ULSTER COUNTY BOARD OF HEALTH

June 10, 2013

AGENDA

CALL TO ORDER

- **OLD BUSINESS**
  a. Approval of May 2013 minutes
  b. Financial Disclosures

- **NEW BUSINESS**

  a. Commissioner's Report:
     - Anti- Nepotism Disclosures
     - Community Health Assessment/Community Health Improvement Plan Update
     - Amendment to the Fee Schedule
     - Sanitary Code Update

  b. Medical Examiner Report:
     - May Cases

  c. Patient Services Report:
     - Measles Alert
     - Flu Update

  d. Environmental Health Report:
     - Mass Gathering Update
     - Washington Ave Sewer ByPass Update

MEETING CONCLUSION

Ulster County Board of Health
Date: Monday, June 10, 2013

Board Members		**Signature**
Delma MD, Dominique	Secretary	
Graham ESQ, Peter	Board Member	
Hildebrandt MPA, Mary Ann	Member	
Kelly RN, Elizabeth	Board Member	
Tack DO, Marc	Chairman	
Woodley MD, Walter	Vice Chairman	
Board Member	Vacant	

Department of Health		**Signature**
Smith, MD, MPH, Carol	Commissioner of Health	
Heller MD, Douglas	Medical Examiner	
Veytia RN, MSN, Nereida	Deputy and Director of Patient Services	
Shelley Mertes	Director Env Servs	

Guests		**Signature**
McCracken, Amy	UC Depart of MH Deputy Commissioner	
Cane, Lee	Mid-Hudson League of Women Voters	

Ulster County Board of Health
June 10, 2013

Members PRESENT: Walter Woodley, MD, Board Member
Dominique Delma, MD, Secretary
Marc Tack, DO, Chairman
Mary Ann Hildebrandt, MPA, Board Member
Peter Graham, ESQ, Board Member

UCDOH PRESENT: Carol Smith, MD, MPH, Commissioner of Health
Shelley Mertens, Environmental Health Director
Nereida Veytia, Deputy/Patient Services Director
Douglas Heller, MD, Medical Examiner

GUESTS: Lee Cane, Mid-Hudson League of Women Voters
Amy McCracken, Deputy Commissioner UC Dept of Mental Health

ABSENT: Elizabeth Kelly, RN, Board Member

EXCUSED:

I. **Old Business:**

- **Approval of Minutes:** A motion was made by Ms. Hildebrandt to approve the minutes of the May 13, 2013 meeting; the motioned was seconded by Mr. Graham and unanimously approved.
- **Financial Disclosures:** A reminder was given for all Board Members to submit their yearly Financial Disclosure Forms to the UC Legislative Office. Dr. Smith's office will resend the email notification.

II. **Agency Reports:**

a. Commissioner's Update:
Dr. Smith reported on the following:

- **Anti-Nepotism Disclosures:** The yearly Anti-Nepotism Disclosure forms were distributed to Board Members and completed.
- **Community Health Assessment/Community Health Improvement Plan Update:** The Community Health Assessment forum held on May 21, 2013 was successful, with approximately 90 in attendance. The information gathered will be compiled and used in creating the Community Health Improvement Plan. These plan documents are required by the State DOH and are to be submitted by November 15, 2013 for review.
- **Amendment to the Fee Schedule:** Dr. Smith has been collecting the fee schedules for other NY counties. So far, there are a lot of variability of fees between counties. Her plan is to compile this information and present it to the Board of Health with recommendations for the UC Fee Schedule sometime in the fall of the year.
- **Public Health Accreditation:** The accreditation process a set of developed standards by which health department performance is measured against those standards, and recognition is achieved for those health departments who meet those standards. Although becoming accredited is a hefty undertaking both fiscally (approximately $30,000 (based upon population))

and departmental efforts, the immediate advantage of going through this process would provide UCDOH the template to continue restructuring and tighten UCDOH systems, including the standardization of policy and procedures. UCDOH is still considering its participation.

b. Medical Examiner: Dr. Heller reported on the May activities of the Medical Examiner's Office (see attached.)

c. Patient Services:
Ms Veytia discussed the following:

- **Measles Alert:** A Public Health Alert (see attached) was distributed to physicians and camp counselors informing them of the NYC Department of the Health and Mental Hygiene reporting more than 30 cases of confirmed measles. This is a concern to Ulster County as many children from this area attend summer camps in Ulster County.
- **Flu Update:** A CDC Health Alert regarding an update on the avain influenza A (H7N9) virus, including recommendations (see attached) was distributed. To date there are 130 confirmed cases in China but no US cases have been identified. UCDOH is working closely with the State MARO office regarding the County's ability to conduct pods should H7N9 event occurs.

d. Environmental Health Report:

- **Mass Gathering Update:** UCDOH is in receipt of the Dutchess County Mass Gathering protocol and currently working on revising it to meet Ulster County needs. All forms, rosters, etc have been reviewed with next step of integrated them in the protocol. Suffolk County permit fee for these types of events is $11,500 which is an all inclusive package. This format does not work for Ulster County and therefore, Ulster is considering establishing a flat fee for the event with fees for other services rendored such as temporary food vendors.
- **Washington Ave Sewer ByPass Update:** The bid for this construction project has been awarded by the City of Kingston. No by-pass will be needed.

Meeting Adjournment: A motion was made by Mr. Graham to adjourn the meeting, motion was seconded by Dr. Tack and unanimously approved.

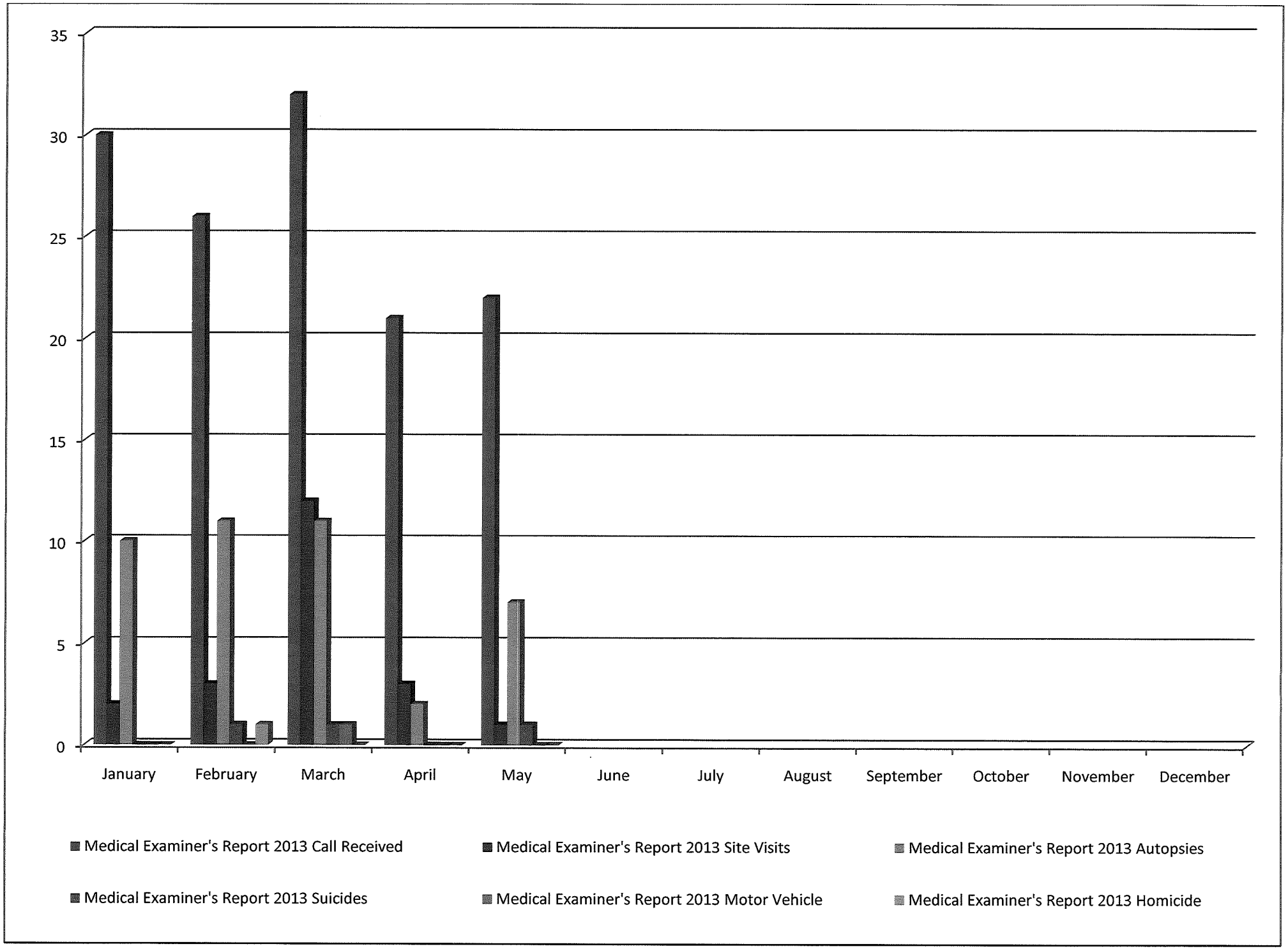
Next Meeting: Due to summer vacations, the July meeting will be cancelled.

Respectfully submitted by:

Katrina Kouhout

Katrina Kouhout
Secretary to the Commissioner of Health
On behalf of UC Board of Health

Medical Examiner Report 2013						
	Call Received	Site Visits	Autopsies	Suicides	Motor Vehicle	Homicides
January	30	2	10	0	0	0
February	26	3	11	1	0	1
March	32	12	11	1	1	0
April	21	3	2	0	0	0
May	22	1	7	1	0	0
June						
July						
August						
September						
October						
November						
December						
Total	131	21	41	3	1	1


35
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January
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Medical Examiner's Report 2013 Call Received
Medical Examiner's Report 2013 Site Visits
Medical Examiner's Report 2013 Autopsies
Medical Examiner's Report 2013 Suicides
Medical Examiner's Report 2013 Motor Vehicle
Medical Examiner's Report 2013 Homicide

Ulster County Department of Health

Public Health Alert

Providers Advised to Consider Measles

June 4, 2013

Please Distribute to School Nurses, Emergency Medicine, Urgent Care Centers, Pediatrics, Family Planning, Primary Care, Infectious Diseases, Internal Medicine, Laboratory Medicine, Infection Control, and Camp Providers

SUMMARY:

- New York City Department of Health and Mental Hygiene has reported more than 30 cases of confirmed Measles without travel history.
- As of 5/28/2013 probable cases are appearing outside of Kings County and are being investigated. Total identified contacts for this outbreak is > 1,000 individuals.
- Proper respiratory isolation of persons suspected of having Measles is extremely important to prevent spread. Protocols such as prompt triage, signage, and masks, should be utilized in healthcare settings. Exam rooms, used by patients suspected of having Measles, should not be used for other patients for at least 2 hours afterward.

Providers should call the Ulster County Department of Health if they suspect Measles at (845) 340-3090.

In consideration of recent measles outbreaks in New York City and surrounding counties, Ulster County is issuing this Public Health Alert to remind providers to consider Measles anytime someone presents with the following:

- rash presenting three days or longer
- temperature ≥ than or equal to 101.0°F
- cough, coryza, or conjunctivitis

UCDOH Permit and Service Fee Schedule

Permit/service	Fee
Water sample	$ 40.00
Sewage disposal systems:	
Daily flow < 1,000	$ 400.00
Daily flow 1,000 - 10,000	$ 500.00
Daily flow > 10,000	$ 600.00
Swimming pool/bathing	$ 200.00
Migrant camps:	
Capacity 1 - 9	$ 100.00
Capacity 10 - 25	$ 150.00
Capacity 26+	$ 200.00
Children's camps:	$ 200.00
Temp residence:	
Seasonal 1 - 10 units	$ 100.00
Seasonal 11 - 50 units	$ 150.00
Seasonal 50+ units	$ 250.00
Year round 1 - 10 units	$ 100.00
Year round 11 - 20 units	$ 150.00
Year round 21 - 100 units	$ 250.00
Year round >100	$ 500.00
Food service:	
Mobile carts	$ 60.00
Seats < 25	$ 100.00
Seats 26 - 75	$ 225.00
Seats > 75	$ 300.00
Temporary Food (< 14 days)	$ 50.00
Caterers/commissaries	$ 200.00
Venders < 25	$ 50.00
Venders 25+	$ 100.00
Frozen dessert	$ 25.00
Refuse/sludge disposal	
Company (or Truck)	$ 150.00
ea. additional truck	$ 30.00

Permit/service (cont'd)	Fee
Realty Subdivisions:	
< 10 lots	$ 250.00
10+ lots	$ 400.00
Line Lot Adjustment	$ 100.00
App for Extension of Approval	$ 150.00
Swimming pool:	
< 25,000	$ 100.00
25,000+	$ 150.00
50,000+	$ 250.00
Mobile home parks:	
1 - 4 sites	$ 150.00
5 - 10 sites	$ 250.00
11 - 25 sites	$ 350.00
26 - 99 sites	$ 500.00
100+	$ 650.00
Public water supply plan:	
Cost < $10,000	$ 150.00
Cost $10,000 - $100,000	$ 300.00
Cost $100,000+	$ 500.00
Construct a Water Well *	$ 250.00
Construct a Resource Well**	$ 250.00
Decommission a Well	$ 250.00
Backflow Prevention Device Review	$ 100.00
Well Contractor Registration	$ 30.00
* Permit for Community Water Supplies	
Late fee:	
Temporary Food Permits ONLY	$ 25.00
All Other Permits	$ 75.00
Public access to records:	
Regular photocopies	$ 0.25
Oversized photocopies	na
Returned check fee	$ 35.00

Distributed via the CDC Health Alert Network
June 7, 2013, 14:00 ET (02:00 PM ET)
CDCHAN-00347

Human Infections with Avian Influenza A (H7N9) Viruses

This health advisory provides an **update** on the avian influenza A (H7N9) virus [H7N9] situation and includes new recommendations on who should be tested for H7N9 in the United States. This document replaces guidance published on April 5, 2013, in CDC Health Advisory 344 "Human Infections with Novel Influenza A (H7N9) Viruses," found at http://emergency.cdc.gov/HAN/han00344.asp. The updated guidance reflects the most current epidemiology of H7N9 cases, which indicates that almost all H7N9 human infections have resulted in severe respiratory illness; H7N9 has been found rarely among those with milder disease. For that reason, CDC is changing its recommendations for H7N9 testing: **The primary changes from previous guidance are (i) a new recommendation to test only patients with an appropriate exposure history and severe respiratory illness requiring hospitalization and (ii) a request that only confirmed and probable cases of human infection with H7N9 be reported to CDC.** In the previous guidance issued on April 5, CDC recommended that all persons with relevant exposure history and illness compatible with influenza, regardless of severity be tested. CDC will continue to update these recommendations as more information becomes available. The current guidance is consistent with interim surveillance recommendations by the World Health Organization for H7N9 found at http://www.who.int/influenza/human_animal_interface/influenza_h7n9/InterimSurveillanceRecH7N9_10May13.pdf

Summary and Background
As of June 3, 2013, Chinese public health officials have reported >130 cases of human infection with H7N9 from 10 provinces and municipalities in mainland China and Taiwan [1, 2]. Most patients were hospitalized with severe respiratory illness and reported poultry contact prior to illness onset [2, 3]. Preliminary results from influenza-like illness surveillance suggest that H7N9 has not caused widespread mild illness in China [4].

Although several clusters of human infection with H7N9 have been identified in China, **sustained person-to-person transmission of the virus has not been demonstrated. At this time, no cases of human infection with H7N9 have been detected in the United States**, despite testing of >60 persons with respiratory illness who reported recent travel to China.

Clinicians should consider the possibility of H7N9 infection in persons presenting with respiratory illness requiring hospitalization and an appropriate travel or exposure history. Influenza diagnostic testing in patients with severe respiratory illness for whom an etiology has not been confirmed may identify human cases of H7N9.

Confirmed and **probable** cases of human infection with H7N9 in the United States should be reported to CDC within 24 hours of initial detection. See http://www.cdc.gov/flu/avianflu/h7n9/case-definitions.htm. However, state health departments are encouraged to investigate all potential cases of H7N9 infection as described below in order to determine case status.

Interim Recommendations for Clinicians and State and Local Health Departments
CDC recommends the following testing practices based on the current epidemiology of H7N9 cases.

Case Investigation and Testing

- Patients who meet both the clinical and exposure criteria described below should be considered for H7N9 testing by reverse-transcription polymerase chain reaction (RT-PCR) methods. Decisions on diagnostic testing for influenza using RT-PCR should be made using available clinical and epidemiologic information, and additional persons in whom clinicians suspect H7N9 infection should also be tested.

  Clinical Illness Criteria

  i. Patients with new-onset severe acute respiratory infection **requiring hospitalization** (i.e., illness of suspected infectious etiology that is severe enough to require inpatient medical care in the judgment of the treating clinician).

  AND

  ii. Patients for whom no alternative infectious etiology is identified.

  Exposure Criteria

  i. Patients with recent travel (within 10 days of illness onset) to areas where human cases of H7N9 have become infected or to areas where avian influenza A (H7N9) viruses are known to be circulating in animals [1].

  OR

  ii. Patients who have had recent close contact (within 10 days of illness onset) with confirmed cases of human infection with H7N9[2]. Close contact may be regarded as coming within about 6 feet (2 meters) of a confirmed case while the case was ill (beginning 1 day prior to illness onset and continuing until resolution of illness). Close contact includes healthcare personnel providing care for a confirmed case, family members of a confirmed case, persons who lived with or stayed overnight with a confirmed case, and others who have had similar close physical contact.

- If infection with H7N9 is suspected based on current clinical and epidemiological screening criteria recommended by public health authorities, respiratory specimens should be collected with appropriate infection control precautions for novel virulent influenza viruses and sent to the state or local health department for testing. Clinicians should obtain a respiratory specimen from these patients, place the swab or aspirate in viral transport medium, and contact their state or local health department to arrange transport and request a timely diagnosis at a state public health laboratory or CDC. **Viral culture should not be attempted in these cases**. For additional guidance on diagnostic testing of patients under investigation for H7N9 infection, please see http://www.cdc.gov/flu/avianflu/h7n9/specimen-collection.htm.

- Commercially available rapid influenza diagnostic tests (RIDTs) may not detect H7N9 viruses in respiratory specimens. Therefore, a negative rapid influenza diagnostic test result does not exclude infection with H7N9. In addition, a positive test result for influenza A cannot confirm avian influenza virus infection because these tests cannot distinguish between influenza A virus subtypes (they do not differentiate between human influenza A viruses and novel[3] influenza viruses). Therefore, when RIDTs are positive for influenza A and there is concern for novel influenza A virus infection, respiratory specimens should be collected and sent for RT-PCR testing at a state public health laboratory. Clinical treatment decisions should not be made on the basis of a negative rapid influenza diagnostic test result since the test has only moderate sensitivity (http://www.cdc.gov/flu/professionals/diagnosis/clinician_guidance_ridt.htm).

Infection Control

Clinicians should be aware of appropriate infection control guidelines for patients under investigation for infection with novel influenza A viruses. For guidance on infection control precautions for H7N9 see http://www.cdc.gov/flu/avianflu/h7n9-infection-control.htm.

Treatment

For guidance on treatment of patients under investigation for H7N9 with antiviral medications, or for guidance on antiviral chemoprophylaxis of exposed contacts, see http://www.cdc.gov/flu/avianflu/h7n9-antiviral-treatment.htm.

For More Information

- CDC avian influenza A (H7N9) virus information is available at http://www.cdc.gov/flu/avianflu/h7n9-virus.htm.
- WHO Situation Updates on avian influenza are available at http://www.who.int/influenza/human_animal_interface/avian_influenza/archive/en/index.html.
- WHO "Frequently Asked Questions on human infection with A (H7N9) virus, China" is available at http://www.who.int/influenza/human_animal_interface/faq_H7N9/en/index.html.
- The Chinese Center for Disease Control and Prevention (China CDC) "Questions and Answers about human infection with A (H7N9) avian influenza virus" is available at http://www.chinacdc.cn/en/research_5311/FAQ/201304/t20130418_80053.html.
- CDC general information about avian influenza viruses and how they spread is available at http://www.cdc.gov/flu/avianflu/avian-in-humans.htm.

End Notes:

[1]As of June 3, 2013, China was the only country where H7N9 viruses were known to be circulating in animals or where human cases have become infected. Patients with direct or close contact with wild birds or poultry, or animal settings, such as live poultry markets while traveling in these areas should be strongly considered for H7N9 testing. For more information on countries affected, please see the CDC avian influenza A (H7N9) information page at http://www.cdc.gov/flu/avianflu/h7n9-virus.htm.

[2]Contact investigation protocols for confirmed cases may supersede the recommendations described here; testing of close contacts with *any level* of respiratory illness may be pursued, if in the judgment of the investigators, this is warranted.

[3]Influenza viruses that do not typically infect humans are called "novel" influenza viruses; this includes influenza viruses that typically infect birds and swine.

References:

1. Centers for Disease Control and Prevention. Emergence of Avian Influenza A(H7N9) Virus Causing Severe Human Illness - China, February-April 2013. MMWR **2013**; 62(18): 366-71. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6218a6.htm?s_cid=mm6218a6_w
2. Li Q, Zhou L, Zhou M, et al. Preliminary Report: Epidemiology of the Avian Influenza A (H7N9) Outbreak in China. N Engl J Med. **2013** Apr 24. [Epub ahead of print]. http://www.ncbi.nlm.nih.gov/pubmed/?term=Epidemiology+of+the+Avian+Influenza+A+(H7N9)+Outbreak+in+China
3. Lee SS, Wong NS, Leung CC. Exposure to avian influenza H7N9 in farms and wet markets. Lancet May 25;381(9880):1815. doi: 10.1016/S0140-6736(13)60949-6. Epub **2013** May 10. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60949-6/fulltext?rss=yes
4. Xu C, Havers F, Wang L, Chen T, Shi J, Wang D. Monitoring avian influenza A(H7N9) virus through national influenza-like illness surveillance, China. Emerging Infectious Diseases [Internet], **2013** Jul [*June 3, 2013*]. http://dx.doi.org/10.3201/eid1908.130662.

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

Categories of Health Alert Network messages:

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

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