CATTARAUGUS COUNTY BOARD OF HEALTH

Public Health
Prevent. Promote. Protect.
Established 1923

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***Joseph Bohan, MD,** President* ***James Lapey,** Vice-President*

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Sondra Fox, RN
Richard Haberer
Georgina Paul, FNP
Theresa Raftis
James Snyder

MINUTES

July 2, 2014

The 827th meeting of the Cattaraugus County Board of Health was held at St. Bonaventure Clubhouse Restaurant, Route 417, Allegany, New York on July 2, 2014.

The following members were present:

Joseph Bohan, MD	James Lapey
Zahid Chohan, MD	Georgina Paul, FNP
Sondra Fox, RN	Theresa Raftis
Richard Haberer	

Also present were:
Kevin D. Watkins, MD, MPH, Public Health Director
Monica Thomas, Ph. D., Dir. of the Franciscan Health Care Prog., St. Bonaventure Univ.
Thomas Brady, County Attorney
Linda Edstrom, County Legislator
Earl McElfresh, County Legislator
Paula Stockman, County Legislator
Donna Vickman, County Legislator
Gilbert Witte, MD, Medical Director
Susan Andrews, Director of Patient Services
Kathleen Ellis, Administrative Officer
Raymond Jordan, Sr. Public Health Sanitarian
Debra Lacher, Secretary to Public Health Director
Eric Wohlers, Environmental Health Director
Chris Chapman, Post Journal
Rick Miller, Olean Times Herald

The meeting was called to order by Dr. Bohan. The roll was called and a quorum declared.

Mr. Lapey made a motion to approve the minutes of the June 4, 2014 meeting. It was seconded by Mr. Haberer, and unanimously approved.

Director's Report: Dr. Watkins stated that at the June Board meeting there were (288) reported cases of measles in the U.S., but since that report, he states the number of measles cases have nearly doubled; the number of reported cases from January 1 to June 27, 2014 are up to (539). The majority of these cases (363) are seen in the state of Ohio, largely among the Amish population. Thirty-one (31) cases have been reported in New York State, (26) of which were in New York City.

The measles virus lives in the mucus, in the nose, and throat of infected people. When they sneeze, cough or talk, droplets spray into the air and the droplets remain active and contagious on infected surfaces for up to two hours. Measles are highly contagious and can be very serious or even fatal. It begins with a fever (103 F-105 F) that lasts for a couple of days, followed by a cough, runny nose, and conjunctivitis (pink eye). A rash starts on the face and upper neck, spreads down the back and trunk, then extends to the arms and hands, as well as the legs and feet. After about five days, the rash fades in the same order it appeared. Serious complications of measles include pneumonia and encephalitis (inflammation of the brain).

Among the reported measles cases in US, most are among unvaccinated individuals and those with unknown vaccination status. (85%) of the measles cases among unvaccinated individuals in the U.S. had declined vaccination because of religious, philosophical, or personal objections, 6% were missed opportunities for vaccination, and 7% were too young to receive vaccination.

Dr Watkins stated that we have a large Amish population in Cattaraugus County and many of the local Amish travel to the Ohio Amish communities and we are very concerned that because they are unvaccinated they may get exposed to the measles virus and bring it back to the Cattaraugus County Amish community.

Plans are being made to work with the Bishops to get our Amish population vaccinated. In addition, Dr. Watkins will work with the Health directors of Chautauqua and Allegany Counties to see if they would follow suite.

Last month a bulletin was handed out at the board meeting regarding the Chikungunya virus and at that time there had been no confirmed cases within the U.S. mainland. As suspected with the high number of travelers to the Caribbean, we now have confirmed cases in (25) states in the U.S. including New York. We thank Paula Stockman for bringing this to the board's attention. New York State Department of Health is advising on prevention, distributing larvicide to kill mosquitoes and educating the public to eliminate water sources in which they can actually breed.

Dr. Watkins reported that all of our mosquitoes pools have been negative for West Nile Virus (WNV) and Eastern Equine Encephalitis (EEE) virus. However, we are fielding a number of calls from residents and county officials regarding the large mosquito population in the community. Adult mosquito population appears most concentrated in Great Valley (Windfall), Kill Buck (School Street), Allegany (Birch Run and Old State Rd) and Weston Mills (Chestnut St.) areas. Other areas with high concentration of adult mosquitoes include Parkside Drive, Ten Mile, N. Nine Mile Roads, and Thorpe Hollow. We've also had reports of a dead crow on Route 62 in South Dayton, and a dead Robin in Olean.

Dr. Watkins accompanied one of our legislators out to some of the high mosquito populated areas because of the large number of residential complaints. While visiting the sites they were able to identify larvae in buckets, and ponds of various homes and businesses. There were streams in the back of some of these homes and wooded areas which can be habitats for where mosquitoes can breed. Mosquitoes continue to be a nuisance, unfortunately we do not have a nuisance program and we are still looking into the cost of such a program to see if the cost for such a program would be feasible. We are looking at independent contractors, maybe municipal costs to operate such a program, and even the cost for homeowners who may want to take care of the matter on their own. At this point we are recommending wearing light colored clothing, covering with long sleeve shirts and pants during dusk and dawn when mosquitoes are most likely to feed and use repellant with DEET. In addition, it is recommended to remove all receptacles that can accumulate water like garbage cans, old tires, buckets, and placing screens in the windows and doors of homes.

Dr. Watkins spoke about the Adolescent Tobacco Use Prevention Act (ATUPA) which was enacted back in 1992, article 13-F of the New York State Public Health Law. The ATUPA law prohibits the sale of tobacco products to minors (anyone under the age of 18). Amendments to ATUPA have clarified and expanded the definition of tobacco products, which include cigarettes, loose cigarettes, cigars, bidis, shisha, smoking paraphernalia and electronic cigarettes (e-cigarettes). Penalties for illegal sales to minors include fines, loss of license to sell lottery tickets and loss of license to sell tobacco products.

Every licensed tobacco retailer is assessed annually for compliance with this law. The 2011-2012 NYS compliance rate was 95.1 percent. In 2013 Cattaraugus County compliance rate was 98%, of 58 checks in Cattaraugus County there was one (1) sale of tobacco products to a minor, resulting in a $350 fine for the merchant.

In Cattaraugus County we use volunteer teenagers 16-17 yrs of age to accompany our staff on compliance checks and all volunteers are required to: give the merchants their license if asked. If a sale is made to the under-aged teenager, our staff then informs the clerk and the owner/manager shortly after the sale, that a sale was made to a minor and an enforcement hearing will be scheduled.

It is reported that: 90% of smokers begin before the age of 21 and every day, almost 3,900 adolescents under 18 years of age try their first cigarette. More than 950 of them will become daily smokers.

Tobacco use is still the single most prevalent cause of death in the United States. Each year in the U.S. cigarette smoking and exposure to second hand smoke causes about 443,000 deaths a year. That is 1 in every 5 deaths. The economic loss is also staggering, smoking cause's disease resulting in about 96 billion dollars of healthcare costs annually. Cigarette smoking accounts for 25,000 deaths in New York State, smoking doubles the risk of a person developing coronary artery disease, stroke, and increases the risk of developing lung cancer by 13 times for women and 23 times for men. Smoking also causes cancer of the esophagus, larynx, oral cavity, the stomach, kidney, and pancreas. More over tobacco has been linked to infertility, low birth weight, still-birth, and sudden infant death syndrome.

As public health officials we are obligated to try to protect the public's health and here in Cattaraugus County the difficulty of reducing the rate of tobacco user is monumental.

As the country has been able to reduce the number of tobacco users at a steady rate each year (by increasing the luxury taxes on a pack of cigarettes) Cattaraugus County rate has remained almost the highest in the state. Seneca Nation of Indians with their own tobacco plant can sell cigarettes at $1.50 a pack, defeating our efforts to thwart the attractiveness of tobacco products aimed at our County residents. The ATUPA program is a State regulated program that we are obligated to enforce. Dr. Watkins opened the floor up for a dialog about how and why the Health Department carries out this important program in the community.

Discussion was held among those in attendance but the fact remains that the ATUPA program is a state regulated program that we are obligated to enforce.

At the last meeting Mr. Snyder had inquired if there was any way to determine if Cattaraugus County veterans were experiencing an extended wait time to see their primary care providers at the Buffalo VA hospital. Dr. Watkins spoke with Mr. Steve McCord, Director of Veterans Affairs for Cattaraugus County, who looked into this issue and states he has not seen any delays in the veteran's follow-up care. Dr. Watkins distributed to those in attendance a VA access audit and wait times fact sheet that showed 97% of appointments scheduled by Buffalo were less than 30 days of the reference date. It does not appear at this particular time that there is any extended wait time for our veterans in this area. There is an extended wait time for some of the VA benefits; certain claims do take well over a year to get acted upon.

Dr. Watkins spoke regarding healthcare access. Lack of primary care physicians is still a major issue for our county. The accessibility of facilities, physicians, rate of no insurance, transportation barriers, and coverage limitations contributes to poor access to good healthcare. There are only 37 primary care physicians in our area with a population of a little under 80,000, that leaves one (1) primary care physician to care for 2,157 patients. This rate should be one (1) to every 350 patients.

Guest Speaker: Dr. Monica Thomas, Director of the Franciscan Health Care Program at St. Bonaventure University was introduced by Dr. Joseph Bohan. Dr. Thomas explained that Bonaventure has 9 dual programs in healthcare. Seven of these programs begin while the students are seniors in high school. They actually are applying to medical school as seniors in high school and we help them through the process. St. Bonaventure works in conjunction with George Washington University. They apply to St. Bonaventure and also to George Washington at the same time. SAT scores, GPA, and ACT for Science scores are factors in the admission process. St. Bonaventure typically receives 350 applicants, 64 students will come to campus for a first interview, 32 of those students are chosen for applications which are given to the Dean of George Washington, 20 of those applicants are invited for a second interview at their campus, 12-15 of those applicants will then receive a seat for George Washington. St. Bonaventure University also has a similar affiliation programs with, Lake Erie College of Osteopathic Medicine (LECOM) in Erie, PA, SUNY Upstate with a BS/BA-MD program, University of Buffalo Dental, and Daemen College with Physical Therapy program. If students do not receive an initial invitation to one of these programs, they can come to St. Bonaventure's and reapply again in their sophomore year, these programs are called the early assurance program. The student then reapplies to the professional school and we work with them to get a seat, waiting for them in 2 years. The average SAT score for our dual program students is 1401, and our average student at the university has a SAT score of 1335.

Enrollment of students at the University is in a slight decline for the last 2 years, the goal of the University is to meet the enrollment numbers for the coming year.

The campus has a Health and Human Performance Lab which recently received a grant for almost $20,000.00 some of this money will be used for research to reach out into the community.

Student health care services reports that 91% of the students are seeking immediate care on campus with colds, flu, or sore throats. They are referred to Olean General Hospital if they have a more serious need.

The Science, Technology, Engineering and Math (STEM) program was just awarded a five year grant in the amount of nearly $600,000.00. This grant will be used to pay for stipends to bring in 25 national science foundation fellows. They will come to the university and major in one of the five sciences.

Hilbert College has just launched a Masters of Public Health Program and the first classes are beginning this summer. St. Bonaventure is looking into the feasibility of tying into that program of study. Also, Dr. Thomas has been asked to look at the MBA Program at St. Bonaventure and the feasibility of tying in Public Health courses to their current program.

Dr. Thomas reported that the University in currently putting together a proposal for a BS in nursing program for students and practicing nurses who are already licensed RN's. This will probably be offered as a hybrid program and many of the courses will be offered on-line as many of the nurses are already practicing in the field.

Dr. Thomas spoke regarding the Healthcare Access Coalition; this group is working to improve the access to health for the community by opening up conversation between local physicians, students, and the community.

Nursing Division Report: Mrs. Andrews reported the latest numbers of rabies post exposure and actual rabid animals which included one (1) bat bite in May, unfortunately there was no bat available for testing as it was not retrieved, and one (1) positive raccoon in the month of June. Mrs. Andrews stated that the public needs to be reminded to never touch wildlife with their bare hands. The rabies virus is typically spread through saliva of an infected animal in the late stages of the disease after it has reached the brain. After 3-5 days of reaching the brain, the animal will show unmistakable symptoms of rabies.

Mrs. Andrews reported one (1) new elevated blood lead level case which was identified through our Women Infant and Children (WIC) rapid lead testing program.

Mrs. Andrews reported no new additional agencies have been approved to provide Certified Home Health Agency (CHHA) services within the county other than VNA, Lakeshore LT and Cattaraugus County Health Department. Several others remain under review but have not been currently approved. Current census is stable from last month but 2014 YTD = (1002) which is a 12% decrease from 2013 which was (1143). One full-time RN remains on leave, and the department is currently interviewing for (2) full time RNs and (1) part-time Home Health Aide (HHA) positions.

Environmental Health Division Report: Mr. Wohlers expanded upon what Mrs. Andrews stated concerning the public touching wildlife with their bare hands. People do not realize that, it is not only dangerous, but it is illegal to keep wildlife according to Department of Environmental Conservation (DEC) laws and regulations.

Mr. Wohlers shared an update on the Community Development Block Grant (CDBG). Public notices have been published in the newspaper, and an environmental review was completed. In August, we hope to begin processing applications for septic systems and private well projects for low to moderate income families. In the past six years there have been no shortages of applicants and projects to spend the grant funding in order to assist county residents.

Now that school is out, inspections are being done on the children's camps within the county, and the summer beach sampling program has been initiated at all the public bathing beaches. We have begun to receive reports of algae and some of the lake communities will routinely take samples and send them to the state lab to check for the toxic blue green algae. The state also has a summertime ozone warning system that is issued for those with respiratory concerns.

A motion was made by Mr. Lapey to move to executive session for legal advice. This motion was seconded by Mr. Haberer and unanimously approved by the board.

Returning after executive session and there being no actions taken during the executive session a motion to adjourn was made by Mr.Lapey; it was seconded by Ms. Raftis and carried to adjourn.

Respectfully submitted,

Kevin D. Watkins, M.D.

Kevin D. Watkins, M.D., M.P.H.
Secretary
KDW/dl

U.S. Department of Veterans Affairs
VA Access Audit & Wait Times Fact Sheet

VETERANS INTEGRATED SERVICE NETWORK (VISN) 2
June 9, 2014

Summary:

At the Department of Veterans Affairs (VA), our most important mission is to provide the high quality health care and benefits Veterans have earned and deserve - when and where they need it. In mid-April, the Secretary of Veterans Affairs directed the Veterans Health Administration (VHA) to complete a nation-wide Access Audit to ensure a full understanding of VA's policy among scheduling staff, identify any inappropriate scheduling practices used by employees regarding Veteran preferences for appointment dates, and review waiting list management.

VA is already taking corrective action to address issues resulting from the audit.

On Wednesday, May 21, VA launched the Accelerating Access to Care Initiative, a nation-wide program to ensure timely access to care. As directed by President Obama, VHA has identified Veterans across the system experiencing waits that do not meet Veterans expectations for timeliness. VA has begun contacting and scheduling all Veterans who are waiting for care in VA clinics or arranging for care in the community, while simultaneously addressing the underlying issues that impede Veterans' access.

Audit Scope:

The nationwide Access Audit covered a total of **731 separate points of access**, and involved over **3,772 interviews** of clinical and administrative staff involved in scheduling process at VA Medical Centers (VAMC), large Community Based Outpatient Clinics (CBOC) serving at least 10,000 Veterans and a sampling of smaller clinics. A complete list of VISN facilities with components reviewed as part of the Access Audit is included in this package.

Audit Findings System-Wide Include:

- A complicated scheduling process resulted in confusion among scheduling clerks and front-line supervisors in a number of locations.
- A 14 day wait-time performance target for new appointments was not only inconsistently deployed throughout the health care system but was not attainable given growing demand for services and lack of planning for resource requirements.
- Overall, 13% of scheduling staff interviewed indicated they received instruction (from supervisors or others) to enter a date different than what the Veteran had requested in the appointment scheduling system.
- 8% of scheduling staff indicated they used alternatives to the official Electronic Wait List (EWL). In some cases, pressures were placed on schedulers to utilize unofficial lists or engage in inappropriate practices in order to make waiting times appear more favorable.

Such practices are widespread enough to require VA to re-examine its entire Performance Management system and, in particular, whether current measures and targets for access are realistic or sufficient.

Audit Findings: Further Review

As a result of these audits, some locations were flagged for further review and investigation. Any instance of suspected willful misconduct is being reported promptly to the VA Office of Inspector General (OIG). Where the OIG chooses not to immediately investigate, VHA leadership will launch either a fact finding or formal

administrative investigation. Where misconduct is confirmed, appropriate personnel actions will promptly be pursued. As a result of the initial audit findings, there are no facilities in VISN 2 that require further review.

Audit Findings: Immediate Actions:

While VHA must assess and learn from the Access Audit, we are immediately redoubling our efforts to quickly address delays in Veterans' health care. VHA is identifying where Veterans are waiting for care and ensuring that timely, quality care is made available as quickly as possible.
Among the immediate actions VA is taking:

- VA has accelerated care for Veterans currently waiting for health care services. **VHA is in the process of contacting in excess of 90,000 Veterans during the first phase of VA's "Accelerating Access to Care Initiative"**
  - VHA will provide Veterans who do not currently have an appointment, or are waiting for additional care or services longer than 30 days the option to be rescheduled sooner if VA capacity exists, keep their scheduled appointment, or be referred to non-VA providers in the community
- VA has suspended all VHA Senior Executive Performance Awards for FY14
- VHA will remove 14-day performance goal from employee performance plans
- VHA will revise, enhance and deploy Scheduling Training
- VHA will implement a site inspection process

Audit Findings: Long Term and Other Actions:

VHA is committed to a renewed and aggressive preparation, teaching, training and coaching of our employees. Throughout the immediate and long term, we will emphasize accountability, and ensure managers and staff engaging in inappropriate practices are held accountable.

- VHA will overhaul the scheduling and access management directive
- VHA will roll out near-term changes to the legacy scheduling system
- VHA will acquire and deploy long-term scheduling software solutions
- VHA will reassess and establish access timeliness goals
- VHA will strengthen accountability for integrity in scheduling and access management

Locality Wait Time Information

On May 15, 2014, **VHA had over 6 million appointments scheduled** across the system. Nationwide, there are roughly 57,436 Veterans who are waiting to be scheduled for care and another 63,869 who over the past ten years have enrolled in our healthcare system and have not been seen for an appointment. VA is moving aggressively to contact these Veterans through the Accelerating Access to Care Initiative.

Facility data for VISN 2 is listed in the attachment. Complete data is located online at www.va.gov/health/access-audit.asp

At the Department of Veterans Affairs (VA), our most important mission is to provide the high quality health care and benefits Veterans have earned and deserve. While VHA must assess and learn from the Access Audit, we are immediately redoubling our efforts to quickly address delays in Veterans' health care.

VHA is identifying where Veterans are waiting for care and ensuring that timely, quality care is made available as quickly as possible through the Accelerating Access to Care Initiative.

Attachment 1

Facility (Data On 5/15/14)	Total Appts Scheduled[1]	Appts scheduled 30 Days or under[2]	Percent Appts scheduled Days or under[3]	Appts scheduled over 30 Days[4]	Percent Appts scheduled over 30 Days[5]	New Enrollee Appt Request[6]	EWL Count[7]	New Patient PC Avg Wait Time[20]	Established Patient PC Avg Wait Time[21]	New Patient SC Avg Wait Time[22]	Established Patient SC Avg Wait Time[23]	New Patient MH Avg Wait Time[24]	Established Patient MH Avg Wait Time[25]
(V02) (528) Albany, NY	34,640	33,599	97%	1,041	3%	675	3	38.13	0.82	46.84	1.95	22.35	2.80
(V02) (528) Bath, NY	14,542	13,776	95%	766	5%	17	18	30.63	2.55	51.76	5.06	34.49	0.12
(V02) (528) Canandaigua, NY	20,087	19,697	98%	390	2%	52	6	71.84	2.76	35.53	2.25	16.60	1.13
(V02) (528) Syracuse, NY	50,508	48,027	95%	2,481	5%	554	60	53.75	2.45	52.43	8.18	34.86	0.92
(V02) (528) Western New York, NY	46,359	44,882	97%	1,477	3%	1064	1	27.61	2.01	41.10	2.24	34.33	5.00

1. Total Appointments Scheduled: Every scheduled appointment at that facility except surgery and procedures.
2. Appointments scheduled 30 Days or under: Number of appointments scheduled between 0-30 days of the reference date (i.e., create date for new patients and desired date for established patients).
3. Percent of Appointments Scheduled 30 Days or under: The percent of total appointments scheduled within 30 days, not including EWL count [Appointments between 0-14 Days + Appointments between 15-30 Days /Total Appointments].
4. Appointments scheduled over 30 Days: Number of appointments scheduled between greater than 30 days of the reference date (i.e., create date for new patients and desired date for established patients).
5. Percent of Appointments Scheduled over 30 Days: The percent of total appointments scheduled beyond 30 days, not including EWL count. [Appointments between 31-60 Days + Appointments between 61-90 Days + Appointments between 91-120 Days/Total Appointments].
6. New Enrollee Appointment Request (NEAR) List: Total number of newly enrolled Veteran that have requested an appointment during the enrollment process during the past 10 years for whom an appointment has not yet been scheduled (NEAR List current as of 6/2/14).
7. Electronic Wait List (EWL) Count: Total number of all new patients (those who have not been seen before in the specific clinic in the previous 24 months) for whom appointments cannot be scheduled in 90 days or less. [EWL<14 Days + EWL 15-30 Days + EWL 31-60 Days = EWL 91-120 Days + EWL>120 Days].
20. New Patient PC Avg Wait Time: Average (Avg) waiting time for a new patient (those who have not been seen before in the specific clinic in the previous 24 months) for a Primary Care (PC) appointment.
21. Established Patient PC Avg Wait Time: Average waiting time for an established patient for a Primary Care (PC) appointment.
22. New Patient SC Avg Wait Time: Average (Avg) waiting time for a new patient (those who have not been seen before in the specific clinic in the previous 24 months) for a Specialty Care (SC) appointment.
23. Established Patient SC Avg Wait Time: Average waiting time for an established patient for a Specialty Care (SC) appointment.
24. New Patient MH Avg Wait Time: Average (Avg) waiting time for a new patient (those who have not been seen before in the specific clinic in the previous 24 months) for a Mental Health (MH) appointment.
25. Established Patient MH Avg Wait Time: Average waiting time for an established patient for a Mental Health (MH) appointment.