Georgia Department of Public Health

Board of Public Health Meeting

Tuesday, June 10, 2014

We Protect Lives.

Commissioner's Update

Brenda Fitzgerald, MD
Commissioner, DPH

Board Resolution
for Capital Bonds

Kate Pfirman, CPA
Chief Financial Officer, DPH

FY2015 Capital Outlay

General Obligation Bonds:$560,000

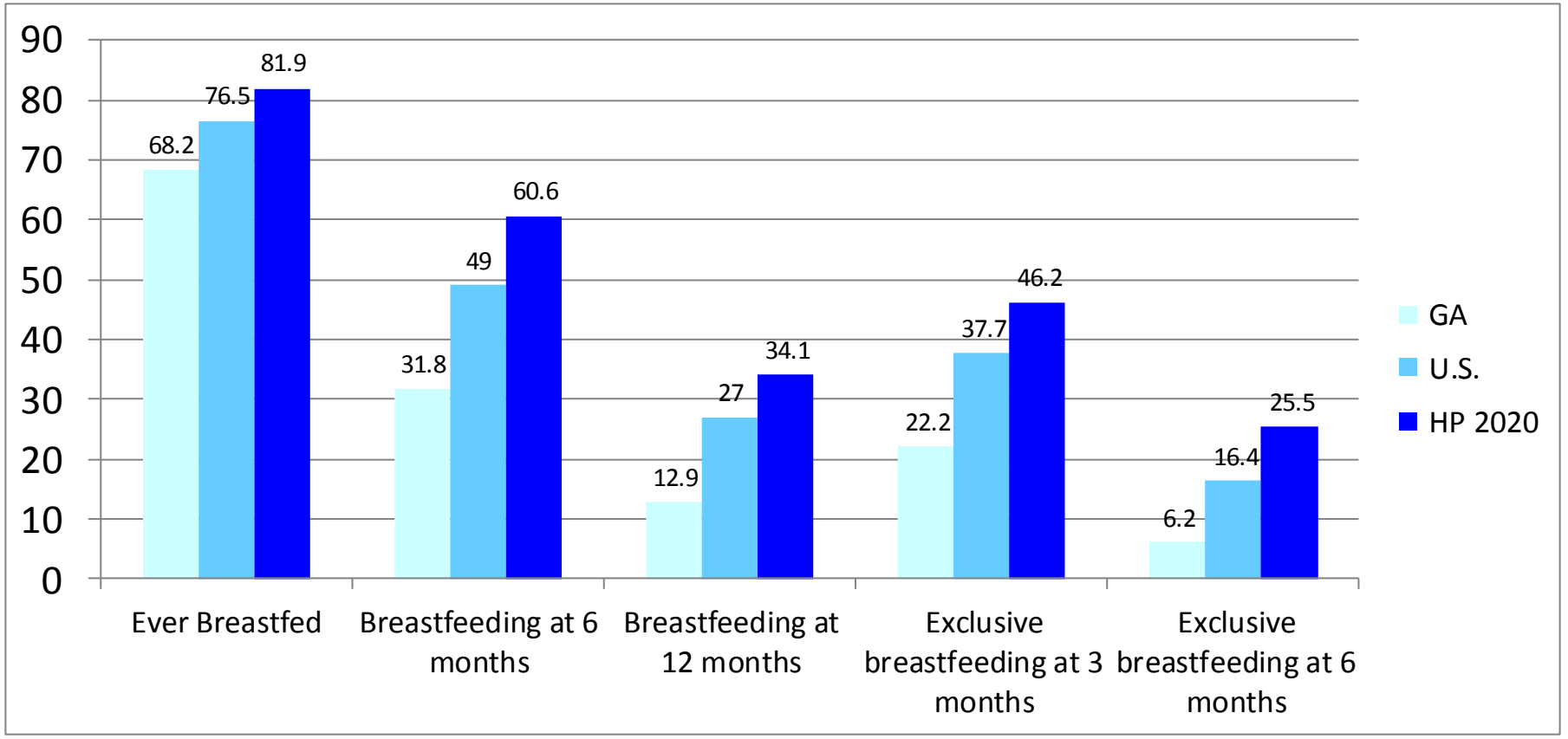
Priority	Project Description
1	Albany and Waycross District Offices - Chiller Replacement
2	Decatur Laboratory - Upgrade Chiller
3	Decatur Laboratory - Replace/Repair 7 Fan Coil Units
4	Waycross Laboratory - Replace/Repair Water Pump Valves
5	Albany District Office - ADA compliant restroom and conference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

Georgia 5-STAR Hospital Initiative

Seema Csukas, MD,PhD
Director, Maternal and Child Health Section

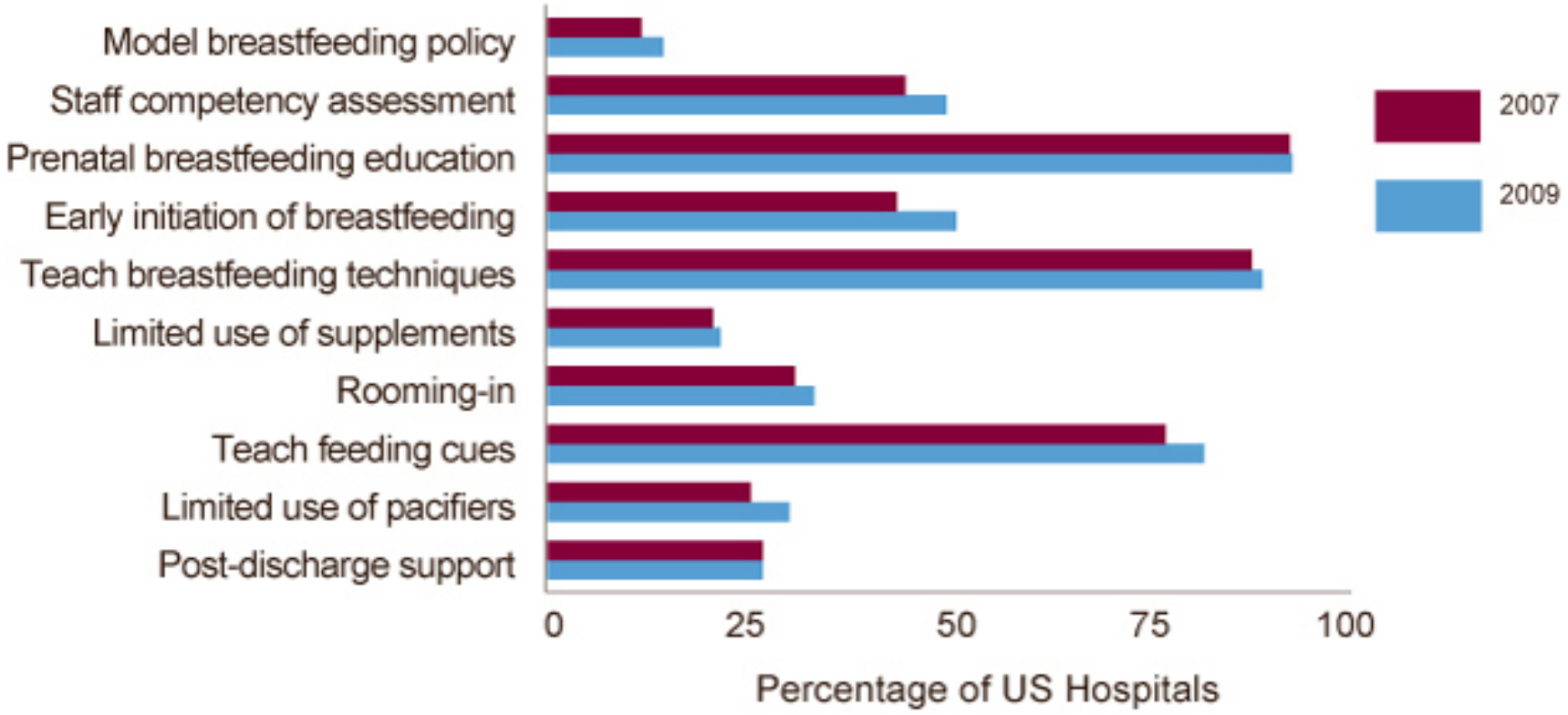
Breastfeeding

Percentage of Children Who Breastfeed, Georgia, U.S. & HP 2020 Goal



CDC NIS Provisional Data, 2010

Baby-Friendly Facilities



SOURCE: CDC National Survey of Maternity Practices in Infant Nutrition and Care (mPINC), 2011

National Initiative for Children's Healthcare Quality (NICHQ) Hospitals in Georgia

- Atlanta Medical Center, Atlanta
- DeKalb Medical, Decatur
- Doctors Hospital, Augusta
- Emory University Hospital Midtown, Atlanta
- Grady Health System, Atlanta
- Piedmont Henry Hospital, Stockbridge
- WellStar Cobb Hospital, Austell

Georgia 5-STAR Hospital Initiative

- Implemented to support public health priorities
  - Georgia SHAPE
  - Infant Mortality

- Implemented to support hospital breastfeeding capacity-building
  - Apply to meet the Baby-Friendly USA national standard
  - Earn a star for every 2 steps achieved in the 10 step process

Georgia 5-Star Hospital Initiative Participants

• Gwinnett Medical Center	Gwinnett County
• Medical Center of Central Georgia	Bibb County
• Midtown Medical Center	Muscogee County
• Phoebe Putney Memorial Hospital	Dougherty County
• Southeast Georgia Health System	Glynn County
• Tift Regional Medical Center	Tift County
• Wellstar Kennestone Hospital	Cobb County

Initiative Components

- Training and Technical Assistance
- 5-day Opening Collaborative Learning Session
- Monthly Webinars
- Monthly Data Collection

Monthly Reporting

- Exclusive Breastfeeding Rates
- Breastfeeding Initiation Rates
- Policy Completion
- Number of Nurses, Physicians, and Ancillary Staff Trained
- Type of Prenatal Breastfeeding Information Provided
- Skin to Skin Rates
- Hand Expression Rates
- Breastfeeding Support Provided within Six Hours
- Safe Bottle Feeding Education Rates
- Rooming-In Rates
- Feeding Cues Education Rates
- Supplements w/o Bottle-top Nipples Rates
- Type of Post Discharge Support Provided

Accomplishments

Aggregate Hospital Data

All Hospitals	Beginning	Ending
Breastfeeding Support	12%	54%
Rooming-in	29%	53%
Skin-Skin	32%	50%
Breastfeeding Initiation	67%	74%
Exclusive Breastfeeding	36%	42%

Individual Hospital Data

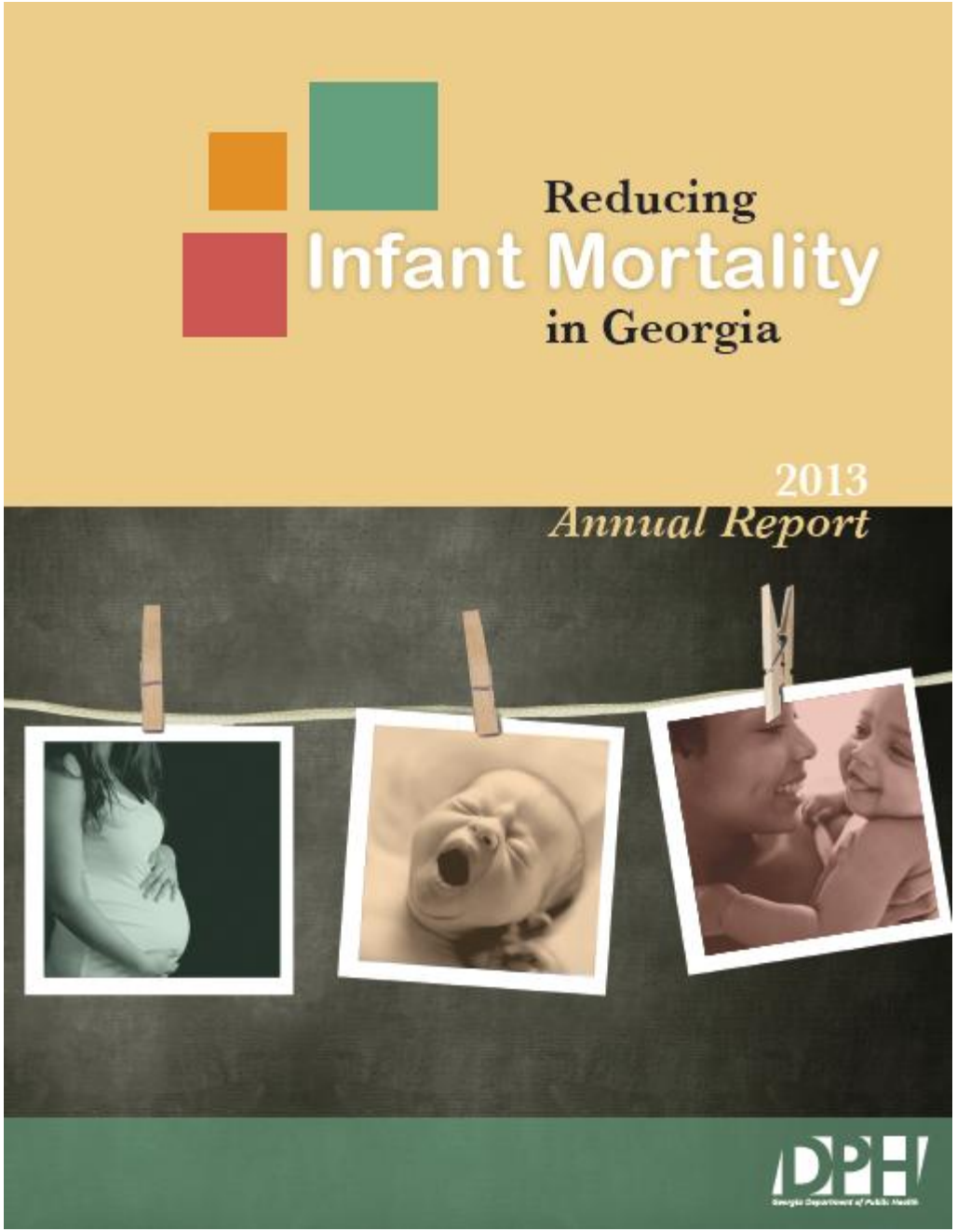
Category	Baseline %	Final %
Most Improved Exclusive Breastfeeding Rate	16%	41%
Most Improved BF Initiation	57%	71%
Feeding Cues	33%	96%
Pacifier Use	80%	4%
Skin-Skin	6%	59%
Rooming-in	18%	68%

Congratulations!

• Gwinnett Medical Center	Gwinnett County
• Medical Center of Central Georgia	Bibb County
• Midtown Medical Center	Muscogee County
• Phoebe Putney Memorial Hospital	Dougherty County
• Southeast Georgia Health System	Glynn County
• Tift Regional Medical Center	Tift County
• Wellstar Kennestone Hospital	Cobb County

Infant Mortality Update

Mitch Rodriguez, MD
Secretary



We Protect Lives.

Georgia Cancer Prevention & Control Plan: 2014-2019

Angie Patterson
Vice President, Georgia CORE

Jean O'Connor, JD, DrPH
Director, Health Promotion Section, DPH

Plan Brings Together Leaders Statewide

- **Addresses the multi-dimensional aspects of cancer**
- **Continues statewide leadership and public-private partnerships**
- **Builds on the strengths of Georgia's cancer prevention, research, and treatment communities**
- **Maintains Georgia's place as a national and international leader in cancer research**




GEORGIA CANCER CONTROL CONSORTIUM

- **Rich history of cancer collaboration over the past 15 years in Georgia**
- **More than 80 stakeholders representing more than 35 organizations**
- **Cancer Control Consortium and its membership, will—**
  - implement the next 5 year plan
  - bring together communities and resources for cancer prevention and control
  - advise the Department and sustain Georgia's focus on cancer
  - re-imagine cancer prevention problems
  - develop new innovative strategies to address Georgia's cancer priorities
  - reduce cancer deaths

Georgia Cancer Prevention and Control Vision and 5-Year Goal

Vision

The Georgia Department of Public Health, as part of the Georgia Cancer Control Consortium, envisions a future in Georgia that is free from cancer deaths and cancer-related health disparities. Cancer impacts all persons in Georgia, and though progress has been made, its toll on the state, remains significant.

Goal

Georgia's overarching goal is to save every possible life and eliminate disparities in prevention, diagnosis, treatment, and access to care. As deaths from some types of cancer are declining rapidly, there is hope that cancers like colorectal cancer could be nearly eradicated through targeted interventions.

The Georgia Comprehensive Cancer Control Plan was supported by Cooperative Agreement Number 5U58DP003875-02 from the Centers for Disease Control and Prevention.

Georgia's Cancer Prevention and Control Priorities: 2014-2019

1. Cancer risk reduction – tobacco and obesity
2. Vaccination for human papilloma virus
3. Breast and cervical cancer screening
4. Colorectal cancer screening
5. Evidence based lung cancer screening
6. Quality cancer diagnosis and treatment
7. Access to palliative care and survivorship
8. Patient case management and care coordination

Cancer Risk Reduction – Tobacco and Obesity

Key Facts

- Tobacco use and exposure is the most preventable cause of cancer-costing Georgians $1.8 billion in direct healthcare costs every year and $3.2 billion in lost productivity (CDC, 2013).
- Obesity is also a risk factor for some types of cancer, including breast and colorectal cancer. Poor dietary habits and insufficient physical activity are the leading contributors to obesity (CDC, 2013).

Georgia's Objective

- Reduce Georgians' exposure to tobacco and secondhand smoke, increase opportunities for physical activity and promote a healthy diet in early care settings, schools, worksites, and community settings through Georgia's Tobacco Use Prevention Program, Georgia's SHAPE Initiative activities, and other chronic disease prevention and management programs .

HPV Vaccine

Key Facts

- CDC and ACIP recommends the 3 dose routine HPV vaccination for all adolescent females and males as early as age nine to reduce the incidence of cancer and reduce the incidence of HP in the population as a whole.
- In Georgia, 52.3% females and 19.8% males ages 13-17 have received one or more doses of HPV vaccine
- Just 29% females and 8.7% males have completed the entire course.

Georgia's Objective

- Increase the number of females and males who receive the HPV vaccine in accordance with the National Advisory Committee on Immunization Practices (ACIP) recommendations.

Breast and Cervical Cancer

Key Facts

- For women in Georgia, breast cancer is the most common cancer diagnosed and the second most common cause of cancer deaths.
- Uninsured women are less likely to report having had a Pap test within the last three years than insured women regardless of race, education level, or age.
- Georgia's Breast and Cervical Cancer Program's funding is only able to serve approximately 15-18% of the eligible population.
- Georgia is fortunate to be one of only three states that receive funding for the Breast Cancer Genomics ESP (Education, Surveillance and Policy) project.
- Applying for the Breast Cancer in Young Women Cooperative Agreement

Georgia's Objective:

- Ensure all women, regardless of income, race or employment status, have access to high quality breast and cervical cancer screening as well as genetic screening, counseling, and preventive clinical services related to HBOC.

Colorectal Cancer Screening

Key Facts

- In Georgia, colorectal cancer is the second leading cause of cancer deaths, responsible for more than 9% of all new cancer cases, and approximately 4,000 annual diagnoses.
- One in three Georgians over age 50 has not been screened according to recommendations.
- Georgia's colorectal cancer mortality rate (17 adults per 100,000 population) is higher than the Healthy People 2020 objective target (14.5 adults per 100,000 population).

Georgia's Objective

- Increase screening for colorectal cancer in adults over 50 years to 85% by 2019, regardless of insurance status, and increase screening among those with a family history of colorectal cancer.

Lung Cancer Screening

Key Facts

- Second most commonly diagnosed cancer
- Accounts for about 15 percent of all newly diagnosed cancers.
- Nine of Georgia's health districts have significantly higher incidence rates for lung cancer in men than the state average
- Incidence rate for males in rural communities is significantly higher than the rate in urban counties
- The United States Preventive Services Task Force (USPSTF) recommends an annual lung cancer screening using low-dose computed tomography for adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.

Georgia's Objective

- Increase the number of qualified Georgia residents who are appropriately screened for lung cancer.

Quality Cancer Diagnosis and Treatment

Key Facts

- Three in every four newly diagnosed cancer patients in Georgia receive oncology care and services at a Commission on Cancer (CoC)-accredited hospital facility or center.
- Adults and minority groups participate less in trials even at leading treatment facilities and centers.
- Georgia has an interactive database of existing clinical trials– www.georgiacancerinfo.org

Georgia's Objective

- Improve the use of quality standards and practice guidelines for the diagnosis, staging and treatment of cancers throughout Georgia.

Palliative Care and Survivorship

Key Facts

- Of the approximately 14 million cancer survivors alive in the US today, nearly 350,000 live in Georgia. The most common cancers among survivors are breast, prostate, and colorectal.
- Palliative care is focused on pain relief, comfort, and relieving suffering to improve quality of life for cancer survivors.
- Survivorship care covers the physical, psychosocial, and economic issues of cancer from diagnosis until the end of life, including the late effects of treatment.
- Commission on Cancer (CoC) patient-centered standards requiring accredited facilities to do palliative care and survivorship planning.

Georgia's Objective

- Increase the proportion of cancer patients in Georgia who receive palliative care and support from the time of diagnosis; and improve the quality of life for all cancer survivors through survivorship care.

Patient Case Management and Care Coordination

Key Facts

- Need for "individualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality medical and psychosocial care and can occur from prior to a cancer diagnosis through all phases of the cancer experience."
- In 2008, GASCO and Georgia CORE partnered to form one of the first statewide multi-disciplinary organizations focused on reducing barriers to care and increasing access to care.
- Cancer Patient Navigators of Georgia (CPNG) has more than 300 members representing counties across Georgia.

Georgia's Objective

- To increase access to cancer patient case management, care coordination and navigators, across the continuum of cancer care: from outreach to end-of-life.

TB Update

J. Patrick O'Neal, MD
Director, Health Protection, DPH

Outbreak of Drug-Resistant Tuberculosis Associated with Homelessness — Fulton County, 2014

Erik J. Reaves, DO, MTM&H

Surveillance, Epidemiology, and Outbreak Investigations Branch
Division of Tuberculosis Elimination

June 6, 2014

DISCUSSION

Discussion

- Since 2009 second wave of transmission involving 29 cases, including 14 (48%) identified in 2014
- Compared to the 2009 Epi-Aid investigation of 16 cases associated with a single homeless facility, this investigation found evidence of potential transmission at multiple facilities
- Although this investigation did not identify clear linkages to 2009 Epi-Aid cases, the persistence of G05625 homeless cases suggests ongoing transmission related to the previous cases

Discussion

- The variable quality and format of data from homeless and correctional facilities limited ability to identify epi-links and identify and prioritize contacts
  - Affected this investigation, but has implications for overall TB control
- Disease severity and TB risk factors among outbreak patients likely contributed to explosive transmission
  - 72% smear-positive, 45% cavitary cases
  - High prevalence of homelessness, incarceration, HIV infection, and substance use

Discussion

- The combination of HIV infection and INH monoresistance in the outbreak are alarming features that raise concern for the development of multidrug resistance
- Without enhanced, aggressive interventions, this undesired outcome will overwhelm TB control capacity and dramatically increases costs
- Large pool of contacts represents potential for future cases

RECOMMENDATIONS

Recommendations are preliminary;
final recommendations will follow in a written report.

1) Find Active Cases

- **Observation: Traditional name-based contact investigations had limited utility**

- **Recommendations:**
  - **Obtain from congregate settings dates of stay for patients during infectious periods**
  - **Collaborate with congregate settings to develop a standardized format for reporting dates of stay**
  - **Systematically track dates of stay in electronic format**
  - **Utilize registration data to identify persons exposed to infectious TB cases at these congregate settings**
  - **Explore options to access registration systems directly (e.g., Pathways HMIS)**

1) Find Active Cases

- **Observation: Large pool of exposed persons needing evaluation (N=1,408)**

- **Recommendations:**
  - **Prioritize evaluation according to case characteristics, high-risk medical conditions, and recent exposure**
  - **Periodically cross-match list of contacts with current registries at congregate settings to locate high-risk contacts**
  - **Collaborate with local health care providers, such as Mercy Care, to ensure evaluation of contacts for active TB as soon as they are located**

1) Find Active Cases

- **Observation: 55% of investigated outbreak patients had HIV infection**

- **Recommendations:**
  - **Cross-match list of contacts with HIV registry information and consider contacts with HIV infection high priority**
  - **Continue to test for HIV infection during case-finding activities**
  - **Ideally, evaluations for persons with HIV infection should include test for TB infection, chest radiography, and sputum examination with culture**
    - **High risk for rapid progression to TB disease after infection**
    - **Potential for development of multidrug-resistant disease**

1) Find Active Cases

- **Observation: Patients were frequently present at homeless facilities during infectious periods**

- **Recommendations:**
  - **Where feasible, case-finding efforts should prioritize individuals with known exposures at these locations, rather than mass screening, to target those at greatest risk**
  - **Assist facilities with implementation and maintenance of robust administrative infection control measures**
  - **Where targeted case-finding is not feasible, consider implementation of active surveillance (i.e., case-finding among all facility clients, not just exposed) over the next 1–2 years, prioritizing suspected sites of transmission**

Facility-based Active Surveillance

- No national guidance exists for active surveillance at homeless facilities
  - Recommended interval for case-finding in health care settings is every 8 weeks until no additional evidence of transmission
- However, sole reliance on mass site-based case-finding is not recommended
  - Substantial proportion of clients are transiently sheltered
  - Efforts are resource-intensive and might not yield evaluations of individuals at highest risk (i.e., those recently exposed)
- When this approach is used, information about exposures (i.e., dates of stay) should be collected to identify persons at highest risk

2) Diagnose Latent TB Infection (LTBI)

- **Observation: Potentially large pool of contacts with LTBI**

- **Recommendation:**
  - **Although either a TST or an interferon-gamma release assay (IGRA) can be used to test for TB infection, consistent use of the same test is ideal for epidemiologic tracking**
  - **Consider more rigorous evaluations (i.e., test for infection, chest radiography, sputum examination with culture) for persons with HIV infection**
  - **Routinely obtain targeted testing data from partners**

3) Treat LTBI

- **Observation: Potentially large pool of contacts with LTBI**
- **Recommendations:**
  - **Prioritize persons for treatment according to risk of progression to TB disease and exposure**
  - **Consider collaboration with non-health department health care providers to treat other LTBI**

3) Treat LTBI

- **Observation: Potentially large pool of contacts with LTBI**

- **Recommendations:**
  - **Offer 4 months of rifampin, ideally under direct observation, and ensure appropriate monitoring**
  - **Consider providing direct observation at congregate settings, and minimize stigmatization through education**
  - **For persons diagnosed with LTBI, maintain electronic records to track treatment status, including whether treatment was offered, initiated, or completed**

4) Implement and Maintain Plan to Control TB among Persons Experiencing Homelessness

- **Observations:**
  - No county-wide plan universally adopted by key partners
  - Homeless facilities lack rigorous infection control measures

- **Recommendations:**
  - Convene task force, led by the local health department, with representation by key partners to implement a universally adopted TB control plan
  - Include education of staff, volunteers, and clients at facilities to avoid stigmatization of patients and contacts
  - Ensure implementation of administrative controls (e.g., screening requirements, cough monitoring) at congregate settings

4) Implement and Maintain Plan to Control TB among Persons Experiencing Homelessness

- **Observations:**
  - No county-wide plan universally adopted by key partners
  - Homeless facilities lack rigorous infection control measures

- **Recommendation:**
  - In the absence of regulation, the TB control plan should include universal adoption of mandatory screening program for facility clients
    - Upon arrival (e.g., within 72 hours), clients should demonstrate evidence of a recent evaluation for TB (e.g., within last 6 months)
    - Evaluate staff members and volunteers on a regular basis (e.g., ≤6 months)

4) Implement and Maintain Plan to Control TB among Persons Experiencing Homelessness

- **Observations:**
  - No county-wide plan universally adopted by key partners
  - Homeless facilities lack rigorous infection control measures
- **Recommendation:**
  - Consult resources from jurisdictions that have successfully facilitated (either through new regulation or voluntary participation) mandatory screening at homeless facilities
  - Incorporate engineering controls (e.g., UV lights) as an adjunct to, but not in place of, administrative controls

5) Monitor Key Indicators

- Consider as evidence for ongoing transmission
  - G05625 cases in unexpected populations (e.g., non-homeless persons not associated with a facility)
  - Increased prevalence of smear-positive cases
  - Longer infectious periods
- Re-assess TB control measures if suspicion for ongoing transmission or few cases identified through contact investigation or other targeted efforts (e.g., administrative screening requirements)
- Provide regular updates to partners about the status of TB control among persons experiencing homelessness

6) Plan for Sustained Response

- Even the most abundantly resourced health departments are overwhelmed by TB outbreaks involving homeless populations
  - These outbreaks can persist for many years
- FCDHW has already mobilized resources and engaged partners to interrupt TB transmission
- Successful control of TB in this population will require long-term investment and political will by all stakeholders

Middle East Respiratory Syndrome (MERS) Update

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

Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

- Globally, as of June 6, 2014, WHO has reported 681 cases of MERS-CoV infection (with 204 deaths) in **18** countries, including the U.S.
- 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.
- In addition, the number of countries reporting **travel-associated** cases has also increased.
- However, currently, there is no evidence of sustained spread of MERS-CoV in communities.

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

Countries in or near the Arabian Peninsula with MERS cases:

- Saudi Arabia
- United Arab Emirates
- Qatar
- Oman
- Jordan
- Kuwait
- Yemen
- Lebanon

Countries with travel-associated MERS cases:

- United Kingdom (UK)
- France
- Tunisia
- Italy
- Malaysia
- Philippines
- Greece
- Egypt
- USA
- Netherlands

Update on Public Health Investigation and Response: Two U.S. MERS Cases (IN, FL)

GOAL: PREVENT SPREAD

- Ensure that appropriate infection control measures were implemented by the hospitals
- Contact tracing, health monitoring, and testing for: 1) healthcare workers who cared for the cases; 2) household/ family members; 3) passengers/crew on all flights (this was out of an abundance of caution).
- CDC: Determine whether MERS-CoV may have spread on the flights and which passengers were at risk by voluntary serosurvey of passengers.

Public Health Investigation Results (Both U.S. Cases)

- All healthcare worker contacts and household contacts tested negative for MERS and remain symptom-free.
- All airline contacts have been traced and contacted; no active MERS infections were documented in any contacts.
- In Georgia, we identified three symptomatic airline contacts of the Florida MERS case but **all tested negative for MERS** at GPHL.
- Interestingly, a business associate of the Indiana MERS case showed initial serologic evidence of MERS CoV infection (possibly indicating spread) but more definitive confirmatory tests at CDC (neutralizing antibody assay) ruled this out.

MERS-CoV Testing for "Patients Under Investigation" in Georgia

In May, we also provided consultation and MERS-CoV testing at GPHL for 3 symptomatic Georgia residents who met CDC's definition for a "Patient Under Investigation" (PUI) (a person with appropriate symptoms and travel history or contact within 14 days)

PUI	Symptoms	Travel HX	Test Date	GPHL rRT-PCR Results
1	Fever, URI	Saudi Arabia	5/19/14	**Negative**
2	Fever, URI	Oman	5/23/14	**Negative**
3	Pneumonia, shortness of breath	Saudi Arabia	5/27/14	**Negative**

Implications for DPH and Healthcare Facilities

It is likely that MERS cases will continue to be exported to other countries by tourists, travelers, healthcare workers, etc.

- Epidemiology Informs Mitigation:

  1. DPH will continue 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 at 1-866-PUB-HLTH**

  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
  - **On May 14, 2014, DPH sent an electronic health alert about MERS to all licensed physicians in Georgia**
  - **On May 27, 2014, we held a webinar with the GHA about MERS for member facilities**

Questions?

Cherie L. Drenzek, DVM, MS
State Epidemiologist
Cherie.Drenzek@dph.ga.gov
404-657-2609

Closing Comments

Kathryn Cheek, MD, FAAP
Chair

The next Board of Public Health meeting
is currently scheduled on
Tuesday, July 8, 2014 @ 1:00 PM.

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