensive Brain Injury Clinic that would serve as a rapid triage center in the event there was a major outbreak somewhere in the world. Currently, Penn's doctors only have the bandwidth to perform fewer than eight comprehensive evaluations a week when a diplomat is medevaced to Penn from overseas.

Sullivan traveled to Philadelphia on Aug. 28 to personally discuss the health attacks with doctors and review their latest medical findings. And in Congress, lawmakers have taken a renewed interest in the case, with Democratic and Republican staff from the House Foreign Affairs Committee meeting recently with the Americans flown from China after a NBC News report about their situation.

In the meantime, the deterioration in U.S. ties to Cuba has been compounded by President Donald Trump's moves to tighten enforcement of longstanding sanctions. After the first tranche of diplomats in Cuba fell ill, the U.S. issued a travel warning for Cuba, withdrew most of its diplomats from Havana and ordered out all relatives of diplomats.

So for more than a year, the embassy has been operating with a skeleton staff and has stopped performing critical services such as issuing visas for Cubans who want to visit the U.S. Those who want visas must travel to the U.S. embassy in a third country such as Guyana, significantly increasing the cost and time involved.

Cuba's Embassy in Washington didn't respond to requests for comment. But James Williams, president of the U.S.-based group Engage Cuba, said the situation was taking a significant human toll on both Cubans and Cuban-Americans.

"These families who are not seeing each other, businesses that are not growing as a result and lives divided with not a really good solution and no prospects on the horizon for a fix," Williams said. "It's just untenable."

Josh Lederman is a national political reporter for NBC News.

Des Moines (Iowa) Register
Friday, December 28, 2018

People to Watch: 'Iowa's doctor' will offer calm guidance when pestilence is on the prowl

Tony Leys
Des Moines Register

Dr. Caitlin Pedati will appear on your TV screen one of these days to talk about something gross.

Pedati, Iowa's new state epidemiologist, will spread the word about food poisoning outbreaks, flu epidemics or diseases inflicted by bacteria, mosquitoes, ticks and untold other pests. She'll explain the threats, the symptoms and what the public should do about them.

On quieter days, she'll try to persuade Iowans to eat their vegetables, get vaccinated, quit smoking, and take a walk once in a while.

Pedati, 33, aims to fill the shoes of Patricia Quinlisk, who retired this fall after serving 24 years in a job that's been described as "Iowa's doctor."

Pedati realizes the life of an epidemiologist is unlikely to be portrayed in an action-packed TV series.

"Telling people to wash their hands or use hand sanitizer is not that thrilling, I suppose," she joked. But such mundane safeguards can prevent illnesses and deaths just as surely as any surgeon or emergency room doctor can.

Pedati speaks in a calm, friendly voice, using everyday words to discuss serious health threats.

That ability impressed Jeneane Moody, executive director of the Iowa Public Health Association. Moody, who helped interview candidates for the job, said the state's epidemiologist must tell jittery Iowans what they should do during stressful disease outbreaks.

"You need to remain calm and stay grounded in the facts," she said. "She sounded authoritative without sounding intimidating. That's a real fine balance."

Pedati's enthusiasm for her work is evident in her new office near the Statehouse.

One wall is decorated with framed, colorful photos of viruses and bacteria, including those that cause flu, AIDS and tularemia. A nearby shelf holds thick books titled "Cancer Epidemiology," "The Common Plague," and "Gray's Anatomy." The shelf is brightened with plush-toy versions of an Ebola virus, a Zika virus and a host of other microscopic enemies, plus a toy white blood cell to fend them off.

Germ-fighting has been on Pedati's mind since she was a kid. She remembers being intrigued by the stethoscope and medical books that her mom, who worked as a nurse, brought to their home in suburban Washington, D.C.

"Some kids grow up wanting to be an astronaut," she said. "I don't remember ever not wanting to be a doctor."

She recalls feeling a secret thrill when her two sisters would become ill, and she could accompany them to their family doctor.

"He'd say, `Do you want to look in Erin's ear, or do you want to look in Meg's throat or listen to their chest?' I just loved it," she said.

Pedati became a board-certified pediatrician after attending medical school at George Washington University. But she was increasingly interested in finding broad solutions to the common health problems she saw while training as a physician in clinics.

Unvaccinated kids would develop the flu. Toddlers would be injured when unsecured TVs tipped over on them. Children would have repeated asthma flare-ups sparked by mold, cigarette smoke or other allergens in their homes.

"I felt like I was seeing the same things over and over again," she said. "After a while, it felt like you were just reinventing the wheel."

She decided to specialize in public health, which seeks to prevent illnesses and injuries instead of treating them after they happen.

She landed a training stint with the federal Centers for Disease Control and Prevention, which sent her to Guatemala to help track emerging infectious diseases. Then she entered a longer-term CDC training program, which sent her to work in the Nebraska health department in 2015.

"I loved public health at the state level. I felt it was somewhere you could really get things done," she said.

Advice from predecessor: Be honest, be clear

Pedati was still working in Nebraska when she heard about the Iowa state epidemiologist job becoming open. Iowa's Department of Public Health hired her last summer.

Pedati was grateful for the chance to work at Quinlisk's side for three months before the longtime epidemiologist retired in September.

The veteran advised her successor to always be honest and clear with Iowans. Don't take the attitude that you're "dumbing down" the message if you use plain language instead of medical jargon, she said.

The best way to prevent panic in a health crisis is to offer Iowans straightforward steps they can take to protect themselves and their families, Quinlisk told Pedati. Also, she said, brace yourself for occasional blowback, including from parents who incorrectly believe vaccinations harm children.

Quinlisk said her successor has a level-headed confidence, which will be important under pressure.

"You often have to make decisions before you know everything you'd like to know," she said in an interview.

For example, she said, a state epidemiologist might have to order a restaurant closed if it is the suspected source of a food-poisoning

outbreak. Public-health officials can't always wait until tests confirm whether such suspicions are correct.

"You have to be honest with people about what you do know and what you don't know," Quinlisk said.

The lesson of the 'Not-So-Rabid-Bear'

Quinlisk faced such a quandary early in her Iowa career. A bear cub at a petting zoo in northeast Iowa had nipped a few children, and an initial test suggested it had rabies. Many children had touched the cub, which was named Chief. One girl had even shared her chewing gum with Chief, then put it back in her own mouth, Quinlisk recalled.

Amid national news of the incident, the epidemiologist urged that more than 100 children immediately start taking a series of shots against rabies, which can be deadly.

About a week later, follow-up tests showed the bear cub did not have rabies. Quinlisk took some lumps for the incident, but she said she made the necessary call based on the information available.

Her staff pranked her afterward by gluing plastic foam to the mouth of a teddy bear. They named it "Not-So-Rabid-Bear" and presented it to the epidemiologist. She kept it in her office for years. Quinlisk left the foaming-mouth teddy bear behind for her successor when she retired.

Pedati said she appreciates the sentiment behind "Not-So-Rabid-Bear." She took to heart Quinlisk's advice that if she always levels with Iowans, they'll understand that her advice can change as facts become clearer.

"Sometimes that's going to happen," Pedati said. "But you always have to act in the public's interest."

The next time viruses fill the air or bacteria foul the food, you'll see her on TV, giving it her best shot.

Caitlin Pedati

AGE: 33

BORN: In New Jersey; grew up in Virginia suburbs of Washington, D.C.

EDUCATION: George Washington University, doctor of medicine and master's in public health, 2012; Georgetown University, bachelor's degree in human science and certificate in population health, 2007.

PROFESSIONAL EXPERIENCE: Named Iowa state epidemiologist and Iowa public health medical director in June 2018. Served as a medical epidemiologist for state of Nebraska, 2017-18. Stationed in Nebraska for the Epidemic Intelligence Service, Centers for Disease Control and Prevention, 2015-17. Served internship and residency, Children's National Health System, Washington, D.C., 2012-15. Worked as laboratory manager and research assistant in George Washington University's microbiology department, 2007-09. Worked as a research

assistant for the American Red Cross and then the Arlington County (Va.) Health Department, 2006-07.

TEACHING EXPERIENCE: Adjunct faculty, and master's thesis adviser, University of Nebraska Medical Center, College of Public Health, 2017-18.

WashingtonTimes.com
Thursday, December 27, 2018

Fentanyl leaves a lethal mess that's costly and complicated to clean up

By Jeff Mordock - The Washington Times

Police in St. Louis pulled over two suspected heroin dealers moving the drug in a rental car.

A bag ripped open during the stop, spilling fentanyl all over the car's trunk. Smaller than a grain of sand, fentanyl is a synthetic opioid so lethal even trace amounts can kill.

The rental car company called Laura Spaulding-Koppel, CEO of crime scene cleanup company Spaulding Decon, to remove the toxic substance. Ms. Spaulding-Koppel told the rental company that it would cost $30,000, midrange for fentanyl cleanup.

The company balked. Executives told Ms. Spaulding-Koppel that their risk management team concluded they would rather clean the car themselves and hope no customers would be exposed.

It was a huge gamble by the rental car company, Ms. Spaulding-Koppel said. Exposure to less than 2 grams of fentanyl -- a substance 25 to 50 times stronger than heroin -- could kill an unsuspecting person who thinks it is merely sand.

"People need to understand the cost of cleanup, but they also need to understand the threat of fentanyl," she said. "There is no forgiveness with it."

Of the roughly 70,000 overdose deaths in the United States in 2017, more than 29,000 were linked to fentanyl and other dangerous synthetic drugs, according to the Centers for Disease Control and Prevention. That represents an 850 percent climb since 2013.

Fentanyl-fueled opioid deaths are moving out of private homes and into libraries, restaurants and other public spaces with alarming frequency. As the death toll climbs, so does the risk of secondary exposure causing an immediate overdose if fentanyl is inhaled, comes into contact with the mouth or eyes, or is absorbed through a cut or other opening.

Fentanyl exposure has claimed lives. In May, a Florida couple were arrested after their infant died of fentanyl and cocaine exposure. Police said the infant's mother was wearing multiple fentanyl patches

that had been cut in half, allowing a lethal amount of residue to spill onto the child.

"I find it shocking how lightly we are taking this threat," said Amit Kapoor, CEO of First Line Technologies, a Virginia chemical company that promises its product Dahlgren Decon can neutralize fentanyl. "It is a big, emerging threat. If someone got their hands on this, it's pretty incredible what they could do."

Dahlgren Decon is licensed by the Navy and was developed to clean up after chemical warfare attacks. Mr. Kapoor discovered its application for opioids after testing it on fentanyl in a lab. He now sells it to state and federal first responders and law enforcement agencies as well as a handful of private companies.

Despite the explosion of fentanyl, no cleanup standards have been established to determine when a fentanyl-tainted property is safe. Compounding the problem are cleanup costs that homeowners can't afford and insurers refuse to pay. Businesses would rather risk a lawsuit than deal with the costly out-of-pocket expenses or rising insurance premiums.

"There are several 600-pound gorillas in the room that we are dealing with," said Thomas Licker, president of the American-Bio Recovery Association. "It's a bit of a nightmare."

Cleanup is complicated

Fentanyl decontamination is a difficult, cumbersome process, those in the industry say.

It requires a complete quarantine of the area and workers dressed head to toe in hazmat suits using high-efficiency vacuums designed to remove tiny particles from every square inch of space. After vacuuming, workers spray specialized chemicals to disinfect the area. Testing equipment is then used to ensure the fentanyl has been removed.

A job takes about 10 hours on average, including breaks every 20 minutes because of blazing temperatures inside the hazmat suits. Jobs typically cost about $400 per hour, with a total price tag ranging from $30,000 to $50,000. One reason for the expense is that the specialized vacuums, which cost as much as $1,200, must be incinerated after cleanup.

"The cost of remediation jobs tends to be expensive, but it includes training expenses and everything else needed to do the job right," Mr. Licker said. "We make money doing it, but we are the ones risking our lives."

Rarely covered by insurance

Most homeowners can't afford the bill, and few insurance policies cover what the companies consider an intentional criminal act. The debate rages on, leaving the public at risk.

"This is an uphill battle because insurance companies are doing

whatever they can not to cover it," Ms. Spaulding-Koppel said.

Chris Hackett, senior director of personal lines for the Chicago-based Property Casualty Insurers Association of America, said most insurers won't cover any damage or pollution resulting from an intentional or criminal act.

"If a policy says it is not going to cover any criminal acts, that is going to include meth, fentanyl and any other drug you can think of," he said. "Sometimes it's better to have general language excluding that stuff rather than a laundry list of items."

The public and businesses aren't the only ones affected. Westport, Massachusetts, Police Chief Keith A. Pelletier said the cost of decontaminating police cars and holding cells after fentanyl exposure is draining his budget. It is typically cheaper to buy a new police car than to have a contaminated one cleaned.

In the dark

Also putting the public at risk is the lack of disclosure laws surrounding overdoses, including those involving fentanyl. No law on the state or federal level forces homeowners to notify potential renters or buyers that an overdose occurred on the property.

The fight parallels the methamphetamine crisis last decade, when lawmakers received pushback because revealing that a house was once used to make the drug would lower its value. A decade later, only 23 states have laws requiring homeowners to disclose that their house was once a meth lab. No such measure exists on the federal level.

Indiana state Rep. Wendy McNamara, a Republican, had her meth disclosure bill passed in 2014 after years of fighting for it. She called the process "extremely difficult."

She would have to write a new bill for fentanyl disclosure rather than expand the methamphetamine law under rules of the Indiana legislature. She isn't sure state lawmakers are ready for the battle, given all of the other debates about the opioid crisis.

"This is a legitimate concern for a lot of folks," she said. "But we are focused so much on trying to stop opioid usage and rehabilitate folks, this is a piece that has gotten lost in the bigger picture of trying to fight the entire opioid epidemic."

Ms. McNamara said local real estate associations partnered with her on the bill. But in other states, such groups fiercely opposed the legislation.

The Iowa Association of Realtors fought a meth disclosure bill introduced in January 2014. At the time, the group said the issue was too complex to address through a law because some properties used as meth labs require only light remediation, while drywall needs to be removed in other cases.

"It's a different train of thought," Mr. Licker said. "Ours is focused

on public health, and theirs is to sell houses."

Wesley Shaw, a spokesman for the National Association of Realtors, said his agency has no policy on meth or fentanyl disclosure and that enacting laws is a state issue.

"Regardless, disclosure is an important aspect of consumer protection, and the duty to disclose known defects does extend to real estate professionals," he said. "NAR believes that any known factors that can affect the value of desirability of a property should be disclosed."

Federal lawmakers have not tackled the issue, which Mr. Kapoor is trying to change.

"We've been trying to educate the folks on Capitol Hill about this threat," he said. "They are more focused on fentanyl detection, but the bigger challenge is, `How do you neutralize it?'"

Businesses and other public entities don't have to disclose overdoses either. In Pennsylvania, overdoses occurred in 12 percent of libraries last year, including four at one Philadelphia library alone, according to a University of Pennsylvania study.

Mr. Kapoor said his company is responding to fentanyl exposure in rental cars, fast-food restaurants and hotels rather than private homes.

Mr. Pelletier said his officers responded to a fentanyl overdose at a midlevel chain hotel. He urged hotel management to hire a remediation company to clean the room. They told him the maids would handle it.

"We took precautions, but I'm worried about the public," he said. "I know a family with kids stayed in that room afterwards, but is there even a protocol for cleaning fentanyl in a hotel room?"

Bloomberg
Thursday, December 27, 2018

A Worrying Rise in Gun Suicides

(Bloomberg Opinion) -- New data from the Centers for Disease Control and Prevention highlights the growing problem of firearm suicides in the U.S. Since 2008, the rate of gun suicides has risen 22 percent and is driving the increase in gun-related deaths. (Suicides make up almost two-thirds of all gun-related deaths.) Among children and teens in particular, the gun-suicide rate is up more than 76 percent. Although only a small percentage of suicide attempts are made with a firearm, more than half of all suicide deaths are carried out with one. The primary victims are older white men.

Many people assume that nothing can be done to curtail such suicides. That is false. While there may be warning signs before a suicide attempt, the attempts themselves are often spontaneous, not planned. Almost half of survivors say they spent less than 10 minutes

deliberating.

It's not surprising then that access to a firearm triples the risk of death by suicide -- not only for those who personally own a gun, but also for those who live in a household with a gun. Likewise, gun ownership rates in states are strongly correlated with rates of firearm suicide. (Gun mortality rates in general follow a pattern: They're higher in states with lax gun laws.)

Researchers at Johns Hopkins University estimated that after Connecticut passed a law requiring individuals to obtain a permit or license to purchase a handgun (along with a background check), the state saw a 15 percent drop in firearm suicides. On the other hand, in Missouri, the 2007 repeal of its purchase permit law was associated with a 16 percent increase in firearm suicide rates.

The firearm suicide rate in the U.S. is eight times higher than in other affluent countries. To reduce that deadly disparity, public officials need to adopt known strategies for harm reduction -- especially among older, rural white men; military veterans; and other populations with high rates of gun ownership and suicide. Interventions by social workers or medical professionals should be tailored demographically, including by sex and age. Some gun dealers have begun to educate customers on the association between firearms and suicide.

Laws also play a crucial role. It helps when states require permits to purchase firearms, impose waiting periods before gun purchases are completed, and adopt red flag laws to empower family members or law enforcement to petition courts to temporarily restrict gun possession by those who pose a risk to themselves or others. Safe storage laws can keep loaded guns beyond the reach of children and teens. Most young people who shoot themselves do so with a family member's gun.

Suicides are not the only manifestation of the U.S.'s uniquely high rates of gun violence. But the CDC report confirms that they're a growing menace. Smart policies can help blunt that trend, and reverse it.

--Editors: Francis Wilkinson, Clive Crook.

To contact the senior editor responsible for Bloomberg View's editorials: David Shipley at davidshipley@bloomberg.net, .

Editorials are written by the Bloomberg Opinion editorial board.

From: Messonnier, Nancy (CDC/DDID/NCIRD/OD)
Sent: 1 Feb 2019 22:32:13 +0000
To: Pallansch, Mark A. (CDC/OID/NCIRD);Clark, Thomas A. (CDC/DDID/NCIRD/DVD)
Cc: Pope, Kristin (CDC/DDID/NCIRD/OD)
Subject: FW: late friday update

Good call

From: Redfield, Robert R. (CDC/OD) <olx1@cdc.gov>
Sent: Friday, February 1, 2019 5:32 PM
To: Messonnier, Nancy (CDC/DDID/NCIRD/OD) <nar5@cdc.gov>
Subject: Re: late friday update

Thank you . I appreciate update like this when they happen. Helps me to be UTD for leadership calls. peace r3

From: Messonnier, Nancy (CDC/DDID/NCIRD/OD) <nar5@cdc.gov>
Date: February 1, 2019 at 5:26:16 PM EST
To: Redfield, Robert R. (CDC/OD) <olx1@cdc.gov>
Cc: Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>, McGowan, Robert (Kyle) (CDC/OD/OCS) <omc2@cdc.gov>, Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>, Berger, Sherri (CDC/OCOO/OD) <sob8@cdc.gov>, Pope, Kristin (CDC/DDID/NCIRD/OD) <kfp7@cdc.gov>
Subject: late friday update

I will try to generally include updates in the Friday SitRep. But since measles is so much in the news, I wanted to make sure you had these as it sounds like they are getting some press. We were just informed of 2 more outbreaks, not connected with the other 3 outbreaks.

(b)(5)

From: Redfield, Robert R. (CDC/OD) <olx1@cdc.gov>
Sent: Friday, February 1, 2019 3:39 PM
To: Messonnier, Nancy (CDC/DDID/NCIRD/OD) <nar5@cdc.gov>
Cc: Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>; McGowan, Robert (Kyle) (CDC/OD/OCS) <omc2@cdc.gov>; Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>; Berger, Sherri (CDC/OCOO/OD) <sob8@cdc.gov>; Pope, Kristin (CDC/DDID/NCIRD/OD) <kfp7@cdc.gov>
Subject: Re: NCIRD outbreaks, etc

Dear Nancy

Very helpful. Thanks. Can you give me a call when it works for you this afternoon. r3

From: Messonnier, Nancy (CDC/DDID/NCIRD/OD) <nar5@cdc.gov>
Date: February 1, 2019 at 1:33:05 PM EST
To: Redfield, Robert R. (CDC/OD) <olx1@cdc.gov>
Cc: Schuchat, Anne MD (CDC/OD) <acs1@cdc.gov>, McGowan, Robert (Kyle) (CDC/OD/OCS) <omc2@cdc.gov>, Daniel, Katherine Lyon (CDC/OD/OADC) <kdl8@cdc.gov>, Berger, Sherri (CDC/OCOO/OD) <sob8@cdc.gov>, Pope, Kristin (CDC/DDID/NCIRD/OD) <kfp7@cdc.gov>
Subject: NCIRD outbreaks, etc

Dr. Redfield,

(b)(5)

(b)(5)

Nancy

From: Messonnier, Nancy (CDC/DDID/NCIRD/OD)
Sent: 27 Dec 2018 10:53:57 -0500
To: Jernigan, Daniel B. (CDC/DDID/NCIRD/ID)
Cc: Thompson, Mark (CDC/DDID/NCIRD/ID)
Subject: RE: Request for Call on Flu Surveillance along US-Mexico border in CA, AZ, NM, and TX

Can I listen in? I think its easier for me to listen in while you lead but I think I should listen.

From: Jernigan, Daniel B. (CDC/DDID/NCIRD/ID) <dbj0@cdc.gov>
Sent: Thursday, December 27, 2018 9:47 AM
To: Chavez, Gilbert (CDC cdph.ca.gov) <gil.chavez@cdph.ca.gov>; Komatsu, Kenneth (CDC azdhs.gov) <ken.komatsu@azdhs.gov>; alexandra.peterson@azdhs.gov; Murray, Erin@cdph.ca.gov (CDC cdph.ca.gov) <Erin.Murray@cdph.ca.gov>; Landen, Michael (CDC state.nm.us) <michael.landen@state.nm.us>; Smelser, Chad CS (CDC state.nm.us) <Chad.Smelser@state.nm.us>; Gaul, Linda (CDC dshs.state.tx.us) <linda.gaul@dshs.state.tx.us>; Hailey.Rucas@dshs.texas.gov; McDonald, Eric (CDC sdcounty.ca.gov) <Eric.Mcdonald@sdcounty.ca.gov>; Thihalolipavan, Sayone@SD County <sayone.thihalolipavan@sdcounty.ca.gov>; Wooten, Wilma WW (CDC sdcounty.ca.gov) <Wilma.Wooten@sdcounty.ca.gov>; Fernandez, April@CDPH <April.Fernandez@cdph.ca.gov>; Celaya, Maria@CDPH <Maria.Celaya@cdph.ca.gov>; Iniguez-Stevens, Esmeralda@CDPH <Esmeralda.Iniguez-Stevens@cdph.ca.gov>; Santibanez, Margarita@CDPH <Margarita.Santibanez@cdph.ca.gov>; Watt, James (CDC cdph.ca.gov) <James.Watt@cdph.ca.gov>; Bregman, Brooke@CDPH <Brooke.Bregman@cdph.ca.gov>; Harriman, Kathleen@CDPH <Kathleen.Harriman@cdph.ca.gov>; Schechter, Robert@CDPH <Robert.Schechter@cdph.ca.gov>; Volk, Maria@CDPH <Maria.Volk@cdph.ca.gov>; Epson, Erin@CDPH <Erin.Epson@cdph.ca.gov>
Cc: Thompson, Mark (CDC/DDID/NCIRD/ID) <isq8@cdc.gov>; Grohskopf, Lisa A. (CDC/DDID/NCIRD/ID) <lkg6@cdc.gov>; Wentworth, David E. (CDC/DDID/NCIRD/ID) <gll9@cdc.gov>; Barnes, John R. (CDC/DDID/NCIRD/ID) <fzq9@cdc.gov>; Messonnier, Nancy (CDC/DDID/NCIRD/OD) <nar5@cdc.gov>; Koppaka, Ram (CDC/DDID/NCIRD/ISD) <vcr4@cdc.gov>; Moser, Kathleen (CDC/DDID/NCEZID/DGMQ) <kzm5@cdc.gov>; Johnson, Drew@CDPH <Drew.Johnson@cdph.ca.gov>
Subject: RE: Request for Call on Flu Surveillance along US-Mexico border in CA, AZ, NM, and TX

Great. Good to have Eric and colleagues from San Diego. Mark Thompson will be sending out an invite with call in.
Dan.

From: Chavez, Gil@CDPH <Gil.Chavez@cdph.ca.gov>
Sent: Wednesday, December 26, 2018 6:40 PM
To: Jernigan, Daniel B. (CDC/DDID/NCIRD/ID) <dbj0@cdc.gov>; Komatsu, Kenneth (CDC azdhs.gov) <ken.komatsu@azdhs.gov>; alexandra.peterson@azdhs.gov; Murray, Erin@cdph.ca.gov (CDC cdph.ca.gov) <Erin.Murray@cdph.ca.gov>; Landen, Michael (CDC state.nm.us) <michael.landen@state.nm.us>; Smelser, Chad CS (CDC state.nm.us) <Chad.Smelser@state.nm.us>; Gaul, Linda (CDC dshs.state.tx.us) <linda.gaul@dshs.state.tx.us>; Hailey.Rucas@dshs.texas.gov; McDonald, Eric (CDC sdcounty.ca.gov) <Eric.Mcdonald@sdcounty.ca.gov>; Thihalolipavan, Sayone@SD County <sayone.thihalolipavan@sdcounty.ca.gov>; Wooten, Wilma WW (CDC sdcounty.ca.gov) <Wilma.Wooten@sdcounty.ca.gov>; Fernandez, April@CDPH <April.Fernandez@cdph.ca.gov>; Celaya, Maria@CDPH <Maria.Celaya@cdph.ca.gov>; Iniguez-Stevens, Esmeralda@CDPH <Esmeralda.Iniguez-Stevens@cdph.ca.gov>; Santibanez, Margarita@CDPH <Margarita.Santibanez@cdph.ca.gov>; Watt,

James (CDC cdph.ca.gov) <James.Watt@cdph.ca.gov>; Bregman, Brooke@CDPH <Brooke.Bregman@cdph.ca.gov>; Harriman, Kathleen@CDPH <Kathleen.Harriman@cdph.ca.gov>; Schechter, Robert@CDPH <Robert.Schechter@cdph.ca.gov>; Volk, Maria@CDPH <Maria.Volk@cdph.ca.gov>; Epson, Erin@CDPH <Erin.Epson@cdph.ca.gov>
Cc: Thompson, Mark (CDC/DDID/NCIRD/ID) <isq8@cdc.gov>; Grohskopf, Lisa A. (CDC/DDID/NCIRD/ID) <lkg6@cdc.gov>; Wentworth, David E. (CDC/DDID/NCIRD/ID) <gll9@cdc.gov>; Barnes, John R. (CDC/DDID/NCIRD/ID) <fzq9@cdc.gov>; Messonnier, Nancy (CDC/DDID/NCIRD/OD) <nar5@cdc.gov>; Koppaka, Ram (CDC/DDID/NCIRD/ISD) <vcr4@cdc.gov>; Moser, Kathleen (CDC/DDID/NCEZID/DGMQ) <kzm5@cdc.gov>; Johnson, Drew@CDPH <Drew.Johnson@cdph.ca.gov>
Subject: RE: Request for Call on Flu Surveillance along US-Mexico border in CA, AZ, NM, and TX

Dan,

California would be glad to participate. As you know, we carry out border-specific influenza surveillance for the US/Mexico border region. Additionally, San Diego County has very robust influenza surveillance. Please send call info.

Thanks.

Gil F. Chavez, MD, MPH
State Epidemiologist
Deputy Director for Infectious Diseases
California Department of Public Health
(916) 440-7434

From: Jernigan, Daniel B. (CDC/DDID/NCIRD/ID) <dbj0@cdc.gov>
Sent: Wednesday, December 26, 2018 3:16 PM
To: Komatsu, Kenneth (CDC azdhs.gov) <ken.komatsu@azdhs.gov>; alexandra.peterson@azdhs.gov; Chavez, Gil@CDPH <Gil.Chavez@cdph.ca.gov>; Murray, Erin@CDPH <Erin.Murray@cdph.ca.gov>; Landen, Michael (CDC state.nm.us) <michael.landen@state.nm.us>; Smelser, Chad CS (CDC state.nm.us) <Chad.Smelser@state.nm.us>; Gaul, Linda (CDC dshs.state.tx.us) <linda.gaul@dshs.state.tx.us>; Hailey.Rucas@dshs.texas.gov
Cc: Thompson, Mark (CDC/DDID/NCIRD/ID) <isq8@cdc.gov>; Grohskopf, Lisa A. (CDC/DDID/NCIRD/ID) <lkg6@cdc.gov>; Wentworth, David E. (CDC/DDID/NCIRD/ID) <gll9@cdc.gov>; Barnes, John R. (CDC/DDID/NCIRD/ID) <fzq9@cdc.gov>; Messonnier, Nancy (CDC/DDID/NCIRD/OD) <nar5@cdc.gov>; Koppaka, Ram (CDC/DDID/NCIRD/ISD) <vcr4@cdc.gov>; Moser, Kathleen (CDC/DDID/NCEZID/DGMQ) <kzm5@cdc.gov>
Subject: Request for Call on Flu Surveillance along US-Mexico border in CA, AZ, NM, and TX

All:
Sorry for the short-notice request, but was trying to see if you or others you identify would be available for a call tomorrow at 1 pm EST to discuss flu surveillance along the border and availability of flu vaccine for migrants. Many of you may have been on the call this afternoon with DHS where there were a number of questions about flu activity in the border region and questions about use of flu vaccine in the very complicated situation with migrants. If possible, it would be great to have you and your immunization coordinator join us to further discuss:

(b)(5)

(b)(5)

I recognize the time of year and short notice may make it difficult to have everyone join, but we would like to hear from you on best next steps to take and which direction to go.
Thanks
Dan.

Daniel B. Jernigan, MD MPH
Director, Influenza Division
National Center for Immunization and Respiratory Diseases
Centers for Disease Control and Prevention
1600 Clifton Rd NE, Atlanta, GA 30329
Phone 404-639-2621, Cell 404-375-7508
djernigan@cdc.gov, www.cdc.gov/flu

From: Jernigan, Daniel B. (CDC/DDID/NCIRD/ID)
Sent: 26 Dec 2018 23:16:22 +0000
To: Komatsu, Kenneth (CDC azdhs.gov);alexandra.peterson@azdhs.gov;Chavez, Gilbert (CDC cdph.ca.gov);Erin.Murray@cdph.ca.gov;Landen, Michael (CDC state.nm.us);Smelser, Chad CS (CDC state.nm.us);Gaul, Linda (CDC dshs.state.tx.us);Hailey.Rucas@dshs.texas.gov
Cc: Thompson, Mark (CDC/DDID/NCIRD/ID);Grohskopf, Lisa A. (CDC/DDID/NCIRD/ID);Wentworth, David E. (CDC/DDID/NCIRD/ID);Barnes, John R. (CDC/DDID/NCIRD/ID);Messonnier, Nancy (CDC/DDID/NCIRD/OD);Koppaka, Ram (CDC/DDID/NCIRD/ISD);Moser, Kathleen (CDC/DDID/NCEZID/DGMQ)
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