COUNTY OF LOS ANGELES
PUBLIC HEALTH COMMISSION
APRIL 26, 2012
MINUTES

APPROVED

COMMISSIONERS

Michelle Anne Bholat, M.D., M.P.H., Chairperson*
Patrick Dowling M.D., M.P.H., Vice-Chair*
Waleed W. Shindy M.D., M.P.H.**
Jean G. Champommier, Ph.D.*

DEPARTMENT OF HEALTH SERVICES REPRESENTATIVE

Jonathan E. Fielding, Director of Public Health and Health Officer***

Angela Haley, Secretary*
Public Health Commission

PUBLIC HEALTH COMMISSION ADVISOR
Jonathan E. Freedman, Chief Deputy*
Public Health

PUBLIC HEALTH COMMISSION YOUTH ADVISOR
Vacant

***Present** ****Excused** *****Absent**

TOPIC	DISCUSSION/FINDINGS	RECOMMENDATION/ACTION/ FOLLOW-UP
I. CALL TO ORDER	*The meeting was called to order at approximately 10:05 a.m. by Chairperson Bholat at Central Health Center.*	*Information only.*

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II. ANNOUNCEMENTS & INTRODUCTIONS	*Introductions of Commissioners and guests were conducted. Jean Champommier, Ph.D., Commissioner, 1st District, introduced himself and indicated he's happy to be returning to the Commission again, he was a previous Commissioner about 20 years ago.*	*Information only.*
III. APPROVAL OF MINUTES	*The April 12, 2012 minutes will be approved when Commissioner Shindy is present.*	

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IV. PUBLIC HEALTH REPORT	*Jonathan Freedman provided the Commission with a Public Health Report and discussed public health activities since the last report on April 12, 2012.* ***2010-2011 Annual Report – L.A. County*** *Mr. Freedman informed the Commission that at the next meeting he will discuss DPH's budget and organization, this annual report is a prelude to what he will discuss. The report is also available on DPH's website.* ***Southern California Physician Magazine Article*** *The feature article in the April 2012 issue of the Southern California Physician, the official magazine of the L.A. County Medical Association, highlights some of the work the Department of Public Health does in order to address a number of critical public health needs throughout the county. Specifically, the article includes the work of Project TRUST, RENEW LA, Choose Health LA, and the PLACE Program.*	

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IV. PUBLIC HEALTH REPORT CONTINUED	***National Governors Association Meeting on Health and Homeland Security*** *The Department of Public Health (DPH) has been invited by the National Governors Association to participate in a conference in Washington, D.C. on April 26-27, 2012 regarding homeland security and fusion center efforts with local public health agencies. DPH staff who are involved in the Joint Regional Intelligence (JRIC) will attend. As you may know, DPH participates in the local JRIC, and DPH's efforts are viewed as a model nationally.* *Mr. Freedman indicated that DPH has about 20 staff who have security clearance with Homeland Security, this allows DPH staff public health information sharing with other public health organizations and homeland security advisors.* ***Report on the Feasibility of Moving the Toxicology Lab From the Department of Agricultural Commissioner/Weights and Measures to the Department of Public Health*** *On December 6, 2011, the Board directed the Chief Executive Officer (CEO) to report back within a month on the feasibility of moving the Environmental Toxicology Lab (ETL) from the Department of Agricultural Commissioner/Weights and Measures (ACWM) to the Department of Public Health (DPH).*	

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IV. PUBLIC HEALTH REPORT CONTINUED	*The report basically discusses the pros and cons of combining both the laboratories.* *Given the complexities of the ETL and PHL, there is no apparent optimal organization alignment of the ETL in the county. As a result, DPH requested a three-month extension to July 10, 2012 for a more comprehensive analysis.*	

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V. ACUTE COMMUNICABLE DISEASE CONTROL (ACDC) PROGRAM	*Dr. David Dassey, Deputy Chief, Acute Communicable Disease Control (ACDC) Program, provided the Commission with an update of the activities within ACDC.* ***ACDC*** *Conducts surveillance and control of over 80 diseases, disease syndromes, and outbreaks:* • *Diseases of considerable public impact and interest: e.g., food and water-associated illnesses, West Nile Virus* • *Novel and emerging communicable diseases: e.g., SARS, avian and pandemic influenza* • *Diseases with potential for bioterrorist activity: e.g., anthrax, plague, smallpox* *Dr. Dassey indicated ACDC is comprised of 80+ employees and their operating budget is around $10 million.* ***Selected Awards 2011-2012*** • *2011 Public Health Excellence Award – David Dassey*	

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V. ACDC PROGRAM CONTINUED	• *DPH Outstanding Employee Award – Irene Culver* • *DPH Best Scientific Article Published – Curtis Croker* • *Best Oral presentation for PHN Practice Conference – L'Tanya English, Lorraine Sisneros, & Heidi Lee* • *National Association of Counties (NACo) Achievement Award, and Center for Infectious Disease Research and Policy (CIDRAP) Recognition for Promising Practice-Schools Online Training – Sadina Reynaldo* ***Published Reports*** *ACDC reaches thousands of health care providers and community stakeholders through numerous reports and articles:* • *Internally: Syndromic surveillance summaries (daily); and outbreak log for selected Public Health Managers (weekly)* • *Externally: Influenza Watch and West Nile Virus Report (seasonally); ACDC Morbidity and Special Studies Report (annually); and RX for Prevention (monthly, PRN)*	

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V. ACDC PROGRAM CONTINUED	***How Do We Determine Priorities?*** *Priorities are based on the relevance and potential impact on the public's health. For instance:* • *Outbreak investigations are given top priority, followed by:* • *Enhanced surveillance* • *Recognition of trends, outbreaks, and emerging diseases* • *Emergency response preparedness* • *Evidence-based primary prevention strategies* ***ACDC Units*** • *Vectorborne and Waterborne Diseases* • *Food Safety* • *Epidemiology and Data Support Section* • *Hospital Outreach* • *Hepatitis, Antimicrobial Resistance, and Influenza* • *Policy and Prevention* • *Planning and Evaluation* • *Training and Response* ***Hepatitis Surveillance & Control*** • *Hepatitis A prophylaxis: enhanced surveillance in food service and day care*	

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V.ACDC PROGRAM CONTINUED	• *Hepatitis B & Hepatitis C* • *Enhanced surveillance for acute cases over age 50 and in cases with nosocomial risk factors* • *Detention of several nosocomial outbreaks in skilled nursing, home health care, and other health care settings* ***Investigation of Hepatitis B Outbreaks Associated with Podiatry*** • *2008: Outbreak 1) Nine patients may have been infected via podiatric care provided by consulting podiatrist: Poor infection control practices; and cross-contamination, inadequate cleaning, sterilization of instruments and equipment.* • *2011: Outbreak 2) Two diabetic patients may have been at high risk due to poor glucose monitoring practices of home health agency or via care provided by consulting podiatrist: Sharing of equipment and aseptic technique during finger stick; and comprehensive infection control recommendations provided* ***Post-Investigation of Hepatitis B Outbreaks Associated with Podiatry*** • *Post investigation – in both facilities*	

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V.ACDC PROGRAM CONTINUED	• *Improvements were made to infection control* • *Articles were published in three podiatric medical association newsletters* • *Peer-reviewed journal thus alerting the profession and healthcare facilities about proper infection control for podiatry.* ***Influenza Incidence Surveillance Project (IISP)*** • *12 projects throughout U.S. funded by CSTE* • *Objectives: Determine incidence and etiology of medically attended ILI (influenza-like illness)* • *Importance: Identify viruses in circulation, causes of ILI, and co-infections* ***Vectorborne Diseases*** • *Surveillance of meningitis and encephalitis* • *Meningococcal disease* • *Mosquito-borne infections* • *WNV, SLE, WEE, dengue* • *Flea and tick-borne diseases: murine typhus, Lyme disease, etc.* • *Unusual diseases: Malaria, Chagas disease, ehrlichiosis, etc.*	

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V.ACDC PROGRAM CONTINUED	***Varicella Active Surveillance Project*** • *Based in Antelope Valley from 1995-2012* • *Numerous major contributions to varicella literature and National Vaccine Policy recommendations* ***Hospital Outreach Unit – HOU*** • *Serves as liaison between ACDC/Public Health and hospitals, large clinics, and jail medical services* • *Improves communication, collaboration with Infection Preventionists* • *Increases mandatory disease reporting* • *Improves disease and syndromic surveillance* • *Assists in surveillance, control and prevention of nosocomial infections and outbreaks* • *Interfaces with partners such as CDC, CDPH, and Coroner* ***Food Safety Unit*** • *Surveillance and control of enteric and other diseases spread by food or drink* • *Timely reporting of foodborne illnesses by healthcare professionals and victims is essential to confirmation and control efforts*	

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V.ACDC PROGRAM CONTINUED	*Dr. Dassey also discussed the following:* • *Electronic Disease Surveillance Systems* • *Automated Disease Surveillance Systems* • *Planning, Evaluation, and Response Section* • *Training and Response* • *Full-Scale Multi-Agency Bioterrorism Exercise on Board a Cargo Ship* • *Professional Training* • *Health Education Materials* • *Healthcare Provider Bioterrorism Education* *Chairperson Bholat asked Dr. Dassey, when you measure your successes, how do you know you made a difference. Dr. Dassey indicated how we measure success is difficult. Our numbers are going down, and by bringing on electronic reporting, we are hearing about things we never knew before.*	*Commissioner Dowling asked if mad cow disease affects DPH. Dr. Dassey indicated one single cow was tested, and according to FDA, it did not go into the food supply, as a result, it doesn't have any impact at all on DPH. E. coli has substantially higher risk to DPH than mad cow disease.* *The Commission thanked Dr. Dassey for an excellent presentation.*

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VI. TUBERCULOSIS CONTROL PROGRAM (TCP)	*Dr. Frank Alvarez, discussed the updated school Tuberculosis (TB) screening policy for school-aged population. Dr. Alvarez also discussed the following:* ***TB Epidemiology*** • *TB Data in L.A. County (LAC) 1991-2011 – Cases and Rates* • *Highest TB Cases Reported Among LHJs in CA and Service Planning Areas (SPAs) in L.A. County, 2011* • *TB cases in LAC, 1991-2011 – U.S. and Foreign Born* ***Policy Background*** • *In 1980, amended California Administrative Code, Title 22, Division 22, Chapter 9, Sections 41301-41329 to enable the Local Health Officer to mandate tuberculosis (TB) testing of school children, if deemed necessary, for that specific jurisdiction.* • *Since the 1985-86 school year, the LAC TB Control Program (TCP) has required that all kindergartners and students who have never previously attended school in California provide written documentation of a TB skin test (or IGRA) result.*	

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VI.TCP CONTINUED	***<u>Purpose of Former Pre-K TB Testing Requirement</u>*** • *To collect County-wide data to access improvement in TB control and better understand the presence of TB infection and disease.* • *To determine the impact of immigration patterns on local TB incidence.* • *To identify children who are candidates for treatment of latent TB infection (LTBI)* • *To measure annual TB infection rates in the school-aged population* • *TB Skin Test Results Among New School Entrants (K-12) and TB Cases (4-18 year old) in LAC 1993-2009* ***<u>Myth 1 About TB</u>*** • *Myth: Being infected with TB (positive skin test or blood test) means you have active TB disease.* • *Fact: Infection does not necessarily mean disease.*	

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VI.TCP CONTINUED	***Myth 2 About TB*** • *Myth: TB testing is the same as TB screening.* • *Fact: Testing for TB is not the same as screening.* ***Myth 1 About Former Testing Requirement*** • *Myth: The Pre-K Testing Requirement was used as a method of finding children with active TB disease.* • *Fact: The requirement was designed to determine/monitor TB infection rates, NOT to find and treat active TB disease cases. TB Control utilizes contact investigations to find active TB cases of all ages.* ***Myth 2 About Former Testing Requirement*** • *Myth: The Pre-K Testing Requirement was an effective means of getting TB-infected children treated.* • *Fact: Monitoring was not in place to ensure that children who tested positive for TB infection began treatment. Evidence suggests that many who did begin treatment did not complete the full treatment regimen.*	

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VI.TCP CONTINUED	***Myth 3 About Former Testing Requirement*** • *Myth: If the requirement were not in place, there would be a rise in pediatric TB cases in LAC.* • *Fact: Jurisdictions that either rescinded their Pre-K Testing Requirement, like Riverside County, or that never had a Pre-K Testing Requirement, like San Diego County, have continued to see a steady decline in pediatric TB cases.* *Ms. Bagchi discussed the following New Approach of testing requirement and the three things to know about the new policy.* ***New Approach*** • *Rescind the testing requirement for children entering kindergarten or a California school for the first time.* • *Incorporate universal TB screening and risk-based testing in existing California State physical examination requirement for children entering first grade.* • *Health providers, as part of this routine health assessment will screen students and test them for TB only if a risk factor is present*	

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VI.TCP CONTINUED	***Factors to Assess High Risk for TB*** ***If any of these is "Yes" – TB Skin Test*** • *Parent/child born outside U.S. in high-prevalence region* • *Travel to high-incidence country > 1 week* • *Contact with confirmed or suspected TB case* ***Why the Change?*** • *To promote evidence-based best practice, as recommended by the CDC, AAP, USPSTF, etc.* • *To avoid redundancy and prevent fragmented care.* • *To prevent false positive children from receiving treatments that may harm their livers.* • *To focus on placing children in medical homes.* • *To focus on more effective interventions (e.g. CI)* • *To focus on higher-risk populations (e.g. homeless)*	

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VI.TCP CONTINUED	***<u>Universal Testing Cost-Effectiveness</u>*** ***Perspective*** — ***Incremental Cost Effectiveness Ratio*** *Health Care System* — *$1,020,000/ATB case Prevented* *Societal* — *$2,450,000/ATB case Prevented* ***Estimated Impact of New Policy*** • *Cost savings for each cohort of children: Healthcare - $1.3 million: Society- $3.3 million* • *Minimal impact on health outcomes – Even smaller if current TB infection trends continue* • *Next step: Analysis of results' robustness to uncertainty*	

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VI.TCP CONTINUED	*Chairperson Bholat stated its amazing to see what TCP has accomplished in a short amount of time and offered her congratulations.* *Commissioner Champommier stated he feels privileged to be able to hear this outstanding presentation, and its tremendous to see institutional change and saving money in the process, and TCP is doing a good job.* *The Commission thanked Dr. Alvarez and Ms. Bagchi for an excellent presentation and a job well done.*	

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VII. NEW BUSINESS	*Angela Haley, Staff, Public Health Commission, informed the Commission of the information in their packets regarding the 2012 Commissioners' Leadership Conference on Wednesday, May 23, 2012. The focus this year will be on the workplace in 2020, the changing technology, and its impact on government employees and operations. Ms. Haley indicated if the Commission is interested in attending, they need to RSVP by Tuesday, May 15, 2012.* *The meeting adjourned at 11:50 a.m.*	