# Health Commission
# City of Stamford
# APPROVED MINUTES
# November 13, 2014

Commissioners Present: Dr. Barbara Decker, Dr. Margaret Cobb, Ms. Patricia Parry

Guests Attended: Ms. Pam Scott, Recording Secretary, Mr. Ted Jankowski, Director of Public Safety, Health and Welfare, and Dr. Michael Parry, Infectious Disease, Stamford Hospital

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| Meeting called to order | | Dr. Decker called the meeting to order at 9:05 a.m. |

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| Additional Agenda Items: | Ms. Parry requested the following items to be added to the agenda:<br>• Walkability/Safety<br>• Health Commission – operational issues<br>• School Nurse Assistant Program (SNAP) | Ms. Parry moved to add additional items to the agenda; Dr. Cobb seconded. Approved unanimously. |

Minutes:

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| Minutes of October 9, 2014 | Minutes from the October 9, 2014 meeting were reviewed. | Ms. Parry moved to approve October 9, 2014 minutes with corrections. Dr. Cobb seconded. Approved unanimously. |

Appeals:

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| There were no appeals | | |

Presentation

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| Dr. Michael Parry<br>Infectious Disease<br>Stamford Hospital<br><br>**Enterovirus D68**<br>**Chikungunya**<br>**Ebola** | Dr. Parry presented current information to the Health Commissioners of the recent emerging infectious diseases reported by the CDC. | |

## Enterovirus D-68

- **Enterovirus D68 (EV-D68) is one of more than 100 non-polio enteroviruses**
  - First identified in California in 1962
  - MMWR Sept 30, 2011: Clusters of Acute Respiratory Illness Associated with Human Enterovirus 68 – Asia, Europe, and US, 2008-2011
- **EV-D68 infection**
- Mild to severe respiratory illness
  - Mild symptoms: flu-like illness but no fever in 80%
  - Severe symptoms: wheezing and difficulty breathing
  - Most cases in children
  - Asthmatics may have a higher risk for severe respiratory illness

- Virus in respiratory secretions, such as saliva, nasal mucus, or sputum
- More likely to get infected with enteroviruses in summer and fall
- Mix of enteroviruses circulate every year
  - Different types of enteroviruses in different years
  - Different clinical syndromes
  - Small numbers of EV-D68 reported regularly to CDC since 1987

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| | ❑ Infants, children, and teenagers are most likely to get infected with enteroviruses and become ill because they do not yet have immunity from previous exposures<br>❑ Adults can get infected with enteroviruses; more likely to have no or mild symptoms<br><br>❑ **Diagnosis**<br>  ❑ Specific lab test (PCR) on nasopharyngeal specimen<br>  ❑ Most labs cannot do specific enterovirus typing like EV-D68<br>  ❑ Only consider EV-D68 testing for patients with severe respiratory illness and when cause is unclear (no intervention; long TAT)<br>  ❑ Co-circulates with other respiratory viruses<br>❑ **Infection Prevention Recommendations**<br>  ❑ Vigilance about preventing the spread of EV-D68<br>  ❑ Standard, Contact, and Droplet Precautions<br>  ❑ Non-enveloped viruses such as EV-D68 may be less susceptible to alcohol than enveloped viruses or bacteria<br>  ❑ Environmental disinfection using hospital-grade disinfectant with EPA label claim for any of several non-enveloped viruses (e.g., norovirus, poliovirus, rhinovirus) | |

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This is an official
CDC HEALTH ADVISORY

Distributed via the CDC Health Alert Network
September 26, 2014, 17:00 ET
CDCHAN-00370

Summary

*The Centers for Disease Control and Prevention (CDC) is working closely with the Colorado Department of Public Health and Environment (CDPHE) and Children's Hospital Colorado to investigate a cluster of nine pediatric patients hospitalized with acute neurologic illness of undetermined etiology. The illness is characterized by focal limb weakness and abnormalities of the spinal cord gray matter on MRI. These illnesses have occurred since August 1, 2014 coincident with an increase of respiratory illnesses among children in Colorado. The purpose of this HAN Advisory is to provide awareness of this neurologic syndrome under investigation with the aim of determining if children with similar clinical and radiographic findings are being cared for in other geographic areas. Guidance about reporting cases to state and local health departments and CDC is provided. Please disseminate this information to infectious disease specialists, intensive care physicians, pediatricians, neurologists, radiologists/neuroradiologists, infection preventionists, and primary care providers, as well as to emergency departments and microbiology laboratories.*

## Chikungunya

Emergency Preparedness and Response

Health Alert Network
HAN Jurisdictions
HAN Message Types
Sign-Up for HAN Updates
HAN Archive
2014
2013
HAN00359
HAN00358
HAN00357
HAN00356
HAN00355
HAN00354
HAN00353
HAN00352
HAN00351

Preparedness for All Hazards > Health Alert Network > HAN Archive > 2013 > HAN00358

Notice to Public Health Officials and Clinicians: Recognizing, Managing, and Reporting Chikungunya Virus Infections in Travelers Returning from the Caribbean

Recommend Tweet Share

This is an official
CDC HEALTH ADVISORY

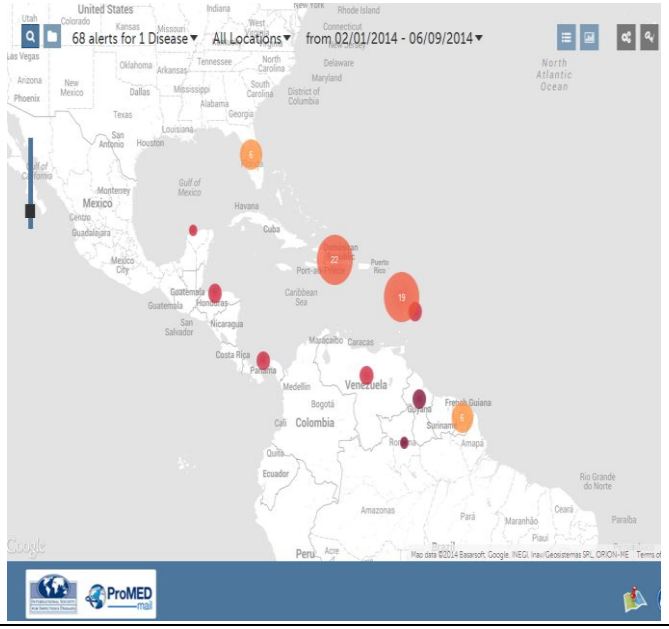
Distributed via the CDC Health Alert Network
December 13, 2013, 1400:00 (2:00 PM ET)
CDCHAN-00358

Summary

On December 7, 2013, the World Health Organization (WHO) reported the first local (autochthonous) transmission of chikungunya virus in the Americas. As of December 12th, 10 cases of chikungunya have been confirmed in patients who reside on the French side of St. Martin in the Caribbean. Laboratory testing is pending on additional suspected cases. Onset of illness for confirmed cases was between October 15 and December 4. At this time, there are no reports of other suspected chikungunya cases outside St. Martin. However, further spread to other countries in the region is possible.

## Chikungunya


## Chikungunya in the Caribbean



**Chikungunya**

>800,000 cases in Western hemisphere
Transmitted by Aedes mosquito
Incubation period usually 3–7 days (range 1–12 days)
Acute onset of fever and arthritis in multiple joints
Joint symptoms usually symmetric and often occur in hands and feet; they can be severe and debilitating
Other symptoms: Headache, myalgia, arthritis, conjunctivitis, nausea/vomiting, rash
Low white blood cell count, abnormal liver and kidney function
No specific treatment
Low fatality rate (1/1000 cases)
Arthritis can linger for months

**Ebola Virus Disease**

## Ebola Virus

- Prototype Viral Hemorrhagic Fever Pathogen
  - Filovirus: enveloped, non-segmented, negative-stranded RNA virus
  - Severe disease with high case fatality
  - Absence of specific treatment or vaccine
- >20 previous Ebola and Marburg virus outbreaks
- 2014 West Africa Ebola Outbreak caused by *Zaire ebolavirus* species (five known Ebola virus species)


## Ebola Virus

- Zoonotic virus – bats the most likely reservoir, although species unknown
- Spillover event from infected wild animals (e.g., fruit bats, monkey, duiker) to humans, followed by human-human transmission

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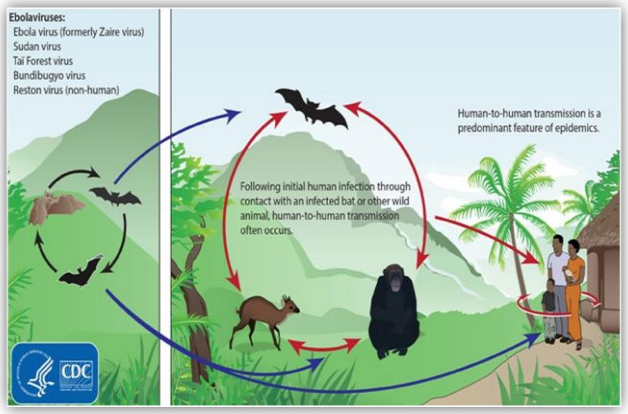
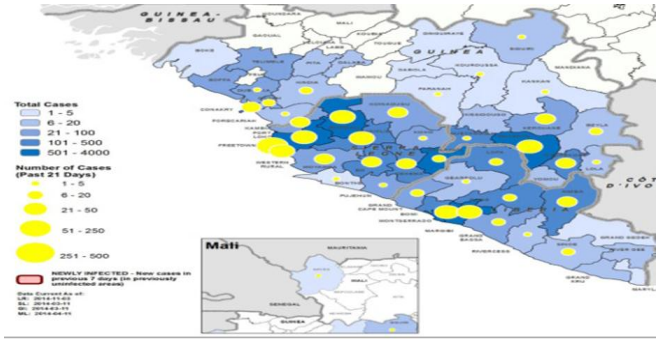



**2014 West Africa Ebola Outbreak**

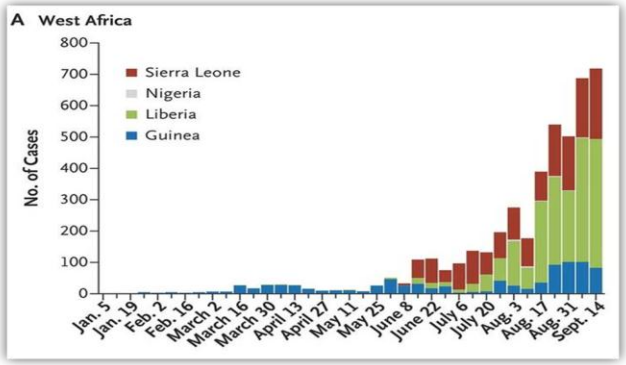
- Outbreak in West Africa
  - Began March, 2014
  - As of 11/7/14
    - >13,000 cases, 5000 deaths
    - >400 cases in health care workers
    - Sierra Leone, Liberia, Guinea
- Reasons for the epidemic
  - Poor nations
  - Limited Health infrastructure
  - No prior experience with Ebola
  - Few HCW with multiple health threats
  - Frequent travelers with porous borders
  - Limited cooperation between neighboring countries
  - Regional conflicts
  - Local customs – burials, take people

home to die
- Fear of going to hospital (empty beds!)




WHO update, November 7, 2014
Total cases = 13,241 Laboratory proven cases = 8142 Deaths = 4950

## 2014 Ebola Outbreak, West Africa




WHO Ebola Response Team. *N Engl J Med* 2014. DOI: 10.1056/NEJMoa1411100
http://www.nejm.org/doi/full/10.1056/NEJMoa1411100?query=featured_ebola#t=articleResults

**Principles of EVD Control**

- Education
- Hygiene – even standard precautions
- Case identification
- Contact tracing, monitoring and quarantine critical
- Personal Protective Equipment (PPE)
- Prompt isolation
- Careful burials

**EVD Cases (United States)**

- ❑ As of October 24, 2014, EVD has been diagnosed in the United States in four people, one (the index patient) who traveled to Dallas, Texas from Liberia, two healthcare workers who cared for the index patient, and one medical aid worker who traveled to New York City from Guinea
- ❑
  - **Index patient** – Symptoms developed on September 24, 2014 approximately four days after arrival, sought medical care at Texas Health Presbyterian Hospital of Dallas on September 26, was admitted to hospital on September 28, testing confirmed EVD on September 30, patient died October 8.
  - **TX Healthcare Worker, Case 2** – Cared for the index patient, was self-monitoring and presented to hospital reporting low-grade fever, diagnosed with EVD on October 10, recovered and released from NIH Clinical Center October 24.
  - **TX Healthcare Worker, Case 3** – Cared for the index patient, was self-monitoring

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| | and reported low-grade fever, diagnosed with EVD on October 15, recovered and released from Emory University Hospital in Atlanta October 28.<br>▪ **NY Medical Aid Worker, Case 4** – Worked with Ebola patients in Guinea, was self-monitoring and reported fever, diagnosed with EVD on October 24, currently in isolation at Bellevue Hospital in New York City. Discharged recovered. No secondary cases<br><br>❑ Total 9 cases in United States including 5 transferred here for care.<br><br>Information on U.S. EVD cases available at http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/united-states-imported-case.html<br><br>**Ebola Clinical Presentation**<br><br>• Fever, headache, myalgias, malaise, fatigue -- day 1-3<br>  • Temp to 40C, relative bradycardia<br>  • Conjunctivitis<br>  • Fever and myalgias persist for 2 weeks<br>  • Fatigue and malaise may precede fever by 1-2 days<br>• GI / abdominal symptoms -- day 3-7<br>  • profuse diarrhea, nausea, vomiting<br>  • 3-12 liter/day<br>  • Oliguria<br>• Rash, day 4-7 | |

- Generalized maculopapular, sometimes pruritic
- Cough, edema, vascular leak, pulmonary edema – day 7-14
  - Septic phase
  - Respiratory failure
  - Difficulty with fluid resuscitation

**Evolving National Strategy**

- Direct monitoring strategy by DOH
  - Early detection of persons at risk
  - Allows for targeted case management
  - Targeted facility referral
- Hospital readiness designation
  - REP teams for hospital review
  - CERT teams for patient management
- Different care guidance for different settings

**Evolving National Strategies:**
**Ambulatory care sites**

- Poorly-designed sites (MD offices, e.g.)
  - Divert patients from these settings
  - No resources for care / testing / PPE
  - Preserve for normal patient care functions
- Telephone triage prior to arrival
- Exterior signage with referral instructions,
- Tel#
- "Just-in-case" guidance
  - No contact policy
  - Call EMS / 911
  - Minimal PPE policy

**Evolving National Strategy:**
**Emergency Departments**

- EDs must have a screening / triage / management plan
- On site manager or incident command system in place as part of the plan
- Laboratory plan
- Waste management plan
- PPE plan
    - Low infectivity persons
    - High infectivity persons
    - Cadre of trained staff

**Evolving National Strategy:**
**Hospital Care**

- Best provided by hospitals with bio-containment units
- Other hospitals coming on line (as CDC acknowledges)
    - Allows most hospitals to function normally
- Detailed plan for proven cases
    - Not business as usual – complex process of care
- Enhanced PPE

**Enhanced Guidance**

- The enhanced guidance is centered on five principles:
    - All healthcare workers undergo

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| | rigorous training and are practiced and competent with PPE, including taking it on and off in a systemic manner<br>• No skin exposure when PPE is worn<br>• All workers are supervised by a trained monitor who watches each worker taking PPE on and off.<br>• Enhanced respiratory protection (N-95 or PAPR)<br>• Impermeable gown<br>CDC 10/20/14<br><br>**Enhanced PPE recommendations**<br><br>• PPE recommended for U.S. healthcare workers caring for patients with Ebola includes:<br>• Double gloves<br>• Boot covers that are waterproof and go to at least mid-calf or leg covers<br>• Single use fluid resistant or impermeable gown that extends to at least mid-calf ***or*** coverall without intergraded hood.<br>• Respirators, including either N95 respirators or powered air purifying respirator (PAPR)<br>• Single-use, full-face shield that is disposable<br>• Surgical hoods to ensure complete coverage of the head and neck<br>• Apron that is waterproof and covers | |

the torso to the level of the mid-calf should be used if Ebola patients have vomiting or diarrhea

## CDC Guidance for Exposed Persons

| "High Risk" Exposure Category | Public Health Action |
|---|---|
| • BBF exposure from symptomatic Ebola patient<br>• BBF exposure during care of Ebola patient without appropriate PPE<br>• Processing BBF of Ebola patient without appropriate PPE<br>• Direct contact with the dead body of possible Ebola patient without PPE<br>• Living in household of Ebola patient who is symptomatic | ***Symptomatic***<br>• Rapid isolation<br>• Medical evaluation / Admission<br>• Contact tracing<br><br>***Asymptomatic***<br>• Direct, active monitoring<br>• Controlled movement<br>• Exclusion from work and public places<br>• Non-congregate activities with 3-foot separation permitted<br>• "Do not board" federal travel restrictions<br>• Allowed travel regulations defined |

## CDC Guidance for Exposed Persons

| "Some Risk" Exposure Category | Public Health Action |
|---|---|
| • Direct contact with BBF of symptomatic patient while using appropriate PPE in countries with widespread Ebola virus transmission<br>• Prolonged close contact in households, healthcare facilities, or community settings (i.e., less than 3 feet) while patient was symptomatic and while not wearing appropriate PPE | ***Symptomatic***<br>• Rapid Isolation<br>• Hospital evaluation / Admission<br>• If not Ebola, manage as asymptomatic exposure<br><br>***Asymptomatic***<br>• Direct, active monitoring<br>• Controlled movement (flexible)<br>• Exclusion from work and public places (flexible)<br>• Non-congregate activities with 3-foot separation |

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| | permitted<br>• "Do not board" federal travel restrictions (flexible) |

## CDC Guidance for Exposed Persons

| "Low Risk" Exposure Category | Public Health Action |
|---|---|
| • No known exposure to the patient, but travel to a country with widespread Ebola virus transmission<br>• Brief, direct contact (e.g. handshake) with patient in early stages of Ebola symptoms while not wearing PPE<br>• Brief proximity for a brief period of time while Ebola patient was symptomatic<br>• Direct contact with symptomatic Ebola patient in a country without widespread Ebola virus transmission while wearing appropriate PPE<br>• Travel on an aircraft with a person with Ebola while the person was symptomatic | ***Symptomatic***<br>• Rapid Isolation<br>• Hospital evaluation / Admission<br>• If not Ebola, manage as asymptomatic exposure<br><br>***Asymptomatic***<br>• Direct, active monitoring<br>- US based HCW caring for symptomatic Ebola patient<br>-Travelers on aircraft sitting within 3 feet of Ebola pt<br>• Active monitoring for all others<br>• No restrictions on work<br>• No restrictions on travel on public conveyances or congregate gatherings |

## CDC Guidance for Exposed Persons

| "No Risk" Exposure Category | Public Health Action |
|---|---|
| • Contact with asymptomatic person who had contact with a person with Ebola<br>• Contact with a person with Ebola before the person developed symptoms<br>• Travel to a country with widespread Ebola virus transmission more than 21 days previously<br>• Having been in a country without widespread Ebola virus transmission and not having any of the prior defined exposures | ***Symptomatic***<br>• Routine care and evaluation<br><br>***Asymptomatic***<br>• No actions needed |


## SCREENING FOR EBOLA

| Travel History | Patient Presentation | Close Contact |
|---|---|---|
| West Africa within 21 days:<br>• Guinea<br>• Liberia<br>• Sierra Leone<br>• D. R. Congo | - Fever ≥100.4 (≥38.0)<br>- Headache<br>- Muscle aches<br>- Vomiting<br>- Diarrhea<br>- Abdominal pain<br>- Hemorrhage | • With anyone sick with symptoms of Ebola?<br>• With blood or body fluids of a person with possible Ebola?<br>• With remains of a person who died of possible Ebola? |

**If Suspected - call Infectious Diseases 203-353-1427 and/or Infection Prevention 203-914-7019**

The Health Commissioners thanked Dr. Parry for the wealth of information he presented to the commission.

# Health Commission
# City of Stamford
# APPROVED MINUTES
# November 13, 2014

**Old Business:**

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| ***Walkability*** | Dr. Decker informed the commissioners of a meeting she attended with Robin Stein, Assistant to the Mayor. She provided him with Mark Fenton's walk audit of 2011, and a list (handout) of health issues that center about safety and exercise. Reduction of pedestrian, cyclist and motorist deaths and injuries are among the healthy People 2020 national health objectives.<br><br>Dr. Decker suggested that the health commission promote a walk to school day. Ms. Parry asked if we could get the number of walkers in each school. Yes we can.<br><br>Ms. Parry commented on Charter Oaks construction on Merrell Ave and the impact on the roadway. Parking is being provided on the road which appears to make the road narrower. In addition, Ms Parry felt that this design would impact safety. | |
| ***Influenza*** | Ms. Parry suggested getting information to the press emphasizing the importance of flu vaccination as we approach the flu season. | |

**New Business**

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| ***Health Commission minutes*** | Ms. Parry commented on the format of the minutes; the lack of headers to explain each column and lack of pagination. In addition, sometimes the mailed packet for the meeting arrives late and is not available to the members in time for the meeting. This month the packet did not arrive via mail before the meeting and Ms. Scott sent it electronically. | Ms. Parry made a motion to send out packet electronically and make paper copies available at the meeting. Dr. Cobb seconded. Passed unanimously. |
| ***SNAP*** | After the presentation by Deidre Anspach, Director of Nursing about the SNAP software, the Health Commissioners discussed creative ways to make data | Dr. Cobb suggested that the health department budget for a data entry person to assist the process. |

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| | entry more streamlined. Commissioners Cobb and Parry asked Director Fountain if she had considered a line item in the budget to provide funds for innovative ways to help this process. Director Fountain indicated that she had not heard any of this and would reach out to the Director of Nursing to get some background information on this report. | Dr. Decker made a motion to table SNAP until the next meeting, giving Director Fountain an opportunity to collect information. Ms. Parry seconded. Passed unanimously. |

Director of Health and Social Services

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| ***Anne Fountain, MPH*** | Ms. Fountain informed the Health Commission of the following upcoming events:<br>• World AIDS Day – December 1 at the United Methodist Church.<br>• Well Ordinance – the Board of Representative will be discussing a new well ordinance at their meeting on Tuesday, November 18. | |

Adjournment:

There being no further business before the regular session of the Health Commission; Dr. Decker moved to adjourn the meeting at 11:15 a.m. The motion passed unanimously.

Submitted by,
*Pam Scott*
Pam Scott/pp/bd
Recording Secretary