ULSTER COUNTY BOARD OF HEALTH

September 8, 2014

AGENDA

CALL TO ORDER

- **OLD BUSINESS**
  a. Approval of June 2014 minutes
  b. NYSDOH "Smart Meter" response

- **NEW BUSINESS**

  a. Commissioner's Report:
     - Mass Gathering Update
     - DSRIP
     - NYSDOH – Steven Sadwicki
     - Unaccompanied Minors

  b. Medical Examiner's Report

  c. Patient Services Report:
     - Flu and Pneumo Vaccine 2014 Clinic Fees

     - Article 28- Clinical Services Site Survey (7/15/2014)
       A) Plan of Correction - 8/12/2014
       B) Professional Credentialing
          - Role of BOH (See Attached policy)
          - Present 3 physicians:
            Dr. Mark Montera - STD/HIV Clinical Services
            Dr. John Anderson - TB Clinical Services
            Dr. Vidayahara Kagali - STD/HIV Clinical Services

  d. Environmental Health Report:
     - Village of New Paltz Water Supply

MEETING CONCLUSION

Ulster County Board of Health

Golden Hill Office Building
239 Golden Hill Lane
Kingston, NY 12401

Date: Monday, September 8, 2014

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

Department of Health		Signature
Smith, MD, MPH, Carol	Commissioner of Health	
Heller MD, Douglas	Medical Examiner	Excused
Veytia RN, MSN, Nereida	Deputy and Director of Patient Services	Excused
Mertens PE, Shelley	Director of Environmental Health Services	~~Excused~~

Guests		Signature
McCracken, Amy	UC Depart of MH Deputy Commissioner	

Ulster County Board of Health
September 8, 2014

Members PRESENT: Marc Tack, DO, Chairman
Peter Graham, ESQ, Board Member
Walter Woodley, MD, Board Member
Dominique Delma, MD, Secretary
Elizabeth Kelly, RN, Board Member
Anne Cardinale, RN GCNS-BC, Board Member

UCDOH PRESENT: Carol Smith, MD, MPH, Commissioner of Health
Shelley Mertens, Environmental Health Director

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

ABSENT:

EXCUSED: Mary Ann Hildebrandt, MPA, Board Member
Douglas Heller, MD, Medical Examiner
Nereida Veytia, Deputy/Patient Services Director

I. **Approval of Minutes:** A motion to approve of the June 2014 minutes was made by Ms. Kelly, seconded by Dr. Tack and unanimously approved.

II. **"Smart Meter" letters follow-up:** The Board reviewed the response letter from NYSDOH. A copy of the letter will be forwarded to Mr. Blelock. (See Attached.)

III. **Agency Reports:**

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

- **Mass Gathering**: Dr. Smith reviewed The Hudson Project mass gathering event:
  - There were no deaths
  - 13 Ambulance Transports
  - 815 Visits to the Medical Tent
  - Approx 150 arrests. Many drug arrests for a variety of drugs.
  - Emergency Operation Center (EOC) was opened 24 hours during the event and DOH members participated in working the EOC
  - A "Hot Wash" of the event was done on August 8th. DOH is currently working on compiling the information into a finalized report. Dr. Smith will share the report with the Board upon completion.
  - Severe thunderstorms on Sunday, July 13th of the event occurred. Dr. Smith and Art Snyder of Emergency Management began counseling the promoters to cancel the event for safety reasons. Promoters were hesitant but

ultimately the show was cancelled and attendees were instructed to "find a buddy" with a car and stay in the car for safety.
    - Many cars stuck in mud after rain subsided
    - The evacuation plan will need to be reworked should a 2015 event take place.

- **Delivery System Reform Incentive Payment program (DSRIP)**: Dr. Smith continues to participate in DSRIP calls with Health Alliance. Attended a Hudson Valley Regional Health Officials Network (HVRHON) meeting in July. It was decided at that meeting that the focus of the HVRHON meetings would be for DSRIP planning.
- **NYLinks Presentation**: Steven Sadwicki,MHSA, Program Manager, AIDS Institute, NYS DOH, is requesting to give a presentation to the Board on the NYLinks project. The project is part of the Governor's End of AIDS initiative. The Board agreed to have him attend the October meeting.
- **Unaccompanied Minors**: Dr. Smith updated the Board on the status of the unaccompanied minors. There are 3300 minors residing within NYS. The Federal Government is sending these minors through an initial processing center before they are sent to new housing locations. Currently, minors in our region are being sent to the Poughkeepsie Children's Home and the Kingston Children's Home. There has been "talk" about the use of the old Cabrini facility but to date that building has not been utilized. UCDOH is not receiving information regarding these minors and their medical status. Dr. Smith reached out to both of the Children's Home for more information. The Kingston Children's Home was unresponsive and the Poughkeepsie Children's Home is working with the Children's Medical Group for their health needs. Tracking of health status of these minors is lost once they leave the facility.
- **Flu and Pneumo Vaccine 2014 Clinic Fees:** The proposed fee schedule was distributed to the Board (See Attached.) Dr. Tack motioned to accept the 2015 fees, Dr. Woodley seconded and unanimously approved.
- **Article 28- Clinical Services Site Survey**: This survey took place on 7/15/2014. DOH submitted a Plan of Correction on 8/12/2014 (see attached.)One of the items noted on the site survey report was the need for a credential review process for DOH medical staff. A credentialing application and policy was created which identified the Board of Health as the reviewer (see attached.) Dr. Tack made a motion to accept the policy, seconded by Dr. Woodley and unanimously approved. Credentialing packets will be distributed to the following medical staff:

    Dr. Mark Montera - STD/HIV Clinical Services
    Dr. John Anderson - TB Clinical Services
    Dr. Vidayahara Kagali - STD/HIV Clinical Services

  Completed packages will be brought to the Board for review and approval.

b. Medical Examiner's Report: The October activities of the Medical Examiner's Office were distributed (see attached.)

c. Environment Health Report:

Ms. Mertens reported out on the following:

- **Village of New Paltz Water Supply:** As a result of the upcoming shut-down of the New York City Aqueduct, the Village of New Paltz has undertaken the task of finding a new supply source of water for the shut-down and potentially for long term use. The plan includes drilling two (2) wells in the Pine Plains Road area. One(1) well has been developed and pretesting and yield testing was completed. Ms. Mertens noted that UCDOH does not regulate private wells and will only get involved in an advisory capacity if a public health hazard exists. The maintenance of private wells is the responsibility of the home owner.

Meeting Adjournment: A motion was made by Dr. Delma to adjourn the meeting, motion was seconded by Ms. Kelly and unanimously approved.

Next Meeting: The next meeting is scheduled for December 8, 2014.

Respectfully submitted by:

Katrina Kouhout

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

NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

August 5, 2014

Marc Tack, M.D.
Board of Health
Ulster County Department of Health
239 Golden Hill Lane
Kingston, New York 12401

Dear Dr. Tack:

Thank you for your letter to former New York State Commissioner of Health Nirav Shah M.D., M.P.H., sharing the concerns from Ulster County citizens regarding Central Hudson Gas and Electric's smart meters. In your letter you ask us for our expert opinion on the materials presented during the Ulster County Board of Health meeting. Though we do not have a program that focuses on non-ionizing radiation (except for sun tanning), our staff has reviewed available literature and we are using that information to respond to your request.

As you know, Automatic Meter Readers (AMR) also called "smart meters" are being used by the utilities to measure electric, gas or water delivered to customers. Smart meters use wireless communication or radio frequency (RF) to transmit their information. Many household electronic devices, such as cellular and cordless telephones, microwave ovens, and wireless routers also produce RF emissions.

Many people may be concerned about health effects from exposure to RF emissions particularly since devices which emit RF are becoming increasingly common. Certain effects associated with the thermal impacts of RF, tissue heating from absorbing energy associated with radiofrequency emissions, have been extensively studied and appear to be well understood. According to the California Council on Science and Technology's report on Health Impacts of Radio Frequency from Smart Meters there has been extensive research conducted into possible health effects from exposure to RF radiation. Studies performed by the National Council on Radiation Protection and Measurements (NCRP), the American National Standards Institute (ANSI), and the Institute of Electrical and Electronics Engineers (IEEE) show that exposures to low level RF fields do not appear to cause any adverse health effects. The RF emission levels from the AMRs are many times lower than the limits set by the Federal Communications Commission (FCC), which is responsible for the licensing and regulation of telecommunication activities using RF transmissions. These limits are many times lower than the level where any health effects have been observed and are based on recommendations from the NCRP and ANSI/IEEE. The thermal impacts of RF are the basis for the FCC established guidelines to protect public health. Non-thermal effects, however, including health effects that may be associated with cumulative or prolonged exposure to lower levels of RF emissions, are not as well understood. Studies have looked at non-specific symptoms such as fatigue, headache, and

irritability, as well as health outcome such as certain types of cancer. Findings from these studies have not established an association and the mechanisms that might lead to non-thermal effects remain uncertain.

The FCC has set a limit on the Standard Absorption Rate (SAR) from electronic devices, which is well below the level that has been demonstrated to affect behavior in laboratory animals. Smart meters, if installed according to the manufacturer's instructions and consistent with the FCC certification, emit RF that is a very small fraction of the exposure level established as safe by the FCC guidelines. The FCC guidelines provide a significant factor of safety against thermal impacts that occur at the power levels and within the RF band used by smart meters. Given current scientific knowledge, the FCC guideline provides a more than adequate margin of safety against the known thermal effects.

I am attaching a technical review of RF exposure levels specifically focused on AMR units prepared by the California Council on Science and Technology as well as a fact sheet from the World Health Organization that discusses Electromagnetic Fields and Public Health. I hope you find them useful. If you would like to discuss further please contact me at 518-402-7550.

Sincerely,

Stephen Gavitt, C.H.P., Director
Bureau of Environmental Radiation Protection

Attachment

cc: C. Smith, M.D.
A. Salame-Alfie, Ph.D.
B. Devine

World Health Organization

Fact sheet N°296
December 2005

Electromagnetic fields and public health
Electromagnetic Hypersensitivity

As societies industrialize and the technological revolution continues, there has been an unprecedented increase in the number and diversity of electromagnetic field (EMF) sources. These sources include video display units (VDUs) associated with computers, mobile phones and their base stations. While these devices have made our life richer, safer and easier, they have been accompanied by concerns about possible health risks due to their EMF emissions.
For some time a number of individuals have reported a variety of health problems that they relate to exposure to EMF. While some individuals report mild symptoms and react by avoiding the fields as best they can, others are so severely affected that they cease work and change their entire lifestyle. This reputed sensitivity to EMF has been generally termed "electromagnetic hypersensitivity" or EHS.
This fact sheet describes what is known about the condition and provides information for helping people with such symptoms. Information provided is based on a WHO Workshop on Electrical Hypersensitivity (Prague, Czech Republic, 2004), an international conference on EMF and non-specific health symptoms (COST244bis, 1998), a European Commission report (Bergqvist and Vogel, 1997) and recent reviews of the literature.

What is EHS?

EHS is characterized by a variety of non-specific symptoms, which afflicted individuals attribute to exposure to EMF. The symptoms most commonly experienced include dermatological symptoms (redness, tingling, and burning sensations) as well as neurasthenic and vegetative symptoms (fatigue, tiredness, concentration difficulties, dizziness, nausea, heart palpitation, and digestive disturbances). The collection of symptoms is not part of any recognized syndrome. EHS resembles multiple chemical sensitivities (MCS), another disorder associated with low-level environmental exposures to chemicals. Both EHS and MCS are characterized by a range of non-specific symptoms that lack apparent toxicological or physiological basis or independent verification. A more general term for sensitivity to environmental factors is Idiopathic Environmental Intolerance (IEI), which originated from a workshop convened by the International Program on Chemical Safety (IPCS) of the WHO in 1996 in Berlin. IEI is a descriptor without any implication of chemical etiology, immunological sensitivity or EMF susceptibility. IEI incorporates a number of disorders sharing similar non-specific medically unexplained symptoms that adversely affect people. However since the term EHS is in common usage it will continue to be used here.

Prevalence

There is a very wide range of estimates of the prevalence of EHS in the general population. A survey of occupational medical centres estimated the prevalence of EHS to be a few individuals per million in the population. However, a survey of self-help groups yielded much higher estimates. Approximately 10% of reported cases of EHS were considered severe.

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close co-operation with a qualified medical specialist (to address the medical and psychological aspects of the symptoms) and a hygienist (to identify and, if necessary, control factors in the environment that are known to have adverse health effects of relevance to the patient). Treatment should aim to establish an effective physician-patient relationship, help develop strategies for coping with the situation and encourage patients to return to work and lead a normal social life.

EHS individuals: Apart from treatment by professionals, self help groups can be a valuable resource for the EHS individual.

Governments: Governments should provide appropriately targeted and balanced information about potential health hazards of EMF to EHS individuals, health-care professionals and employers. The information should include a clear statement that no scientific basis currently exists for a connection between EHS and exposure to EMF.

Researchers: Some studies suggest that certain physiological responses of EHS individuals tend to be outside the normal range. In particular, hyper reactivity in the central nervous system and imbalance in the autonomic nervous system need to be followed up in clinical investigations and the results for the individuals taken as input for possible treatment.

What WHO is doing

WHO, through its International EMF Project, is identifying research needs and co-ordinating a world-wide program of EMF studies to allow a better understanding of any health risk associated with EMF exposure. Particular emphasis is placed on possible health consequences of low-level EMF. Information about the EMF Project and EMF effects is provided in a series of fact sheets in several languages www.who.int/emf/.

FURTHER READING

WHO workshop on electromagnetic hypersensitivity (2004), October 25 -27, Prague, Czech Republic, www.who.int/peh-emf/meetings/hypersensitivity_prague2004/en/index.html

COST244bis (1998) Proceedings from Cost 244bis International Workshop on Electromagnetic Fields and Non-Specific Health Symptoms. Sept 19-20, 1998, Graz, Austria

Bergqvist U and Vogel E (1997) Possible health implications of subjective symptoms and electromagnetic field. A report prepared by a European group of experts for the European Commission, DGV. Arbete och Hälsa, 1997:19. Swedish National Institute for Working Life, Stockholm, Sweden. ISBN 91-7045-438-8.

Rubin GJ, Das Munshi J, Wessely S. (2005) Electromagnetic hypersensitivity: a systematic review of provocation studies. Psychosom Med. 2005 Mar-Apr;67(2):224-32

Seitz H, Stinner D, Eikmann Th, Herr C, Roosli M. (2005) Electromagnetic hypersensitivity (EHS) and subjective health complaints associated with electromagnetic fields of mobile phone communication---a literature review published between 2000 and 2004. Science of the Total Environment, June 20 (Epub ahead of print).

Staudenmayer H. (1999) Environmental Illness, Lewis Publishers, Washington D.C. 1999, ISBN 1-56670-305-0.

For more information contact:

WHO Media centre
Telephone: +41 22 791 2222
Email: mediainquiries@who.int

Corporate links

New York State SPNS Concept Paper

The HRSA HIV/AIDS Bureau (HAB)-sponsored *Special Projects of National Significance* aims to support the development of innovative models of HIV care that respond to the emerging needs of Ryan White HIV/AIDS Program clients. In 2011, HAB launched the SPNS for *Systems Linkages and Access to Care for Populations at High Risk of HIV Infection Initiative.* This multi-state initiative will address issues of access to and retention in high quality HIV care through the development and dissemination of effective and sustainable systemic linkage models.

Background

This SPNS Initiative is funded for 4 years and awarded to states with a high HIV/AIDS incidence. The goal is to create, evaluate, and improve models of systemic linkage that optimize existing cross-agency HIV-related services in order to improve linkage and retention in care of people living with HIV/AIDS.
Successful models will demonstrate:

- An increase in the number of people living with HIV who know their serostatus
- An increase in the number of newly diagnosed individuals linked to care within one month of diagnosis
- An increase in the number of individuals living with HIV who are virologically suppressed
- An increase in number of individuals living with HIV retained continuously in HIV clinical care

Interventions will be rigorously evaluated using state-specific indicators and successes will be used for statewide dissemination. In addition, all demonstration states are part of a multi-state evaluation effort led by the SPNS Evaluation and Technical Assistance Committee (ETAC) at UCSF.

SPNS Demonstration State Awardees:

- Louisiana
- Massachusetts
- New York
- North Carolina
- Virginia
- Wisconsin

New York State SPNS Initiative

The aim of the New York State Systems Linkages Project is to bridge systemic gaps between HIV related services within New York State and achieve better outcomes for PLWHA through improving systems for monitoring, recording, and accessing information about HIV care in NYS. In Years 1 and 2, this will be accomplished through the development of regional groups composed of traditional and non-traditional healthcare and supportive services providers in specific high-incidence communities, creating a learning environment in which collaboration and linkage innovations can be tested and measured. In Years 3 and 4, a statewide scale-up of strategies shown to have promise during the Collaborative phase, as well as a subsequent evaluation of their effectiveness and sustainability will be conducted. Ultimately, the development and scale-up of these interventions will foster communication between service providers and encourage the removal of barriers that limit the effective use of data systems. This will facilitate the entry into and continued engagement in HIV care by those who are unaware of their status, have not entered care or are no longer retained in care.

Key partners in this Initiative include the NYS Division of Epidemiology, Evaluation and Research (*Dr. Lou Smith*), the New York City Department of Health and Mental Hygiene, and the CUNY School of Public Health at Hunter College (*Dr. Denis Nash).* Representatives from the New York City Health and Hospitals Corporation, NYS Consumer Advisory, Clinical Advisory and Young Adult Consumer Advisory Committees will participate in an advisory capacity.

Structure of New York State Activities

Years 1 & 2

The first two years of this Initiative will focus primarily on implementation of regional groups, beginning in Upper Manhattan and Western NYS. Additional areas, identified through a process based on incidence, prevalence, provider density, the

existence of other initiatives, and need, will be implemented. Regional groups will consist of representatives from various service categories, Ryan White funding streams, surveillance units, community groups, and consumers.

Each regional group will be tasked with forging partnerships across funding streams, program areas and providers to develop a catalogue of proven strategies to link HIV-infected individuals to HIV clinical care. The work of every regional group will be thoroughly evaluated using available performance data and pre-approved quality indicators. Models and interventions proven to be highly successful will be integrated into existing NYSDOH frameworks.

Years 3 & 4

The second two years of the NYS SPNS Initiative will turn toward statewide implementation and evaluation of successful interventions. The AIDS Institute will use a multifaceted approach to bring the lessons on linkage to care learned in the first two years to providers and consumers across the state and outside of the Collaborative model. Additionally, the sustainability and effectiveness of these interventions on a statewide level will be evaluated.

To foster implementation and peer learning of successful strategies identified by face-to-face Collaboratives, the AIDS Institute and the National Quality Center (NQC) will utilize the following approach:

- Hold statewide conference calls and webinars
- Attend statewide and regional conferences to highlight key concepts and successful interventions
- Develop web-based modules on linkage and retention through the NQC Quality Academy
- Publish and disseminate resources on linkage to care using websites, project space and targeted mailings

Surveillance and Data Systems

Another principal aim of this project is to integrate and strengthen state and city data systems to improve the quality of available data on linkage and retention. Data from routine assessments of linkage and retention at the agency level, from the larger systems of HIVQUAL, AIRS, Medicaid and NYC and NYS Epidemiology/Surveillance as well as site-level data from the regional groups all will ideally be linked. Ultimately, the long-term coordination of these data systems will facilitate the provision of quality information to NYC & NYS surveillance systems and of wide-ranging high quality care to all populations of PLWHA in NYS. This process will run throughout the four year initiative period.

Evaluation

The evaluation effort for the SPNS project will be led by Dr. Denis Nash. Data on core project indicators will be collected from the regional group sites, control sites as well as existing data sources to analyze trends in key testing, linkage and retention outcomes. The overall evaluation component of this initiative aims to:

- Evaluate the effectiveness of strategies piloted in the regional groups to improve outcomes related to HIV diagnosis, linkage, engagement and retention in high quality HIV care.
- Evaluate the statewide impact of dissemination and scale-up of strategies found by the regional groups to be effective.
- Participate in and contribute to the multi-state evaluation process.

End Goals

At the completion of this 4-year SPNS Initiative, we aim to have:

- Facilitated new levels of collaboration between agencies and organizations providing HIV services in NYS.
- Identified, assessed and scaled-up innovative data-backed interventions for linking and retaining patients in care.
- Integrated these innovations into existing networks and services statewide.
- Coordinated existing data systems within NYS to better analyze and improve linkage and retention.
- Established clear performance measurements to allow for routine and accurate monitoring of HIV care across NYS.
- Developed plans to sustain regionalized linkage and retention efforts in NYS.

Medical Examiner's Report												
	Call Received		Site Visits		Autopsies		Suicides		Motor Vehicle		Homicide	
Year	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014	2013	2014
January	30	29	2	0	10	7	0	1	0	0	0	0
February	26	28	3	5	11	11	1	1	0	0	1	1
March	32	29	12	6	11	7	1	0	1	1	0	0
April	21	24	3	2	2	8	0	2	0	1	0	0
May	22	26	1	4	7	7	1	2	0	0	0	0
June	16	21	1	3	4	9	3	2	0	0	0	0
July	35	21	5	1	12	6	0	3	1	0	1	1
August												
September												
October												
November												
December												
Total	182	178	27	21	57	55	6	11	2	2	2	2

2014 Flu/Pneumo Cost & Recommended Charges for September BOH Meeting

Robin Nigro to: Nereida Veytia 08/28/2014 01:08 PM
Cc: Carol Smith, Kristin Carney, Katrina A Kouhout

Boudy

As requested, the following is the estimated cost to administer flu and pneumonia vaccines at the 2014 clinics.
Staff cost includes Nurses, Clerical Support, & Billing Clerk; Supply cost includes direct patient supplies.
Vaccine cost is the current cost at the lowest price available.

Cost Per Dose	Flu	Pneumo
2011 Count:	189	4
2012 Count:	249	4
2013 Count:	230	6
Admin Cost (Est)		
Nursing PS/FB	$ 5.99	$ 5.99
Clerical PS/FB	$ 2.26	$ 2.26
Tot PS/FB	**$ 8.25**	**$ 8.25**
Vaccine Cost	**$ 9.41**	**$ 66.24**
Supply	**$ 0.76**	**$ 0.76**
Total Est Cost per dose	$ 18.42	$ 75.25
Recommendation	**$ 20.00**	**$ 76.00**
Charges Adopted by BOH		

Note:
2013 Charges were: Flu $20 / Pneumo $70.
The cost of pneumo increased $4.68/dose for 2014; the prior year increase $5.59/dose.

If you have any questions, please feel free to contact me.

Thanx,
Robin F (Nigro) Bissinger
Fiscal Manager

Ulster County Department of Health
Golden Hill Office Building
239 Golden Hill Lane
Kingston, NY 12401-6441
(845) 340-3158 or Internal x3158
(845) 340-4150 Fax
E-Mail: rnig@co.ulster.ny.us

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NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sue Kelly
Executive Deputy Commissioner

August 7, 2014

Carol Smith, M.D.
Commissioner of Health
Ulster County Health Department
239 Golden Hill
Kingston, New York 12401

Facility Name: Ulster County Health Department
Event ID#: 5CU311
Survey Exit Date: 7/15/14

Dear Doctor Smith:

Staff from the New York State Department of Health conducted an Article 28 onsite survey of your facility on the above noted date. The purpose of the survey was to review the facility's compliance with Title 10 New York Codes, Rules and Regulations. As a result of the survey, deficiencies were identified. Enclosed is a copy of the survey report.

Please prepare a specific Plan of Correction on the original Statement of Deficiencies. The Plan is to be generic for each deficiency and must relate to the care of all patients. The Plan is to include specific corrective actions placed in the column labeled "Provider's Plan of Correction," title of the party responsible for each corrective action, and a "Completion Date" for each action plan in the (X5) column. If you require additional space, you may note "See attachment" on the form and attach sheets, which clearly identify, by tag number, the citation being addressed.

An acceptable Plan of Correction is due back to this office within ten (10) calendar days of the date of this letter.

Please ensure that the first page of the Plan of Correction is signed (in X6 Section) by a duly authorized representative of your facility and returned to the address below.

If you have any questions please contact Denise Brelia-Hyland or Kathy Ericsen at 518-402-1004.

Sincerely,

Ruth Leslie

Ruth Leslie
Director
Division of Hospitals and Diagnostic & Treatment Centers

Enclosure

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HP0824D	A. BUILDING: _____ B. WING _____	07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULSTER COUNTY HEALTH DEPARTMENT	239 GOLDEN HILL DRIVE KINGSTON, NY 12401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 000	INITIAL COMMENTS Note: The New York official compilation of codes, rules and regulations (10NYCRR) deficiencies below are cited as a result of a survey (main site located at 239 Golden Hill and Aaron Court clinic located at Willow Park Office complex) conducted in accordance with Article 28 of the New York State Public Health law. The plan of correction, however, must relate to the care of all patients and prevent such occurrences in the future. Intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.	T 000		
T2026	751.2 (h) ORGANIZATION AND ADMINISTRATION. Operator. The responsibilities of the operator shall include but not be limited to: (h) the appointment of medical and dental staff, the assignment of their clinical privileges and reviews of such appointments at least every two years. This Regulation is not met as evidenced by: Based on document review and interview, the operator does not ensure the appointment of medical staff including the assignment of clinical privileges and reviews of such appointments every two years, as evidenced for 2 of 2 staff. (Staff # 7-8). Findings include: Review of credential files on 7/15/14 for Staff # 7 and 8 identified these files lacked documented	T2026	The Commissioner of Health (COH)/Medical Director and Director of Patient Services (DPS) will present the three medical staff currently on staff to the governing body: Board of Health (BOH) in review to ensure they are licensed and currently registered by New York State Department of Education (NYSDOE) and continuance of clinical privileges as per assignment. The approval from the BOH will occur at their next regularly scheduled meeting and documented in employee record their review and renewal. **Responsible person: COH/Medical Director** **Completion Date: September 8, 2014**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HP0824D	A. BUILDING: _____ B. WING _____	07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ULSTER COUNTY HEALTH DEPARTMENT	239 GOLDEN HILL DRIVE KINGSTON, NY 12401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T2026	Continued From page 1 evidence that the assignment of their clinical privileges were reviewed and renewed. Interview on 7/15/14 at 3:00 pm with Staff #1 Director of Patient Services stated Human Resources were responsible to do this process.	T2026		
T2054	751.4 (d) ORGANIZATION AND ADMINISTRATION. Medical director. The operator shall appoint a medical director who: (d) develops and recommends to the operator policies and procedures governing patient care in accordance with generally accepted standards of professional practice. This Regulation is not met as evidenced by: Based on document review and interview the Medical Director did not develop a policy and procedure for monitoring and assessing the quality and appropriateness of patient care. On 7/15, a review of the policies and procedures showed no documented evidence regarding monitoring and assessing of patient care. On 7/15, the surveyor requested from Staff #1 Director of Patient Services the policies and procedures regarding monitoring and assessing patient care. Staff # 1 stated they did not have a policy.	T2054	a. The COH/Medical Director and DPS have developed a policy (See attached: Operator, Organization and Structure) that includes the identification of who is responsible for the establishment of policies and procedures and the management and operation of the Diagnostic and Treatment Center (DTC). This policy will identify the oversight of the COH/Medical Director in the recommendation and approval process of policies/procedures and include patient care monitoring/responsibilities. **Responsible Person: COH/Medical Director and DPS** **Completion Date: 8/11/2014** b. The DPS will provide education to staff on the DTC's Operator, Organization and Structure policy. The staff will be educated on the roles of the COH/Medical Director and DPS in the development of policy and procedure for medical services provided at center and the administration oversight for clinical monitoring and assessment of provision of patient care in all clinical settings. **Responsible Person: DPS** **Completion Date: 9/12/2014**	
T2055	751.4 (e) ORGANIZATION AND ADMINISTRATION.	T2055		

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T2055	Continued From page 2 Medical director. The operator shall appoint a medical director who: (e) develops and recommends to the operator policies and procedures concerning the appointment of medical and dental staff, the assignment of their clinical privileges and reviews of such appointments.. This Regulation is not met as evidenced by: Based on document review and interview the Medical Director did not develop policies and procedures concerning the appointment of medical staff or the assignment of their clinical privileges and reviews of the appointments. Review of the policies and procedures for the Center on 7/15, revealed there was no documented evidence of any policies and procedures concerning the appointment of medical staff or the assignment of their clinical privileges and reviews of the appointments. On 7/15, the surveyor requested that Staff #1 Director of Patient Services provide the policies and procedures for medical staff appointments. Staff # 1 stated they did not have have this policy.	T2055	a. The COH/Medical Director and DPS have developed a policy (See attached: Professional Licensure and Credentialing) to ensure all patients receiving medical services at DTC by a competent and licensed professional by NYSDOE as demonstrated by provision of license and current registration and assignment of clinical duties for licensed employees will commensurate with their licensure, registration and experience. This policy provides procedure for obtaining verification of license upon employment, and there after upon renewal. The credentialing of medical staff by the BOH to take place upon hire and every two years, thereafter to ensure proper assignment of medical staff to clinical duties. **Responsible Person: COH/Medical Director and DPS** **Completion Date: 8/11/2014** b. The BOH will be present with policy (See attached Professional Licensure and Credentialing policy) at their next regularly scheduled meeting. **Responsible Person: COH/Medical Director and DPS** **Completion Date: 9/8/2014** c. The DPS will educate agency's clinical staff on requirements for professional licensure, current registration and performance of duties that commensurate with their license and competency. **Responsible Person: DPS** **Completion Date: 9/12/2014**	
T2110	751.6 (n) ORGANIZATION AND ADMINISTRATION. Personnel. The operator shall ensure: (n) that a record is maintained for each employee which documents his/her attendance at orientation, on-the-job training and in-service	T2110		

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T2110	Continued From page 3 education programs. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence of in-services in 7 of 7 personnel files reviewed. Proof of attendance at annual in-services for fire/safety (#1-5, 7 and 8) and universal precautions (#5, 7, 8) were not present for all employees. Evidence of training at the time of hire was lacking for HIV confidentiality (#5, 7, 8), domestic violence (#4, 5, 7, 8) and advance directives (#5, 7,8). These were confirmed at the time of exit on 7/15 with the Director of Patient Services.	T2110	a. The DPS developed a policy (See attached: Fire and Emergency Response Plan), this policy includes the procedure for initiating fire response and/or emergency evacuation and the role of nurse/clinic supervisor to ensure safe evacuation of all staff and clients. All staff assigned to clinics, on an annual basis will be provided with emergency response plan and their signed acknowledgement to be maintained on file. In addition, policy includes measure to provide annually, clinical medical staff with copy of emergency evacuation plans specific to their assigned clinic sites. A signed acknowledgement of receipt and review of policies will be maintained on file. **Responsible Person: DPS** **Completion Date: 8/11/2014** b. DPS will provide a copy of the Fire and Emergency Response Plan along with a copy of Procedure and Emergency Evacuation Plan to the specific clinic staff who are in need to demonstrate training on file. An employee signed acknowledgement of their review and receipt of plan to be maintained on file for those employees requiring documentation of training. **Responsible Person: DPS** **Completion Date: 8/22/2014**	
T2150	751.8 ORGANIZATION AND ADMINISTRATION. Quality assurance program. This Regulation is not met as evidenced by: Based on document reviews and staff interview it was determined that the Operator failed to have an established Quality Assurance (QA) Program. Review of the policies and procedures for the Center on 7/15, revealed the that there was no documented evidence of an established QA program.	T2150	**See Page 10 for response for Quality Assurance Program 751.8**	

T2110	Continued From page 4 education programs. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence of in-services in 7 of 7 personnel files reviewed. Proof of attendance at annual in-services for fire/safety (#1-5, 7 and 8) and universal precautions (#5, 7, 8) were not present for all employees. Evidence of training at the time of hire was lacking for HIV confidentiality (#5, 7, 8), domestic violence (#4, 5, 7, 8) and advance directives (#5, 7,8). These were confirmed at the time of exit on 7/15 with the Director of Patient Services.	T2110	c. The DPS will educate agency's clinical staff on Fire and Emergency Response Plan. The clinical staff will be educated on the procedure for initiating fire response and/or emergency evacuation. The role and responsibility of nurse and/or clinic supervisor to ensure safe evacuation will be presented. **Responsible Person: DPS** **Completion Date: 9/12/2014** a. The DPS developed a policy (See attached: Exposure Control Plan) to educate clinical staff on universal precautions. This policy outlines the procedures for ensuring compliance with the Agency for Occupational Safety and Health Administration (OSHA) Blood-borne Pathogens Standards and NYS DOH for post-exposure evaluation and prophylaxis **Responsible Person: DPS** **Completion Date: 8/11/2014** b. DPS will ensure a copy of the Exposure Control Plan (ECP) to the specific clinic staff who are in need to demonstrate training on file. A signed employee's signed acknowledgement of their review and receipt of ECP will be maintained on file for those employees requiring documentation of training. **Responsible Person: DPS** **Completion Date: 8/22/2014**	
T2150	751.8 ORGANIZATION AND ADMINISTRATION. Quality assurance program. This Regulation is not met as evidenced by: Based on document reviews and staff interview it was determined that the Operator failed to have an established Quality Assurance (QA) Program. Review of the policies and procedures for the Center on 7/15, revealed the that there was no documented evidence of an established QA program.	T2150	**See Page 10 for Response for Quality Assurance program 751.8**	

T2110	Continued From page 5 education programs. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence of in-services in 7 of 7 personnel files reviewed. Proof of attendance at annual in-services for fire/safety (#1-5, 7 and 8) and universal precautions (#5, 7, 8) were not present for all employees. Evidence of training at the time of hire was lacking for HIV confidentiality (#5, 7, 8), domestic violence (#4, 5, 7, 8) and advance directives (#5, 7,8). These were confirmed at the time of exit on 7/15 with the Director of Patient Services.	T2110	c. The DPS will educate agency's clinical staff on Exposure Control Plan. The clinical staff will be educated on OSHA Blood-borne Pathogen Standard method of implementation and control. Education will be provided on employee procedure for post-exposure evaluation, follow-up and reporting. **Responsible Person: DPS** **Completion Date: 9/12/2014** a.The DPS developed a policy (See attached: Domestic Violence (DV) policy). The policy includes measures to screen patients by use of clinical indicators and documentation of such screening in clinical record. Referral process for patients for domestic violence victims and educations methods. Policy includes the DV training at hiring and annually thereafter. All staff assigned to clinics, on an annual basis be provided with domestic violence plan and their signed acknowledgement will be maintained on file. **Responsible Person: DPS** **Completion Date: 8/11/2014** b. DPS will ensure a copy of the DV policy is provided to all clinical staff who are required to demonstrate training on file. An employee's signed acknowledgement of receipt and review of policy will be maintained on file. **Responsible Person: DPS** **Completion Date: 8/22/2014** c. The DPS will educate agency's clinical staff on DV policy. The clinical staff will be educated on the procedure for assessing DV indicators, approaches to counsel with client and informational handout and DV number to call. **Responsible Person: DPS** **Completion Date: 9/12/2014**	

T2110	Continued From page 6 education programs. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence of in-services in 7 of 7 personnel files reviewed. Proof of attendance at annual in-services for fire/safety (#1-5, 7 and 8) and universal precautions (#5, 7, 8) were not present for all employees. Evidence of training at the time of hire was lacking for HIV confidentiality (#5, 7, 8), domestic violence (#4, 5, 7, 8) and advance directives (#5, 7,8). These were confirmed at the time of exit on 7/15 with the Director of Patient Services.	T2110	a.The DPS developed a policy (See attached: Confidentiality of HIV Related Information), this policy includes the procedure for educating all staff at time of orientation and annually thereafter on the legal prohibition against unauthorized disclosure of confidential HIV information. Clinical staff will be educated on the proper disclosure process and obtaining a written release. **Responsible Person: DPS** **Completion Date: 8/12/2014** b. DPS will ensure a copy of the Confidentiality of HIV Related Information policy is provided to all staff who are required to demonstrate training on file. An employee's signed acknowledgement of receipt and review of policy will be maintained on file. **Responsible Person: DPS** **Completion Date: 8/22/2014** c. The DPS will educate agency's clinical staff on the Confidentially of HIV Related Information policy. The clinical staff will be educated on the agency's procedure for access to client's information, documentation and authorization for disclosure of HIV related information. **Responsible Person: DPS** **Completion Date: 9/12/2014**	

T2110	Continued From page 7 education programs. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence of in-services in 7 of 7 personnel files reviewed. Proof of attendance at annual in-services for fire/safety (#1-5, 7 and 8) and universal precautions (#5, 7, 8) were not present for all employees. Evidence of training at the time of hire was lacking for HIV confidentiality (#5, 7, 8), domestic violence (#4, 5, 7, 8) and advance directives (#5, 7,8). These were confirmed at the time of exit on 7/15 with the Director of Patient Services.	T2110	a. The DPS developed a policy (See attached: Patient Rights policy) that ensures to inform all clients who are receiving clinical services to be informed and the provision of the patient's rights materials and process that are made available to patients through the DTC: Patient Bill of Rights, Patient Complaints, Notice of Privacy Practices, Consent for Services and Health Care Proxy forms. **Responsible Person: DPS** **Completion Date: 8/11/2014** b. DPS will educate the staff on the Patient's Rights policy which includes the conspicuous postings of Patient Bill of Rights and Responsibilities and Notice of Privacy Practices in DTC waiting areas. Education on the procedures for providing to the patient's receiving clinical services, access to their patient rights and be made available to them in designated patient waiting areas. Materials include copies of: Patient's Bill of Rights and Responsibilities, Notice of Privacy Practices and Advance Directives: Health Care Proxy. **Responsible Person: DPS** **Date of Completion: 9/12/2014**	

T2110	Continued From page 8 education programs. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence of in-services in 7 of 7 personnel files reviewed. Proof of attendance at annual in-services for fire/safety (#1-5, 7 and 8) and universal precautions (#5, 7, 8) were not present for all employees. Evidence of training at the time of hire was lacking for HIV confidentiality (#5, 7, 8), domestic violence (#4, 5, 7, 8) and advance directives (#5, 7,8). These were confirmed at the time of exit on 7/15 with the Director of Patient Services.	T2110	c. The DPS will assign the ADPS the task to ensure that patient's rights materials are conspicuously made available to the patients receiving services in the designated DTC waiting room. These materials include copies of: Patient's Bill of Rights and Responsibilities, Notice of Privacy Practices and Advance Directives: Health Care Proxy. **Responsible Person: ADPS** **Date of Completion: 8/25/2014**	

New York State Department of Health

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T2150	On 7/15, interview with Staff #1 Director of Patient Services confirmed that QA activities were being conducted however there was no established QA program. **T2150 Continued from Page 4**	T2150	a.The DPS developed a policy (See Attached: Quality Assurance/Continuous Improvement). This policy includes the establishment of QA/CI Committee that will identify clinical and/or administrative problems at DTC and includes a process for review, recommendations for policy and/or procedure revisions. A sampling of clinical records for services provided to be held. Quarterly findings to be reported to the COH/Medical Director and BOH. **Responsible Person: DPS** **Completion Date: 8/11/2014** b. QA/CI Committee will be initiated and schedule to meet monthly from September 2014-December 2014 to review the results of survey audit, assess the implementation phase of policies and staff training, initiated the audit of sample of 10% medical records for each clinical service provided at DTC in monitoring of care services provided. After December 2014, the committee will meet quarterly 2015. **Responsible Person: DPS** **Completion Date: December 2014 and ongoing on a quarterly** c. The DPS will educate staff on the QA/CI policy and procedure for agency to oversee the effectiveness of monitoring, assessing and problem solving activities. The staff will be educated on the QA/CI committee and their role to identify issues in patient care areas and pursue opportunities to improve and make recommendations and continuous evaluation of policy and procedures. **Responsible Person: DPS** **Completion Date: 9/12/2014**	

	Continued From page 10			
T2170	751.9 Organization and Administration. Patients' rights. Policies and procedures shall be developed and implemented regarding the patients' rights. The operator shall have in effect a written statement of patients' rights which is prominently posted in patient care areas and a copy of which is given to the patient. This Regulation is not met as evidenced by: Based on observation, medical record review and interview, the Operator does not ensure that a current written statement of patients' rights is prominently posted and a copy is given to the patients. Findings include: During a tour at the Aaron Court clinic on 7/15 at 10:30 am it was observed that the patients' rights information was not prominently posted. The patients' rights document was posted above a window to the left of the entrance door to the clinic. Medical record review on 7/15 for patients #1-5,	T2170	a. The DPS developed a policy (See attached: Patient's Rights) that includes procedures to ensure to inform all patients who are receiving clinical services to be informed of their rights and the provision of a written agency's "Bill of Patient's Rights and Responsibilities". Procedure for documentation to denote information provided and available upon request at any time. **Responsible Person: DPS** **Completion Date: 8/11/2014** b. The DPS will assign the task to the ADPS to ensure that a current written statement of the "Patient's Bill of Rights and Responsibilities" is conspicuously posted in DTC patient's waiting area. **Responsible Person: ADPS** **Completion Date: 8/12/2014** c. DPS will educate the staff on the Patient's Rights policy which includes the responsibility to prominently post the current "Patient Bill of Rights and Responsibilities" in the DTC waiting area. Education on the procedures for providing to patients a copy of the Bill of Rights and documentation of patient acknowledgement in clinical record. **Responsible Person: DPS** **Completion Date: 9/12/2014**	

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T2170	Continued From page 11 showed that there was no documented evidence that the patients received a copy of the patients' rights information. Interview with Staff #2 Assistant Director of Patient Services at 10:50 am on 7/15 stated they did not give out the patients rights.	T2170		
T2195	751.10 ORGANIZATION AND ADMINISTRATION. Adverse Event Reporting. This Regulation is not met as evidenced by: Based on document review and interview, the facility failed to have a designated staff member for the New York Occurrence Reporting and Tracking System (NYPORTS) coordinator role. Findings; Review of the "role lookup tool" on 7/15, from the Health Commerce Network showed that there was no one assigned to the role of NYPORTS coordinator. Interview with staff # 1 the Director of Patient Services between 1 PM-2 PM, on 7/15, stated that there is no designated staff member assigned to the role of NYPORTS coordinator.	T2195	a. The DPS developed a policy (See attached: Adverse Event Reporting: New York Patient Occurrence Reporting and Tracking System (NYPORTS)) for timely adverse event reporting through NYPORTS to NYSDOH. This policy includes the designation of authorized NYPORT users and procedure and situations for adverse event reporting. This policy includes the responsibility for ageny's DTC to conduct a thorough investigation within 30 days of even occurrence. **Responsible Person: DPS** **Completion Date: 8/11/2014** b. Manual for NYPORTS designated reporters to have access that include instructions on reporting on the system the event(s) and glossary **Responsible Person: DPS** **Completion Date: 07/17/2014** c. Immediately following the survey, the DPS contacted Colleen Kewley, DOH Health Commerce Staff and requested for the DTC to have NYPORTS access. Designated NYPORTS reporters were DPS and ADPS. **Responsible Person: DPS** **Completion Date: 07/17/2014** d. The DPS will educate agency's clinical staff on the adverse event reporting policy. The clinical staff will be educated on the responsibility for reporting adverse event(s) and the oversight and function of NYPORTS reporting. **Responsible Person: DPS** **Completion Date: 9/12/2014**	

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U7046	Continued From page126	U7046		
U7046	702.4 (a) INFECTION CONTROL AND REPORTING. Medical facilities shall: (a) Establish an infection control committee, composed of representative staff, which shall be responsible for establishing policies and procedures for investigating, controlling and preventing infections in the facility. The policies and procedures shall include those for the isolation of patients with communicable or infectious diseases or patients suspected of having such diseases, for training all personnel rendering care to such patients in the employment of standard infection control techniques, and for obtaining periodic reports of nosocomial infections. Nosocomial infections shall include an increased incidence or outbreak of disease due to biological, chemical or radioactive agents or their toxic products occurring in patients or persons working in the hospital. The committee shall establish methods to ensure that policies and procedures are executed and the infection control program is effective. This Regulation is not met as evidenced by: Based on document review and interview the Operator failed to provide evidence of an established Infection Control committee. On 7/15/14 Staff #1 Director of Patient Services did not provide documentation of Infection Control committee membership activities and meeting minutes. This was confirmed at the exit conference on 7/15 with Staff #1.	U7046	a. The DPS developed a policy (See attached: Clinic Infection Control and Reporting policy). The policy includes measures to minimize the risk of transmission of infection among patients, families and personnel at the DTC. Procedures for staff on handling and reporting such situations is included. Defined is the role of the Infection Control Committee in identifying risk, recommendations and reporting quarterly to QA/QI Committee. **Responsible Person: DPS** **Completion Date: 8/12/14** b. The DPS will educate the staff regarding QA/QI policy and procedures for staff working at clinic site to adhere to general principle of infection, minimize exposure and reporting responsibilities. **Responsible Person: DPS** **Completion Date: 9/12/14**	

ULSTER COUNTY DEPARTMENT OF HEALTH

Policy and Procedure

Name:	**Article 28 Diagnostic and Treatment Center (DTC)** **Professional Licensure and Credentialing**		
Manual Section:	Diagnostic & Treatment Policy Manual Section 0008	(X) New ( ) Revised	Issue Date:
Applicable To:	Patient Services Division		
Written By:	N. Veytia, DPS		Review Date:
Revised By:	N. Veytia, DPS		Revised Date:
Approved by:	Carol Smith, M.D., MPH/Commissioner		Date: 8/11/2014
Approved by:	Nereida Veytia DPS Nereida Veytia, RN, MSN/DPS		Date: 08/11/2014

BACKGROUND/PURPOSE:

To ensure all patients are provided with medical treatment by a competent and licensed professional by New York State Department of Education.

POLICY:

It is the policy of the Ulster County Department of Health (UCDOH) to ensure all licensed employees demonstrate evidence of current registration from the New York State Department of Education or the New York State Department of Health. The assignment of duties for licensed employees will commensurate with his/her licensure, registration, and/or certification, and experience and competence.

UCDOH will not allow any employee or independent contractor who is required to have a license or credential to work at the UCDOH, and/or not practice without a valid, current license or credential.

PROCEDURE:

1. Upon employment, it is the responsibility of all licensed professional staff and contract personnel to present proof of valid and current professional licensure or credentials.

2. Thereafter, it is the responsibility of all licensed professional staff and contract personnel to present proof of professional licensure and credentials as per standards of the New York State Department of Education and/or other credentialing institutions and/or organizations.

3. UCDOH will verify the status of all licensed professional staff through New York State Department of Education at the time of employment and thereafter upon renewal of the employee's license.

4. Verification of the employee's professional licensure and/or certification will be documented in the employee's confidential personnel file.

5. The Commissioner of Health (COH)/Medical Director and Director of Patient Services (DPS) will present to the Ulster County Board of Health (BOH) for the credentialing approval of medical staff upon hire to their appointment and assignment of clinical duties as it commensurate with their licensure and registration, and reviews of such appointments every two years to assure only appropriate license staff perform clinic function that require such licensure. A BOH statement of review of appointment and clinical assignment will be maintained on employee file every two years **(Attachment – State of BOH Review and Renewal of Assignment and Clinical Privileges).**