ULSTER COUNTY BOARD OF HEALTH

July 9, 2018

AGENDA

CALL TO ORDER

- **OLD BUSINESS**

  a. Approval of June 2018 minutes

- **NEW BUSINESS**

  a. New Board Member Introduction

  b. Drug Take Back Act (Vin Martello)

  c. Commissioner's Report (Dr. Smith)
     - Medical Examiner Stats
     - Tick Summit with NYSDOH and DEC – June 19, 2018
     - Dr. Zucker June 2018 Letter
     - NYSDOH Healthy Advisory – Helping Children Who Are Experiencing Traumatic Events
     - NYSDOH Health Advisory – Hepatitis A
     - January –June 2018 Pertussis B Summary
     - Influenza Vaccine Rate 2018-19 Season
     - Children's Camps Compliance with Polystyrene Law

MEETING CONCLUSION

Ulster County Board of Health
July 9, 2018

Members PRESENT: Dominique Delma, MD, Vice Chair
Mary Ann Hildebrandt, MPA, Secretary
Anne Cardinale, RN GCNS-BC, Board Member
Peter Graham, ESQ, Board Member
Walter Woodley, MD, Chairperson
Kathleen Rogan, Board Member

DOH/DMH PRESENT: Carol Smith, MD, MPH, Commissioner of Health
Vin Martello, Director of Community Relations

GUESTS: None

ABSENT: None

EXCUSED:
Marc Tack, DO, Board Member
Shelley Mertens, Environmental Health Director
Douglas Heller, MD, Medical Examiner
Nereida Veytia, Deputy/Patient Services Director

I. **Approval of Minutes:** A motion was made by Ms. Cardinale to approve the June 2018 minutes. The motion was seconded by Ms. Hildebrandt and unanimously approved.

II. **New Board Member Introduction:** Kathleen Rogan was introduced to the Board as a new member. She will serve a term of 7/1/2018-6/30/2023.

III. **Drug Take Back Act:** Vin Martello, UCDOH Director of Community Relations presented to the Board on the NY Drug Take Back Act (see attached).

IV. **Agency Reports:**

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

- **Medical Examiner Stats:** The Medical Examiner stats were distributed to the Board for review. (see attached)
- **Tick Summit with NYSDOH and DEC:** Dr. Smith attended a Tick Summit at the Albany School of Public Health on June 19th. The Governor requested that the State put together a tick committee and study. The purpose of the study was to start cross-section dialogue, look at improving testing, and the DEC presence would assist with looking at improving tick control.
- **Dr. Zucker June 2018 Letter:** The NYS Commissioner of Health letter regarding recreational water illness and Legionnaires disease was distributed to the Board for review (see attached).
- **NYSDOH Healthy Advisory - Helping Children Who Are Experiencing Traumatic Events:** A copy of the NYS Health Advisory regarding helping children who are experiencing traumatic events was distributed to the Board for review (see attached).

- **NYSDOH Health Advisory - Hepatitis A:** A copy of the NYS Health Advisory regarding Hepatitis A outbreaks was distributed to the Board for review (see attached).
- **January - June 2018 Pertussis B Summary:** A report summarizing UC Pertussis cases was distributed to the Board for review (see attached).
- **Influenza Vaccine Rate 2018-19 Season:** Board reviewed the proposed rates for the 2018-2019 Influenza vaccine. A motion was made by Dr. Woodley to approve proposed rates. The motion was seconded by Dr. Delma and was unanimously approved.
- **Children's Camps Compliance with Polystyrene Law:** UCDOH continues to work with the Children's Camps to ensure they are in compliance with this local law.
- **Ulster County Substance Use Task Force:** The first meeting of the Task Force was held on May 24, 2018 with approximately 55 in attendance. Dr. Smith presented as well as Dr. Grovenburg the Ulster Medical Examiner who is also a medical doctor who provides substance abuse treatment to the community. Ellenville Regional Hospital presented on their opioid abuse reduction initiative called the Max Program. The group then divided in to three focus groups: Treatment, Reduce Supply and Demand, and Prevention. This is an ongoing process and the Task Force will continue to meet periodically.

V. **Adjournment:** A motion was made by Dr. Woodley to adjourn the meeting. The motion was seconded by Dr. Delma and unanimously approved.

VI. **Next Meeting:** The next meeting is scheduled for August 13, 2018, 6:30 PM at the Golden Hill Office Building.

Respectfully submitted by:

Mary Ann Hildebrandt, MPA

Mary Ann Hildebrandt, MPA
Secretary - Board of Health

Ulster County Board of Health

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

Date: Monday, July 9, 2018

Board Members		Signature
Cardinale RN GCNS-BC, Anne	Board Member	
Delma MD, Dominique	Vice Chairman	
Graham ESQ, Peter	Board Member	
Hildebrandt MPA, Mary Ann	Secretary	
Tack DO, Marc	Board Member	
Woodley MD, Walter	Chairman	
Rogan, Kathleen	Board Member	

Department of Health and Mental Health		Signature
Smith, MD, MPH, Carol	Commissioner of Health and Mental 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
Martello, Vincent	Department of Health	

UC Board of Health Briefing – NY Drug Take Back Act

On Wednesday, June 20, 2018, on the very last day of the 2017/18 session, the NYS Legislature passed the Drug Take Back Act by *a unanimous vote* of all members of both the Assembly and Senate.

The law takes effect 180 days after the Governor signs it and mandates the following:

- All retail chain pharmacies (10 or more stores physically located in NY) to set up unused medication collection systems (drop box or mail back envelopes) in their stores, per Federal guidelines, at *no charge to customers*.

- Customers will be able to drop off unused medications (except liquids, needles, etc.) with no questions asked.

- Pharmaceutical manufactures will be required to pay 100% of the program, including promotion and awareness components.

- Pharmaceutical manufactures will also be required to create and file a plan with NYSDOH, subject to review and approval, detailing how, when and where collection systems are operating AND how unused medications will be destroyed in legally compliant and environmentally responsible manner.

Why this is a major win for our substance use prevention and environmental protection efforts:

- It's estimated that over 50% of all highly addictive opioid prescription drugs on our streets come from our own medicine cabinets.

- Over 90% of heroin uses began their unfortunate journey with prescription drug abuse.

- Even though we currently have 19 medication collection boxes in police stations throughout Ulster County, they are not the convenient, logical and intuitive choice. The best choice for customers is to bring them back to where they were obtainedin the first place.

- Pharmaceutical residue has been found in fish, wildlife and drinking water supplies throughout our nation. This law will help ensure that our medications are disposed of in a safe and appropriate manner.

Ulster County Department of Health
Medical Examiner's Office - Autopsy Cases
Date of Death between 1/1/2018 and 6/30/2018

Total Number of Cases: 84

Cases by Gender	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
F	7	4	4	2	3	3	0	0	0	0	0	0	23
M	10	6	15	4	14	12	0	0	0	0	0	0	61
Grand Total	**17**	**10**	**19**	**6**	**17**	**15**	**0**	**0**	**0**	**0**	**0**	**0**	**84**

Cases by Manner	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Accidental	9	4	6	4	10	4	0	0	0	0	0	0	37
Homicide	2	1	0	0	0	0	0	0	0	0	0	0	3
Natural	5	2	6	1	6	2	0	0	0	0	0	0	22
Pending	0	1	0	1	1	8	0	0	0	0	0	0	11
Suicide	1	2	5	0	0	1	0	0	0	0	0	0	9
Undetermined	0	0	2	0	0	0	0	0	0	0	0	0	2
Grand Total	**17**	**10**	**19**	**6**	**17**	**15**	**0**	**0**	**0**	**0**	**0**	**0**	**84**

Cases by Category	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
Alcohol	0	0	0	1	0	0	0	0	0	0	0	0	1
Blunt Force Trauma - non-MVA	0	0	1	0	0	2	0	0	0	0	0	0	3
Carbon Monoxide	0	0	0	0	1	0	0	0	0	0	0	0	1
Cardiovascular	3	1	3	1	3	2	0	0	0	0	0	0	13
Cardiovascular and Diabetes	0	0	1	0	0	0	0	0	0	0	0	0	1
Cardiovascular and Obesity	0	1	0	0	0	0	0	0	0	0	0	0	1
Drowning	0	0	1	1	0	1	0	0	0	0	0	0	3
Gunshot Wound	3	1	2	0	0	0	0	0	0	0	0	0	6
Hanging	0	1	1	0	0	0	0	0	0	0	0	0	2
Motor Vehicle Accident	2	0	0	1	3	0	0	0	0	0	0	0	6
Non-Opioid Substance	0	0	1	0	1	0	0	0	0	0	0	0	2
Non-Opioid Substance w/ Alcohol	0	0	0	0	1	0	0	0	0	0	0	0	1
Non-Opioid Substance w/ Other Substances	1	0	0	0	0	0	0	0	0	0	0	0	1
Opioid	3	2	4	0	3	1	0	0	0	0	0	0	13
Opioid w/ Other Substances	2	2	0	1	2	1	0	0	0	0	0	0	8
Other	2	0	3	0	1	0	0	0	0	0	0	0	6
Pending	0	1	0	1	1	8	0	0	0	0	0	0	11
Pneumonia	0	0	1	0	0	0	0	0	0	0	0	0	1
Pulmonary Disease	0	0	0	0	1	0	0	0	0	0	0	0	1
Smoke Inhalation	1	0	0	0	0	0	0	0	0	0	0	0	1
Stab Wound	0	1	0	0	0	0	0	0	0	0	0	0	1
Undetermined	0	0	1	0	0	0	0	0	0	0	0	0	1
Grand Total	**17**	**10**	**19**	**6**	**17**	**15**	**0**	**0**	**0**	**0**	**0**	**0**	**84**

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 2018

Dear Colleague:

As we head into summer, we need to be alert to seasonal illnesses. This month, I will focus on recreational water illnesses, Legionnaires' disease, and extreme heat advisories. I will also tell you about a new smoke-free housing rule that the U.S. Department of Housing and Urban Development (HUD) is implementing this summer.

Recreational Water Illness: The number of waterborne illnesses and outbreaks resulting from exposure to infectious pathogens in treated recreational water venues (i.e., water playgrounds, pools and hot tubs/spas) has increased nationwide in recent years. *Cryptosporidium* has become the leading cause of outbreaks associated with exposure to treated recreational water. This parasite is transmitted when a diarrheal incident occurs in the water and the contaminated water is ingested. *Cryptosporidium* is extremely chlorine-tolerant and can survive for more than seven days even in well maintained pools. Other pathogens associated with recreational water include *Escherichia coli, Giardia, Legionella, Norovirus,* and *Shigella*. Otitis externa can also occur following exposure to recreational water. The common misconception that chlorine instantly kills all pathogens leads to risky behaviors, such as swimming during diarrheal illness, not reporting fecal incidents in pools, and swallowing recreational water.

Clinicians can help protect their patients' health and the health of others by advising swimmers not to swim while ill with diarrhea or when they have open wounds; avoid swallowing the water; and to keep ears as dry as possible and dry ears thoroughly after swimming. Patients with cryptosporidiosis should not swim for an additional two weeks after diarrhea has resolved.

Legionnaires' disease: You are probably aware of the outbreaks of Legionnaires' disease that have occurred across New York State over the last few years. Unfortunately, this disease is also underrecognized and underdiagnosed. Clinicians are in a unique position to make sure cases are detected, allowing rapid investigation by local health departments and, most importantly, the prevention of additional cases. Patients with severe immunosuppression (from organ transplantation, cancer, kidney failure, or other chronic underlying illnesses) are at the greatest risk of acquiring Legionnaires' disease. People with diabetes, chronic lung disease, HIV, current or former smokers, and people over 50 years of age are at moderately increased risk. This disease is rare in children.

As we know, signs and symptoms of Legionnaires' disease are similar to those of pneumonia caused by other pathogens; the only way to tell if a patient with pneumonia has Legionnaires' disease is by testing. The preferred diagnostic tests for Legionnaires' disease are culture of lower respiratory tract secretions (e.g., sputum, bronchoalveolar lavage) on selective media and the *Legionella* urinary antigen test. Molecular techniques can be used to compare clinical isolates to environmental isolates and confirm the source. Physicians play a key role in

outbreak investigations by obtaining sputum samples from patients for this type of source tracking.

If your patient has Legionnaires' disease, the most recent treatment guidelines can be found at http://bit.ly/CommunityPneumonia for community-acquired pneumonia, and http://bit.ly/HospitalPneumonia for hospital-acquired pneumonia. Macrolides and respiratory fluoroquinolones are currently the preferred agents for treating Legionnaire's disease.

Heat Advisory: As the temperature rise and approach 80-105° F, so does the risk of heat-related health conditions, such as heat syncope, exertional heat stroke, non-exertional heat stroke, and heat rash. Those with renal illness and cardiovascular disease have higher risk on subsequent days following a heat event. Risks persist for up to four days after a heat event. Young children, the elderly, those with comorbidities or in frail health, and young adults engaged in outdoor recreation or occupations are more likely to be at risk of heat-related health outcomes. Low-income patients and older adults with documented medical conditions that are aggravated by heat may be eligible to receive an air conditioner—including installation—free of charge. More information regarding the eligibility requirements can be found at: https://www.ny.gov/services/apply-heating-and-cooling-assistance-heap,or from one of New York's 59 county offices for the aging at: https://aging.ny.gov/NYSOFA/localoffices.cfm. While heat illnesses occur mostly in the hot summer months (June, July, and August), there is also significant risk in September. More information for patients on health advice during times of extreme heat can be found at: https://www.health.ny.gov/environmental/emergency/weather/hot/.

New Smoke-Free HUD Housing Rule: With the federal rule prohibiting smoking in HUD multi-unit public housing going into effect this summer, you may see an increase in patients looking for assistance with smoking cessation.

Research shows that combining brief cessation counseling and medication is more effective in helping motivated patients quit than either method alone. Additionally, prescribing a combination of pharmacotherapies approved by the U.S. Food and Drug Administration (FDA) doubles and even triples smoking cessation rates and is safe for most patients. FDA-approved cessation products include five nicotine replacement therapies (NRT) – transdermal patch, gum, lozenge, nasal spray, and oral inhaler – and two non-nicotine oral medications – bupropion SR (Zyban or Wellbutrin) and varenicline (Chantix). Typical combination therapy would include a long-acting medication like a patch or bupropion and short-acting NRT (e.g., gum, lozenge) to manage cravings.

Although New York State's adult smoking rate is at a record low of 14.2%, rates are much higher among adults living with poor mental health, disability, low socio-economic status, unemployment, and/or covered by Medicaid. In fact, adults enrolled in Medicaid smoke at twice the rate of privately-insured adults. New York State Medicaid covers smoking cessation counseling and all seven FDA-approved cessation products, including over-the-counter NRT (a prescription will serve as a fiscal order); however, according to a recent survey of Medicaid-enrolled smokers and recent quitters, fewer than half of enrollees know Medicaid pays for NRT.

The New York State Department of Health's (Department) media campaigns targeting providers and Medicaid enrollees have contributed to increased use of Medicaid smoking cessation benefit—70% of enrollees who used NRT at their last quit attempt reported Medicaid paid for it. Letting your patients with Medicaid know about this life-saving benefit may increase quit attempts by removing financial and psychological barriers.

The Department's "Talk to Your Patients" website https://talktoyourpatients.health.ny.gov/ offers an overview of nicotine addiction and prescribing information, counseling tips, helpful links, and printable posters for your office that can assist you in addressing this topic with your patients.

As always, thank you for the care that you provide to all New Yorkers and your attention to these critical matters. Enjoy your summer!

Sincerely,

Howard Zucker

Howard A. Zucker, M.D., J.D.

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

June 25, 2018

TO: Healthcare Providers, Hospitals, Emergency Departments, and Local Health Departments

FROM: NYSDOH Office of Primary Care and Health Systems Management

HEALTH ADVISORY:
Helping Children Who Are Experiencing Traumatic Events

For all healthcare providers providing care to children and adolescents;
please distribute to Primary Care Providers,
Emergency Departments, Directors of Nursing, Medical Directors, and all patient care areas.

Summary

This advisory provides an update on identifying and providing care to children who are experiencing traumatic events, including children affected by recent events which separated them from their parents while attempting to cross the United States border. Many of these children have been transferred to New York State facilities, and this document provides guidance for New York State healthcare providers and facilities on how to identify and provide care for children affected by trauma.

Information for Healthcare Providers and other Staff Caring for Children

According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), "the term 'trauma' refers to experiences that cause intense physical and psychological stress reactions. It can refer to a single event, multiple events, or a set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being."

The child-parent attachment is critical to children's healthy development and sense of safety. Sudden or unanticipated separations can be particularly traumatic. Prolonged familial separations impact relationships and may lead to further distress. Most refugee children have experienced trauma which may affect their emotional, behavioral, and physical development. However, many refugee children are resilient and may not exhibit symptoms related to trauma.

Trauma Impact

It is important for healthcare providers and other staff caring for children to understand the serious impact of traumatic events on children, screen for trauma, and know how to provide help.

What to Do

- Know the signs and symptoms of traumatic stress in children.
    - Physical responses to trauma and stress are common. Complaints may include feeling sick, body pain, lethargy, stomachaches, and headaches.
    - Many symptoms closely mimic depression or anxiety. Problems with sleeping, eating, anger/aggression, attention, irritability, or pervasive worrying may be present.
- Consider a systematic process to screen for trauma.
- Be prepared to talk to children about what they are feeling and to comfort kids of all ages who have experienced trauma.
- Know where to find materials to share with children and families.
- Remember to check out professional organizations and academic institutions for materials to learn more and find best ways to help children and families. Some suggested resources are included below.
- Consultation with child and adolescent psychiatrists and linkage/referral to mental health services are available through Project TEACH.
- Ensure you have language services available if needed.

Language Access

Language interpretation and translation are an important part of addressing the healthcare needs of children who have experienced traumatic events, especially those children who were recently separated from their families at the United States border. Effective language access services can help to minimize the trauma that these children have endured, and will assist you in continuing to provide excellent patient care.

Click the resources below to find out more about language access services and tips for using them effectively.

- New York State Psychiatric Institute: a fact sheet that provides dos and don'ts for working with an interpreter in a healthcare setting.
- New York State Office of the Attorney General: a brochure that outlines the requirements for providing language assistance in New York State.

Remember Parents and Caregivers

Parent and caregiver reactions to traumatic events affect their ability to help the children in their care. Adults should also get help when they are feeling overwhelmed. Find resources and programs that can help them and share these links:

- Mental Health Program Directory: a portal to help find a provider of mental health services.
- Coping with a Traumatic Event: a fact sheet from the Centers for Disease Control and Prevention that outlines some symptoms one might be experiencing and where to go for help.

Resources

The National Child Traumatic Stress Network (NCTSN): The NCTSN is an organization whose "mission is to raise the standard of care and improve access to services for traumatized children, their families, and communities." They also provide resources related to traumatic separation and refugee and immigrant trauma as well as guidance for primary care providers to understand refugee trauma.

Project TEACH: Primary care providers can call Project TEACH for easy access to consultations with a child-and-adolescent psychiatrist, to receive the training they need to make the best decisions for children with mental health needs, and for help with linkage and referrals to intervention, treatment, and support services for children and families. Additional resources are available at Project TEACH.

Trauma Guide: The American Academy of Pediatrics' Trauma Toolbox for Primary Care Providers. This six-part series includes discussion of adverse childhood experiences (ACEs), identifying and responding to exposure to trauma, strategies to "bring out the best in your children" and protecting physician wellness.

The Resilience Project: The American Academy of Pediatric Project has developed tools to help promote trauma-informed practices.

Identifying signs of stress in your children and teens: This American Psychological Association resource reviews signs for identifying stress in children and teens.

Sesame Street in Communities, Traumatic Experiences: This resource provides information for providers on how to help children after a traumatic experience. The site includes videos and activities for children from the ages of 0-6, and links to advice for adults on offering comfort, exploring emotions, and more.

Trauma and Child Abuse Resource Center: The American Academy of Child and Adolescent Psychiatry has developed tools to support clinicians and families.

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

July 5, 2018

TO: Healthcare Providers, Healthcare Facilities, Clinical Laboratories, and Local Health Departments (LHDs)

FROM: New York State Department of Health (NYSDOH)
Bureau of Communicable Disease Control (BCDC)

HEALTH ADVISORY: OUTBREAK OF HEPATITIS A VIRUS (HAV) INFECTIONS AMONG PERSONS WHO USE DRUGS AND PERSONS EXPERIENCING HOMELESSNESS

For All Clinical Staff in Internal Medicine, Pulmonary and Intensive Care Medicine, Geriatrics, Primary Care, Infectious Diseases, Emergency Medicine, Family Medicine, Laboratory Medicine, and Infection Control/Epidemiology

SUMMARY

- The enclosed Centers for Disease Control and Prevention (CDC) Health Advisory describes efforts undertaken by CDC, state and local health departments in response to HAV outbreaks among persons reporting drug use and/or homelessness and their contacts.
- In New York State outside of New York City, 36 cases have been reported to date in 2018, a 58% increase compared to the average number of cases reported from January through June in each of the last 3 years.
    - Identified risk factors have included the consumption of raw seafood, travel, illicit drug use, unstable housing/homelessness and/or have occurred among men who have sex with men.
- Health care providers are required under New York State Sanitary Code (10 NYCRR § 2.10) to report suspect and confirmed cases of HAV to the local health department where the patient resides.
    - Any suspected cases occurring in a food handler or individual associated with other sensitive settings (e.g. child care, certain health care settings) should be reported immediately by telephone.
- Post-exposure prophylaxis should be offered to all previously unvaccinated persons who are or have been in close contact with a person who has HAV infection, including household members, sex partners, and persons who have shared illicit drugs with an infected patient.
    - Immunoglobulin (IG) dosing recommendations changed as of July 2017. Additional information on the prophylactic use of IG for HAV prevention can be found at https://www.cdc.gov/mmwr/volumes/66/wr/pdfs/mm6636a5.pdf.
    - Local health departments who need hepatitis A vaccine for post-exposure prophylaxis should contact the NYSDOH Bureau of Immunization at 518-473-4437.
- For questions, please contact your local health department or the NYSDOH Bureau of Communicable Disease Control via e-mail at bcdc@health.ny.gov or by phone at (518) 473-4439.

This is an official

CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
June 11, 2018, 0800 ET (8:00 AM ET)
CDCHAN-00412

Outbreak of Hepatitis A Virus (HAV) Infections among Persons Who Use Drugs and Persons Experiencing Homelessness

Summary
The Centers for Disease Control and Prevention (CDC) and state health departments are investigating hepatitis A outbreaks in multiple states among persons reporting drug use and/or homelessness and their contacts. This Health Alert Network (HAN) Advisory alerts public health departments, healthcare facilities, and programs providing services to affected populations about these outbreaks of hepatitis A infections and provides guidance to assist in identifying and preventing new infections.

Background
Hepatitis A infection is a vaccine-preventable illness. The primary means of hepatitis A virus (HAV) transmission in the United States is typically person-to-person through the fecal-oral route (i.e., ingestion of something that has been contaminated with the feces of an infected person).[1] Symptoms include fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, dark urine, clay-colored bowel movements, joint pain, and jaundice. Although rare, atypical extra hepatic manifestations include rash, pancreatitis, renal disease, arthritis, and anemia.[2] Severe infections can result in cholestatic hepatitis, relapsing hepatitis, and fulminant hepatitis leading to death.[3] Average incubation of HAV is 28 days, but illness can occur up to 50 days after exposure.[4] An HAV-infected person can be viremic up to six weeks through their clinical course and excrete virus in stool for up to two weeks prior to becoming symptomatic, making identifying exposures particularly difficult.[5-7] Illness from hepatitis A is typically acute and self-limited; however, when this disease affects populations with already poor health (e.g., hepatitis B and C infections, chronic liver disease), infection can lead to serious outcomes, including death.

The best way to prevent hepatitis A infection is through vaccination with the hepatitis A vaccine. The number and timing of the doses depends on the type of vaccine administered. Vaccines containing HAV antigen that are currently licensed in the United States are the single-antigen vaccines HAVRIX® (manufactured by GlaxoSmithKline, Rixensart, Belgium) and VAQTA® (manufactured by Merck & Co., Inc., Whitehouse Station, New Jersey) and the combination vaccine TWINRIX® (containing both HAV and hepatitis B virus antigens; manufactured by GlaxoSmithKline). All are inactivated vaccines. GamaSTAN S/D (Grifols Therapeutics, Inc., Research Triangle Park, North Carolina) immune globulin (IG) for intramuscular administration is the only IG product approved for HAV prophylaxis. The efficacy of IG or vaccine when administered >2 weeks after exposure has not been established. Additionally, practicing good hand hygiene—including thoroughly washing hands after using the bathroom, changing diapers, and before preparing or eating food—plays an important role in preventing the spread of hepatitis A.

From January 2017 to April 2018, CDC has received more than 2,500 reports of hepatitis A infections associated with person-to-person transmission from multiple states. Of the more than 1,900 reports for which risk factors are known, more than 1,300 (68%) of the infected persons report drug use (injection and non-injection), homelessness, or both.[8-11] During this time, responses conducted in various states resulted in increased vaccine demand and usage, resulting in constrained supplies of vaccine. As available vaccine supply has increased and progress has been made towards controlling ongoing outbreaks in some jurisdictions, vaccine is more readily available. However, both CDC and vaccine manufacturers continue to closely monitor ongoing demand for adult hepatitis A vaccine in the United States.

During the mid-1980s, drug use was a risk factor for >20% of all hepatitis A cases reported to CDC, but no large outbreaks have occurred among persons who use drugs since adoption of the recommendation for hepatitis A vaccination of persons who use injection and non-injection drugs was made in 1996.[12,13] Outbreaks of hepatitis A infections among homeless persons have occurred in other countries, but large outbreaks among the homeless have not been described previously in the United States.[14-17]

Person-to-person transmission of HAV between persons who report drug use and/or homelessness could result from contaminated needles and other injection paraphernalia, specific sexual contact and practices, or from generally poor sanitary conditions.[13] Transience, economic instability, limited access to healthcare, distrust of public officials and public messages, and frequent lack of follow-up contact information makes this population difficult to reach for preventive services such as vaccination, use of sterile injection equipment, and case management and contact tracing. These challenges make outbreaks among these groups difficult to control.

Rapid identification, a comprehensive response, and novel public health approaches may be required to address needs unique to these populations. Urgent action is needed to prevent further HAV transmission among these risk groups.

Recommendations for Health Departments

1. Review the most recent sources of data on hepatitis A diagnoses. Attributes of communities at risk for unrecognized clusters of hepatitis A infection may include the following:
    - Recent increases in the:
        - Number of hepatitis A infections in persons who report drug use;
        - Number of hepatitis A infections in persons who report homelessness;
        - Number of hepatitis A infections in men who have sex with men; and
        - Number of hepatitis A infections in persons who report recent incarceration.
    - High rates of drug use, drug-related overdose, drug treatment admission, or drug arrests.
    - High rates of homelessness.

2. Ensure standard operating procedures to identify and interview cases, perform contact tracing for all new hepatitis A diagnoses, and provide post-exposure vaccination of contacts as soon as the diagnosis is made.

3. Ensure persons who report drug use (injection and non-injection) or are at high-risk for drug use (e.g., participating in drug substitution programs, receiving substance abuse counseling or treatment, recently or currently incarcerated) are vaccinated against hepatitis A virus, and specifically:
    - Consider programs to provide hepatitis A vaccinations in jails, syringe service programs, substance abuse treatment programs, and to at-risk persons in emergency departments, homeless shelters, warming centers, food distribution centers, and any venues where the at-risk populations may congregate or seek medical care.
        - Engage in "Participatory Planning." Ask the facility what they feel is the best way to provide outreach to their population and what is the best way to provide vaccinations or improve vaccination uptake.
        - Have a consistent presence at the service provider if vaccinations are planned on-site. If repeat visits must occur, they should occur on scheduled days and times.
        - Adequately advertise vaccination events beforehand.
    - Engage stakeholders who care for persons who use drugs or may interact more frequently with facilities serving this population (e.g., behavioral specialists, disease intervention specialists).
    - Provide education to persons who report drug use and/or homelessness through targeted media campaigns encouraging vaccination and proper hand hygiene.

4. Remind venues that may encounter undiagnosed infections, such as emergency departments and community-based clinical practices (e.g., family medicine, general medicine) of the importance of reporting hepatitis A infections to the health department.[18]

5. Local health departments should notify their state health department and CDC (viralhepatitisoutbreak@cdc.gov) of any suspected clusters of acute hepatitis A.

Recommendations for Health Care Providers

1. Consider hepatitis A as a diagnosis in anyone with jaundice and clinically compatible symptoms.

2. Encourage persons who have been exposed recently to HAV and who have not been vaccinated to be administered one dose of single-antigen hepatitis A vaccine or immune globulin (IG) as soon as possible, **within 2 weeks after exposure**. Guidelines vary by age and health status (please see https://www.cdc.gov/hepatitis/outbreaks/InterimOutbreakGuidance-HAV-VaccineAdmin.htm for additional information).

3. Consider saving serum samples for additional testing to assist public health officials in the investigation of transmission (i.e., confirmation of antibody test, HAV RNA test, genotyping, and sequencing). Contact the public health department for assistance with submitting specimens for molecular characterization.

4. Ensure all persons diagnosed with hepatitis A are reported to the health department in a timely manner.

5. Encourage hepatitis A vaccination for homeless individuals in areas where hepatitis A outbreaks are occurring.

6. Encourage hepatitis A vaccination for persons who report drug use or other risk factors for hepatitis A.

7. CDC recommends the following groups be vaccinated against hepatitis A:
   - All children at age 1 year
   - Persons who are at increased risk for infection:
     - Persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A;
     - Men who have sex with men;
     - Persons who use injection and non-injection drugs;
     - Persons who have occupational risk for infection;
     - Persons who have chronic liver disease;
     - Persons who have clotting-factor disorders;
     - Household members and other close personal contacts or adopted children newly arriving from countries with high or intermediate hepatitis A endemicity; and
     - Persons with direct contact with persons who have hepatitis A.
   - Persons who are at increased risk for complications from hepatitis A, including people with chronic liver diseases, such as hepatitis B or hepatitis C.
   - Any person wishing to obtain immunity.

For More Information

1. Centers for Disease Control and Prevention. Division of Viral Hepatitis A Outbreak Website. https://www.cdc.gov/hepatitis/outbreaks/2017March-HepatitisA.htm

2. Centers for Disease Control and Prevention's Hepatitis A Virus Website.

https://www.cdc.gov/hepatitis/hav/index.htm

3. Centers for Disease Control and Prevention. Viral Hepatitis Surveillance – United States, 2016. https://www.cdc.gov/hepatitis/statistics/2016surveillance/pdfs/2016HepSurveillanceRpt.pdf

4. Centers for Disease Control and Prevention. Hepatitis A General Information Fact Sheet. https://www.cdc.gov/hepatitis/hav/pdfs/hepageneralfactsheet.pdf

5. Centers for Disease Control and Prevention. The Pink Book. Chapter 9: Hepatitis A. https://www.cdc.gov/vaccines/pubs/pinkbook/downloads/hepa.pdf

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2. Lemon SM, Ott JJ, Van Damme P, Shouval D. Type A viral hepatitis: A summary and update on the molecular virology, epidemiology, pathogenesis and prevention. *J Hepatol* 2017.

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8. California Department of Public Health. Hepatitis A Outbreak in California. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Hepatitis-A-Outbreak.aspx.

9. Kentucky Department for Public Health. Acute Hepatitis A outbreak Weekly Report. https://chfs.ky.gov/agencies/dph/dehp/Documents/Acute%20Hepatitis%20A%20Outbreak%20Week%2021%20Report.pdf

10. Michigan Department of Health and Human Services. Michigan Hepatitis A 2016-2018 Outbreak Summary. https://www.michigan.gov/documents/mdhhs/HepA_Summ_County_SEMI2016_updated91517_601552_7.pdf

11. Utah Department of Health. Hepatitis A Outbreak. http://health.utah.gov/epi/diseases/hepatitisA/HAVoutbreak_2017.

12. Craig AS, Watson B, Zink TK, Davis JP, Yu C, Schaffner W. Hepatitis A outbreak activity in the United States: responding to a vaccine-preventable disease. *Am J Med Sci* 2007; **334**(3): 180-3.

13. Villano SA, Nelson KE, Vlahov D, Purcell RH, Saah AJ, Thomas DL. Hepatitis A among homosexual men and injection drug users: more evidence for vaccination. *Clin Infect Dis* 1997; **25**(3): 726-8.

14. Cheung RC, Hanson AK, Maganti K, Keeffe EB, Matsui SM. Viral hepatitis and other infectious diseases in a homeless population. *J Clin Gastroenterol* 2002; **34**(4): 476-80.

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18. National Notifiable Diseases Surveillance System. Hepatitis A, Acute 2012 Case Definition. https://wwwn.cdc.gov/nndss/conditions/hepatitis-a-acute/case-definition/2012/

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##

Ulster County Department of Health
2018 Pertussis Summary

Quarter

January to March	April to June	July to September	October to December

Number of cases reported for quarter: __3_____

Does not meet case definition: **1 case**	Date: **February 2018**	Age:	Male ____ Female ___ Other ___	Vaccine status: Tdap/date: Dtap/date:	Town/city: School district:
	Date:	Age:	Male ___ Female ___ Other ___	Vaccine status: Tdap/date: Dtap/date:	Town/city: School district:
Meets case definition/probable: **1 case**	Date: **February 2018**	Age: **44**	**Male √** Female ___ Other ___	Vaccine status: **Incomplete; not immunized** Tdap/date: Dtap/date:	Town/city: **Highland** School district: **Highland**
	Date:	Age:	Male ___ Female ___ Other ___	Vaccine status: Tdap/date: Dtap/date:	Town/city: School district:
Meets case definition/confirmed: **1 case**	Date: **May 2018**	Age: **70**	**Male √** Female ___ Other ___	Vaccine status: **Tdap: 05/14/18** Dtap/date:	Town/city: **Kingston** School district: **Kingston**

FLU CHARGE CALCULATION - 2018
Prepared by K Nelson 06/19/18

Cost Per Dose	Flu		
2015 Count:	148	148	
2016 Count:	81	81	
2017 Count:	19	19	
Admin Cost (Est)			
Nursing PS/FB	$ 6.73	2017 Cost $6.62	
Clerical PS/FB	$ 2.59	2017 Cost $2.56	
Tot PS/FB	**$ 9.33**		
Vaccine Cost	**$ 15.47**	2017 Cost 16.02	(Per 01/2/18 PO #2018-17)
Supply	**$ 0.21**	2017 Cost $.21	
Recommendation	**$ 26.00**	(Rounded up due to portion of overhead calculation.)	
Charges Adopted by BOH		2017 Chgs Adopted by BOH =	**$26.00**

NURSING COST

PS Calculation			
Avg Time per Shot		8	(Minutes) Shot + Med Eval & Educ
Avg Nursing Rate	$	32.29	
PS Cost per Shot	$	4.31	
FB @ 56.42%	$	2.43	
PS + FB	**$**	**6.73**	

Nursing Rate Avg		
Alexander	$	32.26
Dittus	$	32.69
Lantos	$	31.71
Nerone	$	32.70
Vacant	-	
Pomerantz	$	32.26
Smith	$	34.68
Snyder	$	29.72
	$	226.02
Avg =	$	32.29

Supply

Syringe	$	0.18	16-19 NYS PC 66414 Bid Price
Alcohol Prep	$	0.00845	16-19 NYS PC 66414 Bid Price
Band Aid	$	0.02150	16-19 NYS PC 66414 Bid Price
Supplies Cost	**$**	**0.21**	Note: No change.

Fee Collection & Bill Processing

Avg Billing Hrs		1.27	(4 min x 19 shots)/60
Avg Clerk rate	$	24.86	
PS Cost	$	31.49	
FB @ 56.42%	$	17.77	Last "Actual" per 3/2/18 Comm of Fin Memo
PS + FB	$	49.26	
Cost per Shot	**$**	**2.59**	Ttl Clerk PS / Est Doses Administered

Clerical Rate Avg		
Jordan	$	26.06
McTague	$	26.53
Russo	$	21.99
	$	74.58
Avg =	$	24.86

06/19/18 Notes to self:

Need to fill in last year's rates above

Hourly PS rates should be updated to 4QYY rates

Get cost of Syringe - what kind, size, etc. (3cc / 22 guage / 1") per 16-19 NYS PC 66414 Bid Price

Get cost of Alcohol Prep & what size (smallest one per NV) - Per 16-19 NYS PC 66414 Bid Price

Get Cost of Bandaid & what kind (standard bandaid or cottonball & tape) - Per 16-19 NYS PC 66414 Bid Price

Confirm # of shots per bottle (Prefilled Syringes = 1 Dose / Flu Via = 10 Doses)

Rcommended charges s/b rounded up to the nearest dollar (covers a portion of overhead not calculated into the cost)