Record High US Measles Cases: Patient Vaccination, Clinical Assessment and Management

Clinician Outreach and Communication Activity (COCA) Webinar
July 1, 2014
Objectives

At the conclusion of this session, the participant will be able to accomplish the following:

- Discuss the current status of measles outbreaks in the U.S.
- Describe the clinical presentation of measles and the guidelines for patient assessment and management
- Outline CDC vaccination recommendations for the general public, international travelers, and healthcare professionals
- Identify CDC measles resources and training materials for clinicians
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Jane Seward, MBBS, MPH
Deputy Director
Division of Viral Diseases
National Center for Immunization and Respiratory Diseases
Centers for Disease Control and Prevention
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Jane Seward, MMBS, MPH
Deputy Director, Division of Viral Diseases
National Center for Immunization and Respiratory Diseases
Centers for Disease Control and Prevention (CDC)

COCA Call
July 1, 2014
What is Measles

- Febrile rash illness caused by measles virus
- Among the most contagious of infectious diseases
- Preventable with a highly effective vaccine that is recommended in routine immunization schedules
Measles Transmission

- Transmitted via respiratory droplets and aerosol
  - spread by coughing and sneezing, close personal contact or direct contact with infected nasal or throat secretions

- Contagious from 4 days before to 4 days after rash onset

- $R_0 = 12-16$ with secondary attack rates in susceptible household contacts $\sim 90\%$
Clinical Presentation

- **Prodrome (2-4 days)**
  - Fever (up to 105°F)
  - Cough, Coryza, and/or Conjunctivitis (the three “C’s”)
  - Enanthem (on mucous membranes) (Koplik spots)

- **Rash ~14 days after exposure (range 7-21 days)**
Measles Rash

- Erythematous maculopapular rash
  - Spreads from head to trunk to extremities
  - May become confluent

- Rash lasts for 5-6 days and fades in order of appearance
## Measles Complications

More common in children < 5 years and adults

<table>
<thead>
<tr>
<th>Complication</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
<td>8%</td>
</tr>
<tr>
<td>Otitis media</td>
<td>7-9%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1-6%</td>
</tr>
<tr>
<td>Encephalitis</td>
<td>1 per 1,000 cases</td>
</tr>
<tr>
<td>Death</td>
<td>1 -3 per 1,000 cases</td>
</tr>
<tr>
<td>Subacute Sclerosing Panencephalitis (SSPE)</td>
<td>1 per 100,000 cases 7-10 years after measles</td>
</tr>
</tbody>
</table>
Global Burden of Measles

Deaths
- Estimated 2.6 million deaths/year in 1980
- 78% decrease in estimated deaths from 2000 to 2012
  - 122,000 deaths in 2012 (~14 deaths/hour)
- Remains a leading cause of vaccine preventable deaths in children < 5 years old

Complications with sequelae include blindness

Cases
- Estimated 20 million per year
- 77% decrease in reported measles incidence from 2000 to 2012
Measles Case Distribution by Month and WHO Regions, 2008-2014

This is surveillance data, hence for the last month, the data may be incomplete.

SEAR India is not included in this graph.

As of 27 May 2013, South Sudan has reassigned to the Africa region (AFR) from the Eastern Mediterranean region (EMR).

Data source: surveillance DEF file
Data in HQ as of 5 May 2014
Global transmission patterns of measles viruses from the Philippines, 2014
Measles Annual Disease Burden U.S. Decade Prior to Vaccine (1950s)

- 3-4 million estimated and ~ 500,000 reported cases
- 48,000 hospitalizations
- 4,000 encephalitis cases
- 450-500 deaths
Measles and MMR Vaccines

- **Live, viral vaccines**
  - Measles vaccine licensed in 1963
  - Combination MMR vaccine licensed in 1971
    - Only MMR vaccine is available now in the US

- **Excellent safety profile with 50+ years use**
  - Low risk of febrile seizures in children 12-23 months (1 in 3,000 doses)
  - Temporary pain/stiffness in joints, mostly in teenage or adult women
  - Temporary low platelet count – ITP (~ 1 out of 30,000 doses)

- **Vaccine Effectiveness**
  - 1-dose: ~93%
  - 2-dose: ~97%
Measles Cases, United States, 1962-2014*

Number of cases

Year

*2014 case count preliminary as of June 20
Reported Measles Incidence
United States, 1992-2014*

*2014 case count preliminary as of June 20
Measles Elimination* in the U.S.

• Declared in 2000 and achieved due to:
  – High two-dose vaccine coverage
  – High quality measles surveillance and response
  – Improved measles control in the World Health Organization Region of the Americas

• Elimination does not mean “gone forever” - imported cases and limited spread occur every year

* Defined as interruption of continuous measles transmission for lasting > 12 months
# Measles Cases and Incidence by Age and Vaccination Status, U.S. 2001-2008

<table>
<thead>
<tr>
<th>Age group</th>
<th>Unvaccinated</th>
<th>Vaccinated</th>
<th>Unknown vaccination status</th>
<th>All</th>
<th>Incidence³</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;6 months</td>
<td>4 (100)</td>
<td>0</td>
<td>0</td>
<td>4 (1)</td>
<td>0.2</td>
</tr>
<tr>
<td>6–11 months</td>
<td>58 (98)</td>
<td>1 (2)</td>
<td>0</td>
<td>59 (13)</td>
<td>3.5</td>
</tr>
<tr>
<td>12–15 months</td>
<td>24 (80)</td>
<td>3 (10)</td>
<td>3 (10)</td>
<td>30 (7)</td>
<td>2.6</td>
</tr>
<tr>
<td>16 months to 4 years</td>
<td>30 (79)</td>
<td>6 (16)</td>
<td>2 (5)</td>
<td>38 (9)</td>
<td>0.3</td>
</tr>
<tr>
<td>5–9 years</td>
<td>35 (90)</td>
<td>3 (8)</td>
<td>1 (3)</td>
<td>39 (9)</td>
<td>0.3</td>
</tr>
<tr>
<td>10–19 years</td>
<td>71 (78)</td>
<td>18 (20)</td>
<td>2 (2)</td>
<td>91 (21)</td>
<td>0.3</td>
</tr>
<tr>
<td>20–39 years</td>
<td>35 (30)</td>
<td>43 (37)</td>
<td>38 (33)</td>
<td>116 (26)</td>
<td>0.13</td>
</tr>
<tr>
<td>40–59 years</td>
<td>26 (47)</td>
<td>6 (11)</td>
<td>23 (42)</td>
<td>55 (13)</td>
<td>0.08</td>
</tr>
<tr>
<td>≥60 years</td>
<td>4 (67)</td>
<td>0</td>
<td>2 (33)</td>
<td>6 (1)</td>
<td>0.01</td>
</tr>
<tr>
<td>Total</td>
<td>287 (66)</td>
<td>80 (18)</td>
<td>71 (16)</td>
<td>438</td>
<td>0.14</td>
</tr>
</tbody>
</table>

Parker Fiebelkorn et al, JID, 2010;202:1520-1528
Measles, United States, 2001-Present*
(Importations indicated by red bar, available since 2001)

*2014 case count preliminary as of June 20
Measles, United States, 2001-2014*
Importations by WHO Region

*2014 case count preliminary as of June 20
Measles, U.S., 1997-2014*
Cumulative Number by Month of Rash Onset

* As of June 20, 2014 (data incomplete for June)
Measles U.S. 2014*

514 cases reported from 20 states including 16 outbreaks

- 48 importations
  - 23 from the Philippines
  - 43 (90%) US residents
- 98% cases import-associated
- 56 cases (11%) hospitalized

Cases in US residents (N=506)

- 81% unvaccinated
- 12% unknown vaccination status (most are adults)
- 7% vaccinated

Among unvaccinated

- 87% were personal belief exemptors
- 3% travelers age 6 months to 2 years
- 7% were too young to be vaccinated
- 3% unknown/misc

* Provisional reports to CDC through June 20, 2014
Measles, United States, Jan – June 20, 2014
Source of Importations (N=48)

<table>
<thead>
<tr>
<th>WHO Region</th>
<th># of cases</th>
<th>Countries of travel</th>
</tr>
</thead>
<tbody>
<tr>
<td>African</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>1</td>
<td>Pakistan</td>
</tr>
<tr>
<td>European</td>
<td>5</td>
<td>Dubai/Germany/London (1), Republic of Georgia (1), Netherlands (1), France/Belgium</td>
</tr>
<tr>
<td>Americas</td>
<td>3</td>
<td>Brazil (1), Canada (1), Chile (1)</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>8</td>
<td>India (6), Indonesia (1), Thailand/South Korea (1)</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>31</td>
<td>China (3), Philippines (23), Singapore (1), Saipan (1), Vietnam (1), SE Asia/Philippines (1), FSM (1)</td>
</tr>
</tbody>
</table>

*Reflects travel patterns to and from the US for residents and visitors as well as measles activity at regional and country level
<table>
<thead>
<tr>
<th>Year</th>
<th>Outbreak Name</th>
<th>State</th>
<th>Cases #</th>
<th>Import Status</th>
<th>Genotype</th>
<th>Setting</th>
<th>1st &amp; last rash onsets</th>
<th>Duration</th>
<th>Median Age</th>
<th>Age Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>Brooklyn</td>
<td>NYC</td>
<td>58</td>
<td>Imported (UK)</td>
<td>D8</td>
<td>Household/community</td>
<td>3/13/2013 – 6/9/2013</td>
<td>13 weeks</td>
<td>10 y (early)</td>
<td>0 mos – 32 y</td>
</tr>
<tr>
<td>2005</td>
<td>Tippecanoe County</td>
<td>IN</td>
<td>34</td>
<td>Imported (Romania)</td>
<td>D4</td>
<td>Church/household</td>
<td>5/16/2005 - 6/24/2005</td>
<td>6 weeks</td>
<td>12 y</td>
<td>9 mo - 49 y</td>
</tr>
<tr>
<td>2008</td>
<td>DuPage/Cook County</td>
<td>IL</td>
<td>30</td>
<td>Imported-virus</td>
<td>D4</td>
<td>Homeschool</td>
<td>5/17/2008 - 7/3/2008</td>
<td>7 weeks</td>
<td>10 y</td>
<td>8 mo - 43 y</td>
</tr>
<tr>
<td>2013</td>
<td>Stokes/Orange County</td>
<td>NC</td>
<td>23</td>
<td>Imported (India)</td>
<td>D8</td>
<td>Community</td>
<td>4/5/2013 – 5/7/2013</td>
<td>5 weeks</td>
<td>14 y</td>
<td>12 mo - 59 y</td>
</tr>
<tr>
<td>2013</td>
<td>Tarrant/Denton County</td>
<td>TX</td>
<td>21</td>
<td>Imported (Indonesia)</td>
<td>D9</td>
<td>Church</td>
<td>7/21/2013 – 8/21/2013</td>
<td>5 weeks</td>
<td>11 y</td>
<td>4 mos – 44 y</td>
</tr>
<tr>
<td>2011</td>
<td>Hennepin County</td>
<td>MN</td>
<td>21</td>
<td>Imported (Kenya)</td>
<td>B3</td>
<td>Shelter</td>
<td>2/15/2011 - 4/24/2011</td>
<td>10 weeks</td>
<td>23 m</td>
<td>3 mo - 51 y</td>
</tr>
<tr>
<td>2008</td>
<td>Brooklyn/Kings County</td>
<td>NYC</td>
<td>21</td>
<td>Imported (Israel, Belgium)</td>
<td>D4</td>
<td>Community</td>
<td>2/17/2008 - 4/25/2008</td>
<td>10 weeks</td>
<td>15 m</td>
<td>5 mo - 11 y</td>
</tr>
<tr>
<td>2014</td>
<td>Manhattan</td>
<td>NYC</td>
<td>20</td>
<td>Imported-virus</td>
<td>B3</td>
<td>Community</td>
<td>2/16/2014 – 3/24/2014</td>
<td>5 weeks</td>
<td>23 y</td>
<td>3 mo – 36 y</td>
</tr>
</tbody>
</table>

*as of June 20, 2014
Measles outbreak response has a high economic burden in the U.S.

<table>
<thead>
<tr>
<th>Year</th>
<th>Location</th>
<th>Number of cases (outbreaks)</th>
<th>Estimated public health cost*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>US</td>
<td>107 (16)</td>
<td>$2.7-5.3M</td>
</tr>
<tr>
<td>2011</td>
<td>Utah</td>
<td>13 (2)</td>
<td>&gt;$330,000</td>
</tr>
<tr>
<td>2008</td>
<td>California</td>
<td>12 (1)</td>
<td>$125,000</td>
</tr>
<tr>
<td>2008</td>
<td>Arizona</td>
<td>14 (1)</td>
<td>$800,000 (limited to cost for 2 hospitals to respond to 7 cases in their facilities)</td>
</tr>
<tr>
<td>2005</td>
<td>Indiana</td>
<td>34 (1)</td>
<td>$168,000</td>
</tr>
<tr>
<td>2004</td>
<td>Iowa</td>
<td>1</td>
<td>$142,000</td>
</tr>
</tbody>
</table>

*Public health and health care costs expended to control the spread of measles
Keys to Measles Prevention Diagnosis, & Response

- **Vaccine**
  - Vaccine coverage to maintain high population immunity

- **Measles diagnosis**
  - Clinical history and examination
  - Specimen collection and lab testing

- **Case Response**
  - Reporting
  - Contact Investigation
  - Presumptive evidence of immunity
  - Isolation and Quarantine
  - Post Exposure Prophylaxis
MMR Vaccine Routine Recommendations*

- **Children and adolescents**
  - Two doses at 12-15 months and 4-6 years or at least 28 days after the first dose
  - Catch up vaccination as needed

- **Adults without evidence of measles immunity**
  - Two doses (healthcare personnel, post high school students, travelers)
  - One dose (others)


*ACIP, AAP/COID, AAFP, ACOG, ACP, ACNM available at [http://www.cdc.gov/vaccines/schedules/hcp/adult.html](http://www.cdc.gov/vaccines/schedules/hcp/adult.html)
MMR Vaccine Travel Recommendations

- Persons aged $\geq 12$ months without other evidence of immunity should receive 2 doses*
  - Includes providing a 2nd dose to children prior to age 4-6 yrs
  - Includes adults** who have only received one routine dose in the past

- Children aged 6-11 months should receive 1 dose
  - If vaccinated at age 6-11 months, still need 2 subsequent doses at age $\geq 12$ months

* 2nd dose of MMR vaccine should be administered at least 28 days after the 1st dose
** Born in 1957 or later
MMR Vaccination Coverage

Coverage (%)

NIS data available at http://www.cdc.gov/vaccines/imz-managers/coverage/imz-coverage.html
Suspected Measles: Diagnosis and Response

- Many U.S healthcare professionals have never seen a case of measles

- Delay in diagnosis contributes to transmission

- Consider measles in differential diagnosis of febrile rash illness
  - e.g. Kawasaki’s, Scarlet fever, Dengue
  - Travel History or Exposure to Recent Travelers or measles in the local community
  - Documented Vaccine History

Suspected Measles: Diagnosis and Response

- **Lab testing**
  - Serology for IgM
  - Viral specimen (nasopharyngeal, oropharyngeal, or nasal swab) for PCR (and genotyping)
  - Acute and convalescent specimens for IgG may be useful, especially in vaccinated cases

- **Report immediately to local health department**

- **Offer vaccine or immune globulin immediately to household members without evidence of immunity**

Public Health Response
(for confirmed and suspect cases)

- **Isolation of cases**
  - Infectious period 4 days prior through 4 days after date of rash onset

- **Notification and Surveillance**
  - Immediately notifiable to CDC (within 24 hours)
  - Contact CDC Quarantine Station if relevant travel
  - Alert physicians statewide
  - Enhanced measles surveillance

- **Contact investigations and response efforts**

Measles Isolation Guidance

- If measles is suspected in a clinic, ER or hospital setting, **isolate immediately**
- Airborne isolation room or private room with the door closed, mask patient if feasible
- Ensure healthcare personnel have evidence of immunity
- In hospital setting, respiratory precautions including N95 masks or PAPR, even for those with evidence of immunity

Contact Investigation for Exposure to Measles

- Persons exposed during cases infectious period
  - Includes exposure to area 2 hours after case left

- Establish presumptive evidence of immunity for contacts

- Quarantine of contacts without presumptive evidence of immunity (through 21 days after exposure)

- Postexposure prophylaxis (PEP)
  - Vaccine or Immune globulin (IG)

## Presumptive Evidence of Immunity for Measles

<table>
<thead>
<tr>
<th>Routine</th>
<th>Students at post-high school educational institutions</th>
<th>Health-care personnel</th>
<th>International travelers</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Documentation of age-appropriate vaccination with a live measles virus-containing vaccine:</td>
<td>(1) Documentation of vaccination with 2 doses of live measles virus-containing vaccine, or</td>
<td>(1) Documentation of vaccination with 2 doses of live measles virus-containing vaccine, or</td>
<td>(1) Documentation of age-appropriate vaccination with a live measles virus-containing vaccine:</td>
</tr>
<tr>
<td>– preschool-aged children: 1 dose</td>
<td>(2) Laboratory evidence of immunity, or</td>
<td>(2) Laboratory evidence of immunity, or</td>
<td>– infants aged 6–11 months: 1 dose</td>
</tr>
<tr>
<td>– school-aged children (grades K-12): 2 doses</td>
<td>(3) Laboratory confirmation of disease, or</td>
<td>(3) Laboratory confirmation of disease, or</td>
<td>– persons aged ≥12 months: 2 doses, or</td>
</tr>
<tr>
<td>– adults not at high risk: 1 dose, or</td>
<td>(4) Born before 1957</td>
<td>(4) Born before 1957</td>
<td>(2) Laboratory evidence of immunity, or</td>
</tr>
<tr>
<td>(2) Laboratory evidence of immunity, or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Laboratory confirmation of disease, or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Born before 1957</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Postexposure Prophylaxis (PEP)  
MMR Vaccine

- **Administer within 72 hours of exposure**
  - May return to normal activities (except health care settings)
  - Still monitor for symptoms
  - Can be given down to age 6 months
  - Be aware of possibility of vaccine rash

Postexposure Prophylaxis (PEP) Immune Globulin

- Administer within 6 days of exposure

- **Recommended Dose**
  - Intramuscular (IGIM): 0.5 mL/kg (max = 15 mL)
  - Intravenous (IGIV): 400 mg/kg

- **Recommended for the following groups (risk of severe disease and complications)**
  - Infants aged <12 months (IGIM)
  - Pregnant women without evidence of immunity (IGIV)
  - Severely immunocompromised patients (IGIV)

Measles In the Postelimination Era

- Measles is due to **Failure to Vaccinate**

- **Measles Elimination is a Global Problem**
  - Continued threat of importations

- Measles occurs in the U.S.

- **Maintenance of Elimination is Resource Intensive**
  - Maintaining vaccine coverage
  - Intensive case/contact investigations
  - Healthcare workers diagnostic skills
  - Advanced laboratory techniques
Resources for Healthcare Professionals

- Clinical Information
- Complications
- Transmission
- Practice Guidelines
  - Diagnosis
  - Lab testing
  - Isolation & Treatment
- Vaccination Recs
  - Children & Adults
  - International Travelers
- Measles Images
- Outbreak Statistics

http://www.cdc.gov/measles/hcp/
Resources for Healthcare Professionals

- **Webinar: Measles 2014 Update**
  - Clinical Presentation, Outbreaks, Vaccination Recommendations, & Patient Management
  - [http://www.vicnetwork.org/](http://www.vicnetwork.org/)

- **NetConference: Why Measles Matters**

- **Banners and Buttons Linking to CDC Clinician Site**

- **CDC Fact Sheets and Resources**
  - Fact sheets on measles and vaccine safety to guide discussions with patients and parents

- **Put CDC’s Measles Content for Clinicians on Your Website**
  - Easy steps to syndicate CDC’s measles information to your website
  - [http://www.cdc.gov/syndication/](http://www.cdc.gov/syndication/)

- **Children with Measles Video**
  - [http://www.cdc.gov/vaccines/ed/epivac/default.htm](http://www.cdc.gov/vaccines/ed/epivac/default.htm) (Session 6)
Resources for the Public

- Measles Website
  - Disease Information
  - Vaccination Information and Recs
  - Travel Recommendations
  - Outbreak Statistics

- Infographics, Videos, & Podcasts

- Measles Feature

- Put CDC’s Measles Content for Your Website

- Resources in Spanish
Acknowledgements

- State and local health departments
- CDC staff: measles & rubella epidemiology, laboratory, health economics, communications

- Greg Wallace
- Amy Fiebelkorn
- Paul Gastanaduy
- Susan Redd
- Mark Papania
- Susan Reef
- William Bellini

- Paul Rota
- Jennifer Rota
- Joe Icenogle
- Emily Abernathy
- Ismael Ortega-Sanchez
- Jeanette St Pierre
- Sarah Poser
- Jessica Allen
Thank You

Questions?

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  - “Click” the Q&A tab at the top left of the webinar tool bar
  - “Click” in the white space
  - “Type” your question
  - “Click” ask

- On the Phone
  - Press Star (*) 1 to enter in the queue to ask a question
  - State your name
  - Listen for the operator to call your name
  - State your organization and then ask your question
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CNE: The Centers for Disease Control and Prevention is accredited as a provider of Continuing Nursing Education by the American Nurses Credentialing Center’s Commission on Accreditation. This activity provides 1.0 contact hours.

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CECH: Sponsored by the Centers for Disease Control and Prevention, a designated provider of continuing education contact hours (CECH) in health education by the National Commission for Health Education Credentialing, Inc. This program is designated for Certified Health Education Specialists (CHES) and/or Master Certified Health Education Specialists (MCHES) to receive up to 1.0 total Category I continuing education contact hours. Maximum advanced level continuing education contact hours available are 0. CDC provider number GA0082.

CPE: The Centers for Disease Control and Prevention is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. This program is a designated event for pharmacists to receive 0.1 CEUs in pharmacy education. The Universal Activity Number is 0387-0000-14-129-L04-Pand enduring 0387-0000-14-129-H04-P. This program is knowledge based.

AAVSB/RACE: This program was reviewed and approved by the AAVSB RACE program for 1.0 hours of continuing education in jurisdictions which recognize AAVSB RACE approval. Please contact the AAVSB RACE program if you have any comments/concerns regarding this program’s validity or relevancy to the veterinary profession.
Continuing Education guidelines require that the attendance of all who participate in COCA Conference Calls be properly documented. All Continuing Education credits/contact hours (CME, CNE, CEU, CECH, ACPE and AAVSB/RACE) for COCA Conference Calls/Webinars are issued online through the CDC Training & Continuing Education Online system [http://www.cdc.gov/TCEOnline/](http://www.cdc.gov/TCEOnline/).

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Thank you for joining!
Please email us questions at coca@cdc.gov

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