



Georgia Department of Public Health

Board of Public Health Meeting

Tuesday, May 13, 2014



We Protect Lives.

Commissioner's Update

James Howgate, MPH
Chief of Staff, DPH

Board Resolution for Capital Bonds

Kate Pfirman, CPA
Chief Financial Officer, DPH

FY2015 Capital Outlay

General Obligation Bonds:\$560,000

Priority

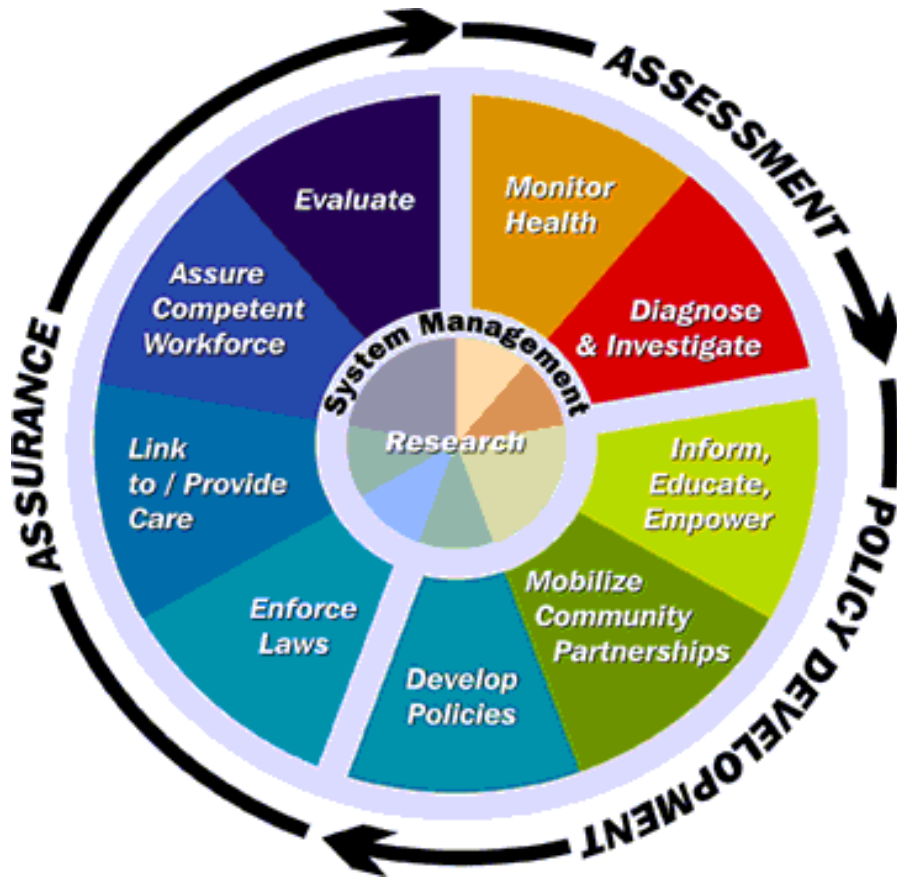
Project Description

- 1 Albany and Waycross District Offices - Chiller Replacement
- 2 Decatur Laboratory - Upgrade Chiller
- 3 Decatur Laboratory - Replace/Repair 7 Fan Coil Units
- 4 Waycross Laboratory - Replace/Repair Water Pump Valves
- 5 Albany District Office - ADA compliant restroom and conference room

Accreditation

Scott Uhlic, MCP, REHS

Purpose of Public Health Standards



- ✓ Assure the essential public health services
- ✓ Improve agency and system quality
- ✓ Build and strengthen strategic partnerships to improve population health

The Public Health Standards Address:

- ✓ Leadership
- ✓ Strategic planning
- ✓ Community engagement
- ✓ Customer focus
- ✓ Workforce development
- ✓ Evaluation and quality improvement
- ✓ Governance

Accreditation Benefits

- **Performance feedback and quality improvement.** The accreditation process provides valuable feedback to health departments about their strengths and areas for improvement, laying the foundation for improved protection, promotion and preservation of their community's health.
- **Accountability and credibility.** Accreditation is a way for health departments to show how effectively they are allocating resources. Achieving accreditation demonstrates accountability to elected officials and communities, resulting in increased credibility for public health departments.
- **Staff morale and visibility.** The recognition of excellence that comes with meeting accreditation standards positively impacts staff morale and enhances the visibility of the health departments in their communities, enabling them to compete successfully for additional resources.

Why DPH Accreditation

- Provides focus for DPH
- Provides framework for decision making
- Aligns activities to match strategies and priorities
- Plans activities to achieve maximum public benefits
- Helps explain what we do & why we do it
- Helps evaluate performance
- Continuous quality improvement

National Standards for Public Health Departments

ADMINISTERED BY PHAB: A Non-profit, non-governmental organization that is accrediting body for national public health accreditation

GOAL: To improve and protect the health of every community by advancing the quality and performance of public health departments (state, local, Tribal, territorial).



Accreditation Prerequisites

These documents lay the groundwork for health department programs, policies, and interventions, and the remainder of the review for accreditation.

I. Community Health Assessment

- Purpose is to learn about the health status of the population that the health department serves.
- Describes the health status of the population, identifies areas for health improvement, determines factors that contribute to health issues, and identifies assets and resources that can be mobilized to address population health improvement.
- Developed through a participatory, collaborative process with various sectors of the community.

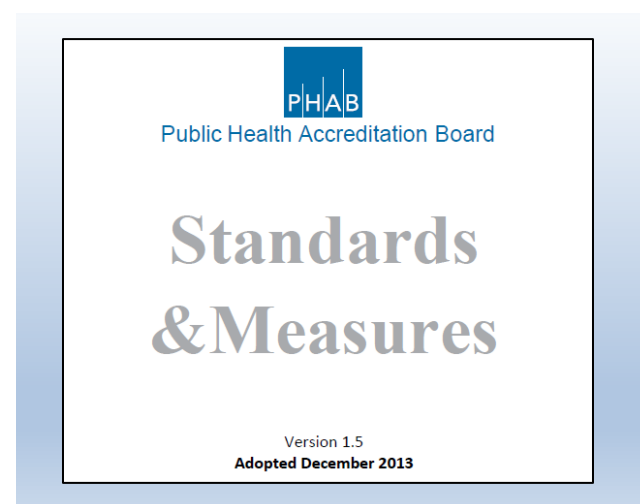
II. Community Health Improvement Plan

- Purpose is to describe how the health department and the community will work together to improve the health of the population that it serves.
- Based on the CHA.
- Community-driven with participation of public health system partners and process to set priorities.
- More comprehensive than roles and responsibilities of health department alone; includes community partners' roles and responsibilities.

III. Health Department Strategic Plan

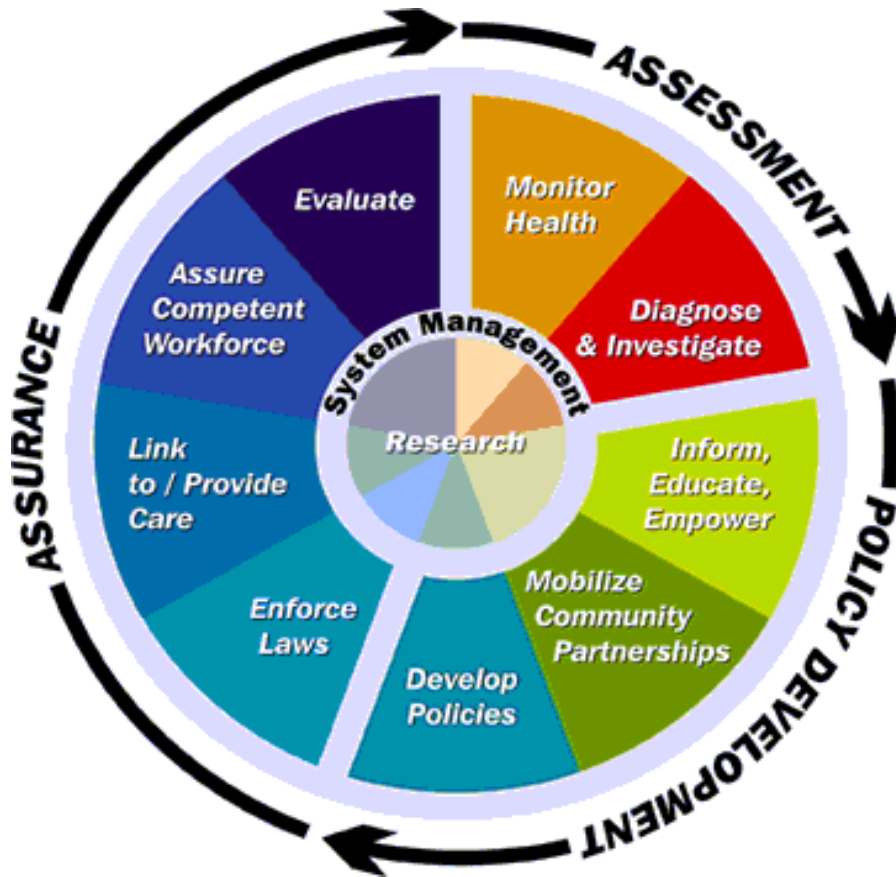
- Purpose is to describe what the health department plans to achieve in 3-5 years.
- Provides guidance for decision making, strategy setting, priority setting, and taking action.
- Focuses on the activities and programs of only the health department, not the broad community

National Standards for Public Health Departments



PHAB Standards and Measures

Version 1.5



- Based on the Core public health functions and the 10 Essential Public Health Services (EPHS)
- 12 Domains: 10 EPHS + Administrative and Governance

National Standards for Public Health Departments

12 Domains



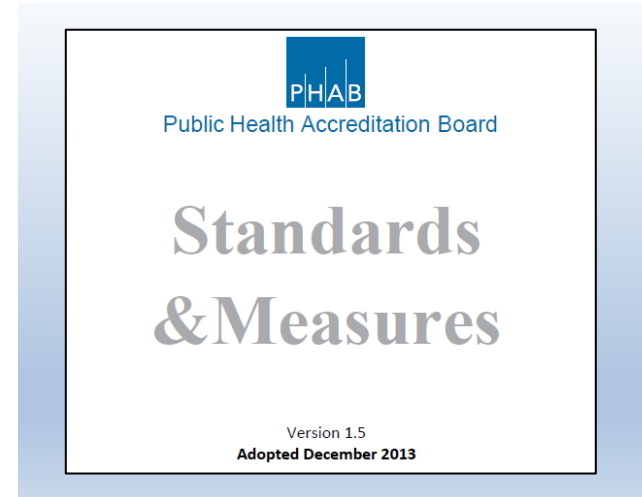
32 Standards



109 Measures



Documentation



Organizational Self Assessment

Standards	Percentage of Measures Met within Standard
Standard 1.3: Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health	100%
Standard 1.4: Provide and use the results of health data analysis to develop recommendations regarding public health policies, processes, programs or interventions	100%
Standard 2.1: Conduct timely investigations of health problems and environmental public health hazards	100%
Standard 2.3: Ensure access to laboratory and epidemiological/environmental public health expertise and capacity to investigate and contain/mitigate public health problems and environmental public health hazards	100%
Standard 3.1: Provide health education and health promotion policies, programs, processes, and interventions to support prevention and wellness	100%
Standard 3.2: Provide information on public health issues and public health functions through multiple methods to a variety of audiences	100%
Standard 4.1: Engage with the public health system and the community in identifying and addressing health problems through collaborative processes	100%
Standard 4.2: Promote the community's understanding of and support for policies and strategies that will improve the public's health	100%
Standard 5.1: Serve as primary and expert resource for establishing and maintaining public health policies, practices, and capacity	100%
Standard 5.3: Develop and implement a health department organizational strategic plan	100%
Standard 5.4: Maintain an all hazards emergency operations plan	100%
Standard 6.1: Review existing laws and work with governing entities and elected/appointed officials to update as needed	100%
Standard 6.2: Educate individuals and organizations on the meaning, purpose, and benefit of public health laws and how to comply.	100%
Standard 6.3: Conduct and monitor public health enforcement activities and coordinate notification of violations among appropriate agencies	100%
Standard 7.1: Assess health care service capacity and access to health care services	100%

Standard 7.2: Identify and implement strategies to improve access to health care services	100%
Standard 8.1: Encourage the development of a sufficient number of qualified public health workers	100%
Standard 10.1: Identify and use the best available evidence for making informed public health practice decisions	100%
Standard 10.2: Promote understanding and use of the current body of research results , evaluations, and evidence-based practices with appropriate audiences	100%
Standard 11.2: Establish effective financial management system	100%
Standard 12.1: Maintain current operational definitions and statements of public health	100%
Standard 12.2: Provide information to the governing entity regarding public health and the official responsibilities of the health department and of the governing entity	100%
Standard 12.3: Encourage the governing entity's engagement in the public health department's overall obligations and responsibilities	100%
Standard 1.2: Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population	75%
Standard 2.4: Maintain a plan with policies and procedures for urgent and non-urgent communications .	75%
Standard 11.1: Develop and maintain an operational infrastructure to support the performance of public health functions	71%
Standard 2.2: Contain/mitigate health problems and environmental public health hazards	67%
Standard 8.2: Ensure a competent workforce through the assessment of staff competencies, the provision of individual training and professional development, and the provision of a supportive work environment.	60%
Standard 1.1: Participate in or lead a collaborative process resulting in a comprehensive community health assessment	0%
Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan .	0%
Standard 9.1: Use a performance management system to monitor achievement of organizational objectives	0%
Standard 9.2 Develop and implement quality improvement processes integrated into organizational practice, processes, and interventions	0%

Red Areas

- Participate in or lead a **collaborative process** resulting in a comprehensive community health assessment.
- Conduct a **comprehensive planning process** resulting in a community health improvement plan.
- Use a **performance management system** to monitor achievement of organizational objectives.
- Develop and implement a **quality improvement process** integrated into organizational practice, processes and interventions.

DPH Accreditation Readiness

- DPH has appointed an accreditation coordinator at the state level to guide statewide accreditation efforts by the department of public health. This includes promoting and supporting district and local health department accreditation activities.
- The Department of Public Health has established an accreditation steering committee to oversee DPH accreditation.
 - Domain Leads
 - CHA/CHIP committee
- The Department of Public Health has 4 PHAB-trained site visitors on staff.
 - Document Review committee
- DPH staff participated in an Organizational Self-Assessment

Health District Accreditation Readiness

- Georgia has one health district that has applied for accreditation and has 2 other health districts actively engaged in preparing for accreditation application.
- Accreditation readiness assessments of nine health districts have been conducted by Georgia Southern University (GSU). GSU staff met with the health directors and selected staff to determine their interests and preparedness for accreditation.
- 5 Districts currently engaged in developing accreditation prerequisites.
- 3 Districts interested in pursuing accreditation
- 7 Districts that are undecided

DPH Accreditation

- CHA /CHIP committee
 - CHA framework
 - Community Engagement
 - Community Health Improvement Planning Process
- Domain Leads
 - Assemble documentation
 - Gap analysis
- Performance Management
 - Agency wide system

DPH Accreditation support to Districts

- Formulate templates for community health assessments, community health improvement plans, strategic plans, and QI plans;
- Identify resources to develop strategies and development of community health improvement process for community engagement;
- Attempt to identify funds for small grants to support accreditation activities in the districts that have shown their commitment to becoming accredited;
- Utilize DPH PHAB site visitors who will review and comment on the plans and documentation that districts prepare before it is submitted; and assist in preparation of PHAB site visit
- Review and update state policies and procedures, which will be needed for both state and district accreditation purposes;
- Identify resources to provide additional QI support and training at the district and state levels;
- Provide technical assistance through accreditation coordinator.

Questions

Middle East Respiratory Syndrome (MERS) Update

Cherie L. Drenzek, DVM, MS
State Epidemiologist, DPH

Overview

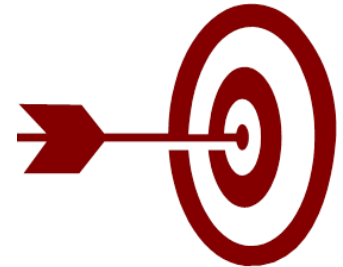
- Recurring Themes
- Update about Middle East Respiratory Syndrome (MERS) globally (including the identification of the first 2 imported cases in the United States)
- Implications for DPH

Recurring Themes

1. Emerging infectious diseases are only a plane ride away (“It’s a small world after all..”)

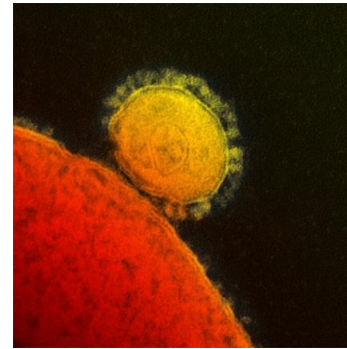


2. Epidemiology must inform mitigation and prevention.



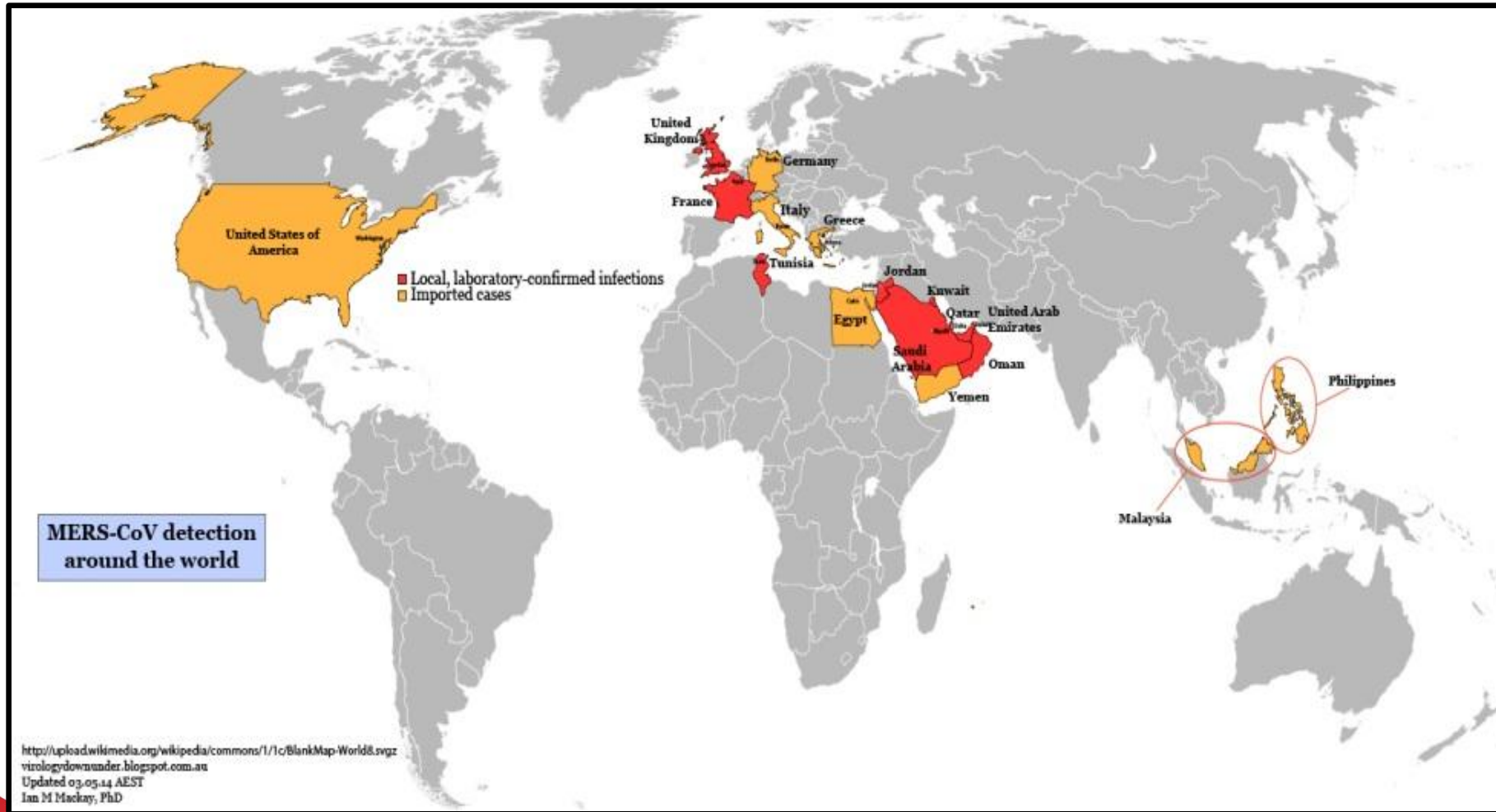
Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

- In April 2012, a novel coronavirus called Middle East Respiratory Syndrome Coronavirus (MERS-CoV) was identified as the cause of severe respiratory infections and deaths among persons in Jordan and Saudi Arabia and has now spread to **17** countries, including the U.S.
- Globally, as of May 12, 2014, WHO has reported **538** cases of MERS-CoV infection (with **145** deaths).
- Since March 2014, there has been a very large **increase** in the number of MERS cases reported from Saudi Arabia and the UAE, where several healthcare-associated outbreaks are occurring.
- Currently, no evidence of sustained spread of MERS-CoV in communities.

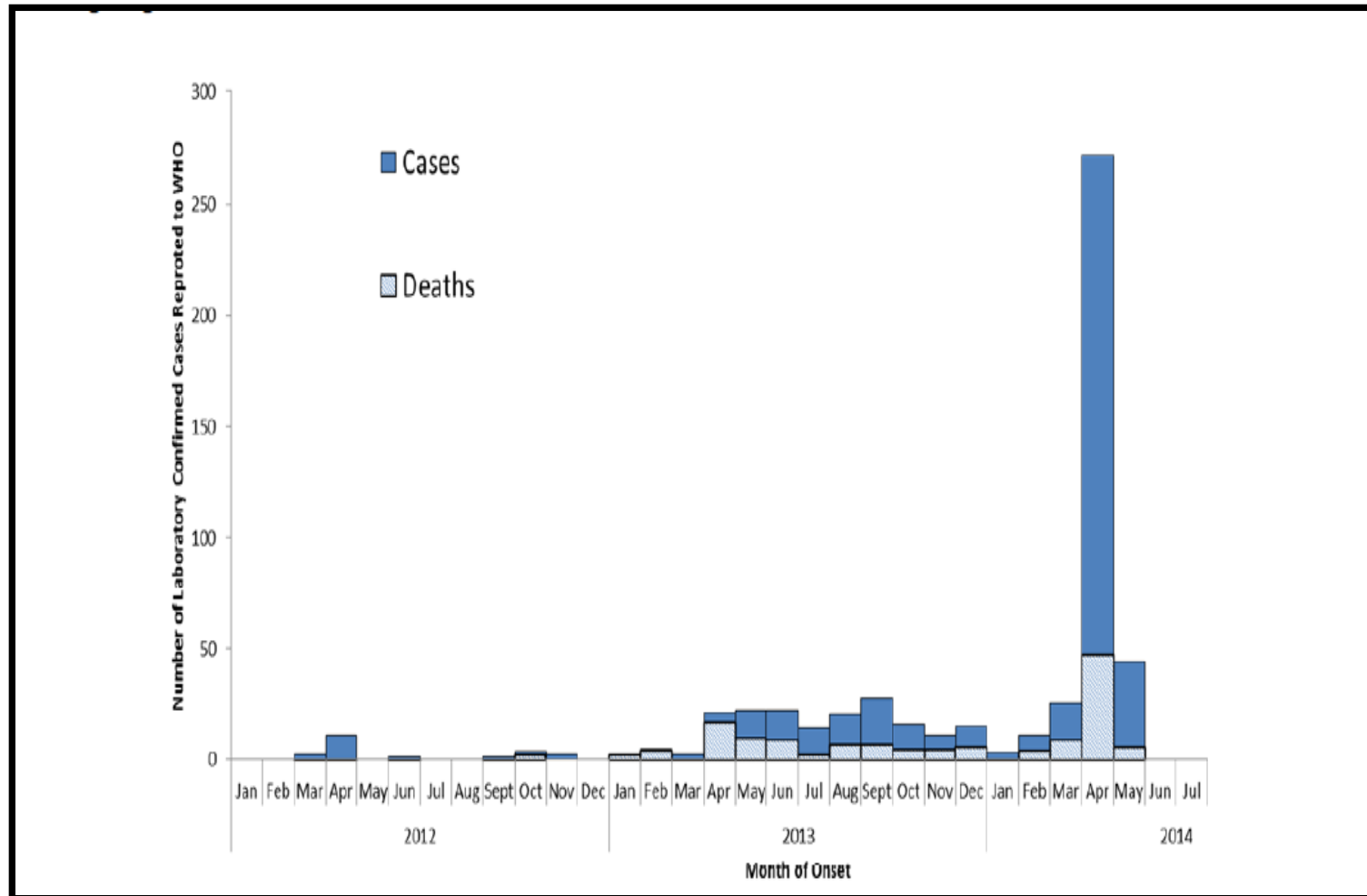


Credit: Rocky Mountain Laboratories, National Institute of Allergy and Infectious Diseases, NIH

Distribution of Confirmed Cases of MERS CoV, by Country, April 2012 – May 2014



Epidemic Curve of MERS-CoV Cases, Worldwide, April 2012-May 2014 (n = 538)



Epidemiology Informs Mitigation: MERS Co-V, 2012-14

Epi Summary: What We Do Know

- Severe illness; relatively high case-fatality rate (27%)
- Most cases male (65.6%); median age = 49 years (range: 9 mo - 94 yrs)
- Median incubation period = 5 days (range: 2-14 days).
- Some asymptomatic infections documented
- There is no vaccine or specific treatment
- MERS-CoV found in healthy dromedary **camels** in Egypt and Saudi Arabia (same sequence as case-patients)
- Travel-associated cases and clusters
- **The majority of human-to-human infections have occurred in healthcare facilities; about 20% of MERS cases in healthcare workers**

MERS-CoV:

What We **Don't** Know:

- It is likely that MERS-CoV originally came from an animal source. However, the reservoir animal(s), the possible intermediate animal host(s), and the ways the virus transmits from animals to humans are **not known**.
- We still don't understand the transmission patterns of this virus.
 - Not easily transmitted from person to person. Seems to require very **close** contact, such as caretaking.
 - When is an infected person most infectious?
 - We don't know whether there is risk of transmission on airlines (seems low risk)
 - We don't know the risk factors for infection in health care settings
 - We don't know the role of asymptomatic infections in spread

Why the recent upsurge in MERS cases?

Unknown, but WHO theories include:

- More sensitive case detection?
- Seasonal patterns? (last April increased as well)
- Mutations in the virus resulting in more human-to-human transmission? (not supported by recent genome sequencing)
- Increased zoonotic transmission?
- Amplified by hospital outbreaks due to breaches in recommended infection control and prevention measures (need standard, contact, and airborne precautions)

WHO concludes: “There is no evidence of sustained human-to-human transmission in the community and the transmission pattern overall remains unchanged.”

First Imported Case of MERS CoV in the U.S.—Indiana

- Reported to CDC by the Indiana Department of Health on May 1, 2014
- The case-patient is a healthcare provider who resides (and works) in Saudi Arabia who traveled to the U.S. to visit relatives in Indiana.
 - On April 24, he flew from Riyadh to London then to Chicago (had a low-grade fever in flight).
 - On April 24, he took a bus from Chicago to Indiana.
 - On April 27, he experienced fever, runny nose, coughing, and shortness of breath.
 - On April 28, he went to an emergency department of a hospital in Munster, Indiana and was admitted.
- Patient was cared for in a hospital isolation room under full precautions (standard, contact, and airborne)
- Patient did well and was discharged from hospital on the weekend of May 9.

Second Imported Case of MERS in U.S.--Florida

- Confirmed by CDC on May 12, 2014
- Unrelated to Indiana MERS case
- The 2nd case is also a healthcare worker (44 y.o. male) who resides and works in Saudi and traveled to the U.S. to visit family in Orlando
- Four flights: on May 1, he traveled from Jeddah to London, then London to Boston, then Boston to Atlanta, then Atlanta to Orlando
- Case-patient reportedly “felt unwell” during all 4 flights and had fever, chills, and a slight cough.
- Stayed with family in Orlando during May 1-May 8
- On May 9, presented to hospital ED, then was admitted the same day
- In hospital, cared for under isolation and full infection control precautions (standard, airborne, contact)
- Patient doing well—in good condition

Public Health Investigation and Response: Both U.S. MERS Cases

- Ensuring appropriate infection control measures are being taken by the hospital(s)
- Contact tracing and investigation for: 1) healthcare workers who cared for them; 2) household/ family members; 3) passengers/crew on all flights (this is out of an abundance of caution).
- Close contacts (family, HCW) tested for MERS, asked to stay home, monitor health, if go out, must wear a mask, also voluntary furlough of HCWs for 14 days after exposure.
- Airline passengers—represent less risk, asked to monitor health and seek medical attention if fever or signs of respiratory illness
- Determine whether MERS-CoV may have spread on the flights and which passengers were at risk by serosurvey of passengers.

Public Health Investigation Results: Indiana Case

- All healthcare worker contacts (53) and household contacts (5) tested negative for MERS and remain symptom-free.
- All contacts on the case's flights (66) and bus trip (10) have been traced and contacted; all also tested negative for MERS and are free of symptoms.
- HCWs on furlough will be re-tested for MERS after Day 14 before they can return to work.

Implications for DPH

- It is likely that MERS cases will continue to be exported to other countries by tourists, travelers, healthcare workers, etc.
- Epidemiology Informs Mitigation:
 1. Enhanced surveillance for cases among travelers/contacts
 2. Clinicians should have raised index of suspicion for MERS-CoV among patients with fever and respiratory symptoms within 14 days after traveling from the Arabian Peninsula or if in close contact with a symptomatic traveler. **Call DPH for triage/testing.**
 3. In healthcare settings, **stringent infection control** is the primary means of controlling MERS-CoV transmission. Standard, contact, and airborne precautions are recommended.
- Outreach/education to healthcare and community partners
- Preparedness for emerging diseases has overarching benefits for improved community health.

Closing Comments

Kathryn K. Cheek, MD, FAAP
Chairperson

The next Board of Public Health meeting
is currently scheduled on
Tuesday, June 10, 2014 @ 1:00 PM.

To get added to the notification list for upcoming meetings, send
an e-mail to huriyyah.lewis@dph.ga.gov