Eastern Highlands Health District
Board of Directors Regular Meeting
Agenda
Coventry Town Hall Annex
Thursday January 17, 2019 4:30 PM

Scheduled Item: EHHD Public Hearing – Proposed FY19/20 Operating Budget, Proposed FY 19/20 CNR Budget, Proposed FY19/20 Fee Schedule

Call to Order

Approval of Minutes (December 13, 2018)

Public Comments

Old Business

1. Proposed Fiscal Year 19/20 Operating Budget, Proposed FY 19/20 CNR Budget, and Proposed FY19/20 Fee schedule

New Business - none

Finance Committee

2. Quarterly financial report for the period ending 12/31/2018 (to be distributed at meeting)

Town Reports

Directors Report

3. Substance Abuse in our Communities Workgroup – update (no attachment)
4. FDA Food Code Transition – update
5. Five Guiding Values - staff discussion
6. Notice of 1/17/19 Round Table Discussion regarding regionalization of Fairfield County municipal health departments
7. Mass Dispensing Area (MDA) Consolidation
8. Impending staff vacancies

Communications/Other

9. New Haven Register re: Public Health has a free-rider problem
10. DPH re: Influenza Season Update for week 1
11. Commissioner Pino re: departure as DPH commissioner
12. Commissioner Pino re: State wide influenza campaign
13. DPH Publication, "Connecticut Epidemiologist"
14. R Miller re: School Food License Fee reminder
15. A Schulz re: EHHD MRC

Personnel Committee

16. Executive session - personnel matter in accordance with CGS 1-200(6)(a), EHHD Director of Health Performance
17. EHHD Director of Health Compensation (no attachment)

Adjournment

Next Board Meeting – February 21, 2018, 4:30PM at Coventry Town Hall Annex

Eastern Highlands Health District
Board of Directors Regular Meeting Minutes - DRAFT
Coventry Town Hall Annex
Thursday, December 13, 2018

Members present: R. DeVito (Ashford), J. Elsesser (Coventry), J. Higgins (Andover), E. Paterson (Mansfield), J. Stille (Bolton), D. Walsh (Coventry), M. Walters (Columbia), S. Werbner via phone (Tolland)

Staff present: R. Miller, M. Brosseau, C. Trahan, C. Gamache, K. Dardick (5:06 pm)

Call to Order: E. Paterson called the meeting to order at 4:32 pm.

Election of Board Officers (Chair, Vice Chair, Assistant Treasurer)

E. Paterson called for nominations.

J. Elsesser made a MOTION, seconded by J. Stille to nominate and elect E. Paterson as Chair and J. Stille as Assistant Treasurer. MOTION PASSED unanimously.

J. Stille made a MOTION, seconded by J. Elsesser to nominate and elect J. Elsesser as Vice Chair. MOTION PASSED unanimously.

Approval of minutes of October 18, 2018

J. Stille made a MOTION, seconded by J. Elsesser to approve the minutes of the October 18, 2018 meeting as presented. MOTION PASSED unanimously.

Proposed Fiscal Year 2019/2020 Operating Budget, CNR Budget, and fee schedule – set public hearing date

R. Miller gave an overview of the salient points of the proposed finance committee operating budget, fee schedule and Capital Non Recurring budget. The primary points included:

- Total spending proposal of $840,604 which is an increase of 3.5% from FY 18/19
- Member Town contribution rate increased by 2% from $5.31 to $5.42 per capita
- Total spending proposal of $33,000 for CNR budget.

R. Miller noted that drivers of the budget included increases in staff salary, contracted environmental inspection services and training/professional development.

R. Miller reported that the fee schedule includes additional revenues from Water Treatment Wastewater reviews, cosmetology registrations and inspections and farmers market permit rate increases. R. Miller noted that the increase in Farmers market fees is an effort to cover the costs expended by the health district with respect to these permits.

J. Elsesser noted that the Finance Committee met 2 weeks prior to the regular board meeting and made adjustments including a decrease in the town contribution rate. They also combined items of the strategic plan in the CNR budget. The Finance Committee also

reviewed the fee schedule. J. Elsesser noted that he anticipates the biggest issue will be the increase in food service fees. He also noted that he feels it is a responsible budget.

Discussion ensued regarding the fee comparison schedule and the proposal the handle the cosmetology inspections.

J. Elsesser reported that the Finance Committee had a discussion about the use of fund balance. The proposed budget reflects a decrease in the amount taken from fund balance. The Finance Committee feels it is necessary to get away from using fund balance to balance the budget.

R. Devito questioned whether the amount allocated for training, included training for the staff. R. Miller informed the board that there is money allocated for staff training.

R. Devito requested a breakdown of the merit raises for staff.

D. Walsh made a MOTION, seconded by J. Stille to set a public hearing date of Thursday, January 17, 2019 at 4:30 PM, Coventry Town Hall Annex, 1712 Main Street Coventry, Connecticut, to hear the public's comments regarding the Eastern Highlands Health District Proposed Fiscal Year 2019/2020 Operating budget, capital non-recurring budget, and fee schedule as presented on December 13, 2018. Motion PASSED unanimously.

General Fund expenditure request for EHHD Sanitary Code legal review

R. Miller presented an overview of the request.

D. Walsh made a MOTION, seconded by J. Stille to authorize an expenditure not to exceed $7,000 from the General Fund for the purpose of conducting a legal review and edit of the EHHD Sanitary Code to align the code with the FDA Food Code, and establish a Cosmetology enforcement section.

Discussion was initiated with J. Higgins inquiring if template language is available. R. Miller informed the board that there is template language for the cosmetology enforcement, but the FDA food code is too new.

MOTION PASSED unanimously.

Finance Committee – Comprehensive Annual Financial Audit Report – June 30, 2018; Independent Auditors Report on Internal Control; Auditors communication to Board of Directors

R. Miller reported that the Finance Committee met and reviewed the financial audit report dated June 30, 2018. The Finance Committee passed a motion to accept the reports as presented.

J. Elsesser offered "Congratulations on a clean audit". He noted that there are positive trends in the report most notable are the fund balance and accuracy of budgeted fee revenue.

Personnel Committee

D. Walsh reported that the Personnel Committee met to discuss the performance evaluation of R. Miller. D. Walsh noted that it will be finalized and distributed to the board in January. D. Walsh thanked everyone for their participation in the evaluation process.

Town Reports

Columbia – M. Walter reported that the marina on route 6 moved across the street and the auto repair shop has expanded, giving a healthy entrance to the town of Columbia.

Tolland – S. Werbner reported that Cardio Express is closing in Tolland.

Andover – J. Higgins reported that a wing of the Andover Elementary School will be dedicated to house the Senior Center. An agreement is being finalized.

Bolton – J. Stille reported that the report on the Notch Road Municipal Center has been finalized. Report concludes there is structural damage beyond repair in the building. Other options for the town hall are being investigated.

Coventry – J. Elsesser reported that discussions continue with Bolton regarding connecting to the sewer system. J. Elsesser also reported that CT Water Company will be reconstructing the Northfield Water System. Discussions have begun with the town council about reconstructing the roads.

J. Elsesser informed the board that the sale of Reids fell through.

Director's Report

Substance Abuse in our Communities Workgroup – Update

R. Miller reported that outreach to public libraries is underway to see if they are interested in a program that will give narcan kits to the library.

Strategic Plan Progress – Online permit application/tracking system

R. Miller reported that the View permit online portal has been launched to a small group of contractors.

1st Quarter FY 18/19 Activity Report

R. Miller noted that the septic permits have increased while the Food Service inspections have decreased. He noted that the food service inspection decreases are a result of efforts being concentrated in other areas, and continued problems with staff medical leave.

FDA Food Code Transition – proposed regulations - update

R. Miller reported that the regulations have still not been posted to the E-Reg site. It is likely that the implementation of the FDA Food code will be delayed a couple more months.

Communications

Dr. Dardick reported that though it is still early in the season, flu activity is quiet so far.

He also reported a shortage of the shingles vaccine.

R. Miller called attention to the communication on the Cottage Food Businesses, noting that the health department has nothing to do with the oversight of these businesses.

Dr. Dardick noted as a point of interest that a new lyme vaccine is in phase 2 of development.

Adjournment

J. Elsesser made a MOTION, seconded by J. Stille to adjourn at 5:48pm. Motion PASSED.

Next Board Meeting, January 17, 2019, 4:30 PM at Coventry Town Hall Annex

Respectfully submitted,

Robert Miller
Secretary

Eastern Highlands Health District

4 South Eagleville Road • Mansfield CT 06268 • Tel: (860) 429-3325 • Fax: (860) 429-3321 • Web: www.EHHD.org

Eastern Highlands Health District
Public Hearing
Proposed FY 19/20 Operating Budget & CNR Budget, and Fee Schedule

The Eastern Highlands Health District will hold a Public Hearing on Thursday, January 17, 2019, at 4:30 p.m. at the Coventry Town Hall Annex, 1712 Main Street, Coventry, Connecticut, to hear citizen's comments on the Proposed FY 2019-2020 District Operating, Capital Nonrecurring Budget, and Fee Schedule. At this hearing interested persons may appear and be heard and written communications received. Copies of the proposed District Budgets and Fee Schedule are available in the Andover, Ashford, Bolton, Chaplin, Columbia, Coventry, Mansfield, Scotland, Tolland and Willington Town Clerk offices. Written comments will be received up to the close of the hearing and can be directed to the Health District Board of Directors at 4 South Eagleville Road, Storrs, CT 06268

Dated at Mansfield, Connecticut, this 3rd day of January, 2019.

Robert L. Miller
Director of Health

Classifieds

classified@thechronicle.

Legal Notice

Legal Notice

Eastern Highlands Health District
Public Hearing
Proposed FY 19/20 Operating Budget & CNR Budget, and Fee Schedule

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Dated at Mansfield, Connecticut, this 3rd day of January, 2019.

Robert L. Miller
Director of Health

Legal Notice

Legal Notice

TOWN OF COVENTRY
PLANNING AND ZONING COMMISSION

The Coventry Planning & Zoning Commission will hold a Public Hearing on Monday, January 14, 2019 at 7:00 p.m. in the Annex Building, 1712 Main Street, Coventry, CT to hear the following:

1. #18-12S Special Permit Application of Save N Go, Inc., for sandwich shop operations within existing Save N Go structure at 1657 Boston Tpke., (Assessors Map 10, Block 17, Lot 1A-1) Commercial Zone.

Maps and application information are on file in the Land Use Office. Interested persons may appear and written communication received prior to the close of the public hearings.

Help Wanted

Help Wanted

Juniper Hill Village

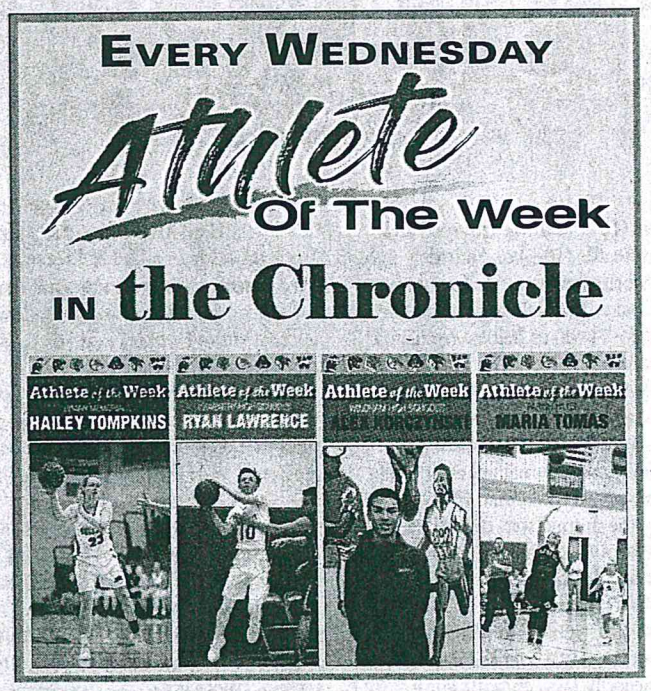
Elderly Housing Management, Incis seeking a per diem/part time Waiter/Waitress to work at Juniper Hill Village, a senior living community in Storrs, CT.

This position will help serve the residents lunch and/or dinner in the main dining room. Wait Staff experience a plus.

Requirements:

- **Ability to read, write and communicate in English**
- **Ability to tolerate the pace of a busy kitchen**
- **Ability to comply with state and local health department requirements**
- **Good interpersonal skills and reliability**
- **This position requires physical effort (lifting up to 25 lbs, reaching at or above shoulder height, ability to bring meals to temporarily disabled residents.**

WALK-INS WELCOME TO COMPLETE AN APPLICATION. INTERVIEWS WILL BE SCHEDULED BY APPOINTMENT.
Address: 1 Silo Circle, Storrs, CT
Salary: $10.10 to $11.00 /hour depending on experience



EMPLOYMENT

Help Wanted

WARNING
Readers are advised that some "work at home" ads or ads offering information on jobs, government homes or vehicles, may require an initial investment. We urge you to investigate the company's claims thoroughly with the Better Business Bureau of the state you are writing or calling before sending any money and proceed at your own risk. If you choose to call an 800 number, let the tape recorded message end before you hang up.

BARGAIN BOX

Bargain Box

LOVESEAT 72" wide, motorized, dark brown, plush. Exc cnd. Pd $1300. Will sell $300. Firm. Call 860-942-8692

MERCHAN

Garden/La Equipme

SNOW THR Craftsman stage, tractor ment, very cond. $350, 456-3092

REAL EST FOR RE

Unfurnishe Rent

WMTC 1, 2 & Sec./Refs. No & up. IMA 860-

Office Spa For Re

OFFICE space in Mansfield ham, Tolla suites to 3,1 Call Tom 4953.

AUTOMO

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TIRES Goodrich Salom 215 Like new, Call 860-9

Local Service Directory

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PUBLIC NOTICE

PUBLIC NOTICE

Eastern Highlands Health District
Public Hearing
Proposed FY 19/20 Operating Budget & CNR Budget, and Fee Schedule

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Dated at Mansfield, Connecticut, this 3rd day of January, 2019.

Robert L. Miller
Director of Health

Journal Inquirer
January 3, 2019

Eastern Highlands Health District

4 South Eagleville Road • Mansfield CT 06268 • Tel: (860) 429-3325 • Fax: (860) 429-3321 • Web: www.EHHD.org

January 4, 2019

Dear Famers Market Food Vendor,

Eastern Highlands Health District will hold a Public Hearing, Thursday January 17, 2019. At this meeting public comments will be heard on the proposed FY 19/20 Operating Budget, Capitol Non Recurring Budget and fee schedule. Please see the enclosed notice of the Public Hearing.

The fee schedule includes proposed increases in the farmer's market food vendor permit fees. The purpose of these increases is to cover costs incurred by the Health District in managing the farmer's market food safety program.

The proposed budget and fee schedule can be found on our website at www.ehhd.org .

Please contact my office if you have specific questions.

Yours in health,

Robert L. Miller, MPH RS

Director of Health

Letter sent to area cosmetology businesses.

Eastern Highlands Health District

4 South Eagleville Road • Mansfield CT 06268 • Tel: (860) 429-3325 • Fax: (860) 429-3321 • Web: www.EHHD.org

January 3, 2019

Allure Hair Studio
3 Mason St
Coventry, CT, 06238

Greetings,

Eastern Highlands Health District will hold a Public Hearing, Thursday January 17, 2019. At this meeting public comments will be heard on the proposed FY 19/20 Operating Budget, Capitol Non Recurring Budget and fee schedule. Please see the enclosed notice of the Public Hearing and proposed fee schedule for additional information.

The proposed fee schedule includes registration/inspection fees for cosmetology businesses such as yours. The purpose of the fee is to cover costs incurred by the Health District to conduct annual sanitary inspections in these establishments, as required by Connecticut State Statute Section 19a-231.

More information regarding the annual sanitary inspections will be provided in the spring of 2019.

Please contact my office if you have specific questions.

Yours in health,

Robert L. Miller, MPH RS

Director of Health

Eastern Highlands Health District

4 South Eagleville Road • Mansfield CT 06268 • Tel: (860) 429-3325 • Fax: (860) 429-3321 • Web: www.EHHD.org

Memorandum

To: Board of Directors

From: Robert L. Miller, MPH, RS, Director of Health

CC: Finance Committee

Cherie Trahan, Chief Financial Officer

Date: 12/12/2018

Re: Proposed Operating Budget, CNR Budget, and Fee Schedule for Fiscal Year 2019/2020

Proposed Fiscal Year 2019/2020 Operating Budget

Submitted herewith for your review is a proposed operating budget for fiscal year 2019/2020. The proposal incorporates an expenditure increase of $28,367, or 3.5%. The total budget has increased from $812,237 to $840,604. The member town contribution rate increased by 2.0% from $5.31 to $5.42 per capita (The average FY18/19 contribution rate for contiguous health districts is $6.45).

Primary Budget Drivers

The primary issues driving the fiscal year 2019/2020 budget are a proposed increase in the staff salary account appropriation, an increase in other contracted purchased services, and an increase in training/professional development line. The following salient factors are incorporated into this budget proposal.

1. Level funding from the adopted FY18/19 figure is proposed for the state grant – in - aid. The EHHD FY18/19 budget already includes a 20% reduction in funding from FY16/17 statutory levels. The state appropriated; and, we have received 108% of the FY18/19 budget.

2. A total member town contribution increase of 1.9%. This includes the 2.0% rate increase, plus changes in the population estimates.

3. A fee for service revenue increase of 10.6%. This aggregate increase incorporates estimated projections for the current fiscal year, extrapolates them into FY20, adds both proposed rate increases for selected service fee categories, and adds revenue from two (2) new service fee categories.

4. An appropriation from fund balance of $27,293 is proposed to balance the budget. This appropriation is a 13.1% reduction compared to the FY18/19 adopted budget.

5. An increase of 7.9% in grant offsets for regular staff salary and benefits is anticipated.

6. A salary line item increase of 3.0%. This increase accommodates proposed merit wage increases pursuant to our personnel policies.

7. A benefit expenditure increase of 0.7%. The increase is due primarily to increases in salary rates offset by a modest reduction in health insurance rates.

8. An increase in operational expenditures of 16.2%. This increase is due primarily to purchased contractor environmental inspector services to address material increases in mandated service demands.

9. Transfers Out to CNR remains at $3,000. This is a planned appropriation to our CNR fund.

The above changes are summarized on the following chart:

	PROPOSED EXPENDITURE/REVENUE CHANGES FOR FY19/20				
		Adopted 18/19	Proposed 19/20		
Revenues				Change	Percent
	State Grant in Aid	$ 123,280	$ 123,140	$ (140)	-0.1%
	Town contributions	$ 429,270	$ 437,590	$ 8,320	1.9%
	Fees for Service	$ 228,280	$ 252,581	$ 24,301	10.6%
	Appropriation of Fund Balance	$ 31,407	$ 27,293	$ (4,114)	-13.1%
	Total	$ 812,237	$ 840,604	$ 28,367	3.5%
Expenditures					
	Grant Deductions	$ (82,542)	$ (89,056)	$ (6,514)	7.9%
	Salaries	$ 584,555	$ 602,270	$ 17,715	3.0%
	Benefits	$ 210,320	$ 211,760	$ 1,440	0.7%
	Operations	$ 96,904	$ 112,630	$ 15,726	16.2%
	Transfers Out to CNR	$ 3,000	$ 3,000	$ -	0.0%
	Total	$ 812,237	$ 840,604	$ 28,367	3.5%

Highlighted below is additional narrative for selected account appropriations proposed for FY19/20

Revenues

- **State Grant – in – Aid.** This line item is essentially level funded with a total proposed appropriation of $123,130. This is based on a conservative review of the state adopted biennium documents. There is no information from DPH regarding anticipated appropriations for FY19/20 at this time. Consequently, the actual impact on the local health grant-in-aid remains uncertain.

- **Town Contributions**. A total combined increase of $8,320, or 1.9% is proposed for this revenue category. The increase is due to a proposed increase in the per capita contribution rate for member towns of 2.0%, plus changes in the population estimates provided by DPH. Overall population estimates have slightly declined. Individual town increases can be reviewed on pages 6 and 7 of the budget presentation. Contribution rate history can be found on page 13 of the budget presentation.

- **Fees for Service.** A total combined increase is estimated at $24,301, or 10.6%. The estimate is based on estimated revenue projections for the current fiscal year, increases in selected service fee rates, and new revenues from newly proposed fee for service categories. The new categories include "Private well Water Treatment Waste disposal plan reviews", and "Cosmetology Registration/Inspection". Fee schedule history, and the FY19/20 proposed fee schedule can be found on page 11. Comparison rates for other area health districts can be found on page 12 of the budget presentation.

  Material changes in the proposed FY19/20 appropriation for 40639 (Engineered Plan Review) and 40645 (Nonengineered Plan Review) is the result of account consolidation.

- **General Fund Appropriation.** An appropriation of $27,293 is proposed in this budget. This is a reduction of 13.1% from the previous fiscal year. Of note, this budget estimates year-end fund balance on June 30, 2020 will be 30% of the FY19/20 operating expenditures. (See page 4 for the GF roll forward report for FY19/20.) While adopted budgets in the recent past have been balanced with the general fund, the fund balance has not been drawn down in the past four fiscal years. At this time, we are estimating a drawdown of approximately $48,360, for FY18/19 (This includes a $7,000 appropriation for anticipated additional legal fees, and $20,000 end of the year transfer from the GF to CNR. Both of these item will require Board authorization).

Expenditures

- **51050 Grant Deductions.** While projecting grant funding is difficult due to its volatility, this proposed budget anticipates an increase of 7.9% in grant deductions. This is based on the improved reliability of both the Medical Reserve Corp, and Public Health Preparedness Grants. (See page 15 for details on total grant revenue anticipated.)

- **51601 Regular Salaries.** The total increase presented for salaries is $17,715, or 3.0%. Pursuant to our broad band, merit based pay plan this is the appropriation recommended to fund on average 2.5% merit increases for regular staff. The 2.5% rate increase is consistent with current state labor data.

- **52105 Medical Insurance.** The total decrease anticipated is $1,090, or 0.9%. No change in enrollment is anticipated.

- **52210 Training.** A total increase of $1,500 is proposed to fund attendance of the annual NACCHO conference for the Director.

- **53960 Other Purchased Services.** A total increase of $13,500 is proposed. The increase in the appropriation will provide funding for a contracted environmental health inspector (FTE 0.2) that will address material increases in mandated inspection demands. There are two service areas at issue. First, CGS section 19a-231 requires an annual sanitary inspection of "salons". There is an identified 61 salons in our jurisdiction. To date, this remains an unimplemented mandate. And second, over the past 10 years the number of temporary food permits issued by this agency has increased 245%. Due to field staffing limits, a material number of those permitted events go uninspected. (Please see page 17 for historic data on temporary food permits issued, and available inspection counts for the past eleven years.)

Proposed FY 19/20 Capital Nonrecurring Budget Narrative (See Page 14)

Revenues

- **Transfer In – General Fund.** This is a planned transfer of $3,000 from the general fund.
- **Surplus Vehicle Proceeds.** Estimated proceeds of $3,000 from the surplus sale of one fleet vehicle.

Expenditures

- **Automobiles.** An expenditure of $17,000 is proposed for the purpose of replacing on fleet vehicle in accordance with our fleet replacement schedule.
- **Strategic Planning & CHA/CHIP.** An expenditure of $10,000 is proposed to provide funding for a consultant to support an *update* of our existing agency strategic plan; and, phase in funding for a community health assessment/community health improvement plan in the out years.
- **IT Infrastructure Upgrade.** An expenditure of $6,000 is proposed to provide funding for internet kiosks at each of the agency satellite offices to accommodate online permitting and payments.

Recommendation

The budget detailed here within incorporates direction provided by the Finance Committee at their November 27, 2018 special meeting. The Finance Committee will be reviewing this proposal one final time just prior to the regular board meeting on December 13, 2018. Assuming the Finance Committee concurs, the following motion is recommended: ***Move, to set public hearing date of Thursday, January 17, 2019 at 4:30 PM, Coventry Town Hall Annex, 1712 Main Street, Coventry Connecticut to hear the public's comments regarding the Eastern Highlands Health District Proposed Fiscal Year 2019/2020 Operating Budget, Capital non-recurring budget, and fee schedule as presented on December 13, 2018.***

Eastern Highlands Health District

Proposed Budget

Fiscal Year 2019 – 2020

December 13, 2018

Board of Directors Meeting

Table of Contents	Page #

Eastern Highlands Health District
Budget Presentation
FY 19/20

Vision – Healthy people, healthy communities…healthier future.

Mission Statement – Eastern Highlands Health District is committed to enhancing the quality of life in its communities through the prevention of illness, promotion of wellness and protection of our human environment.

AGENCY SUMMARY AND AUTHORITY

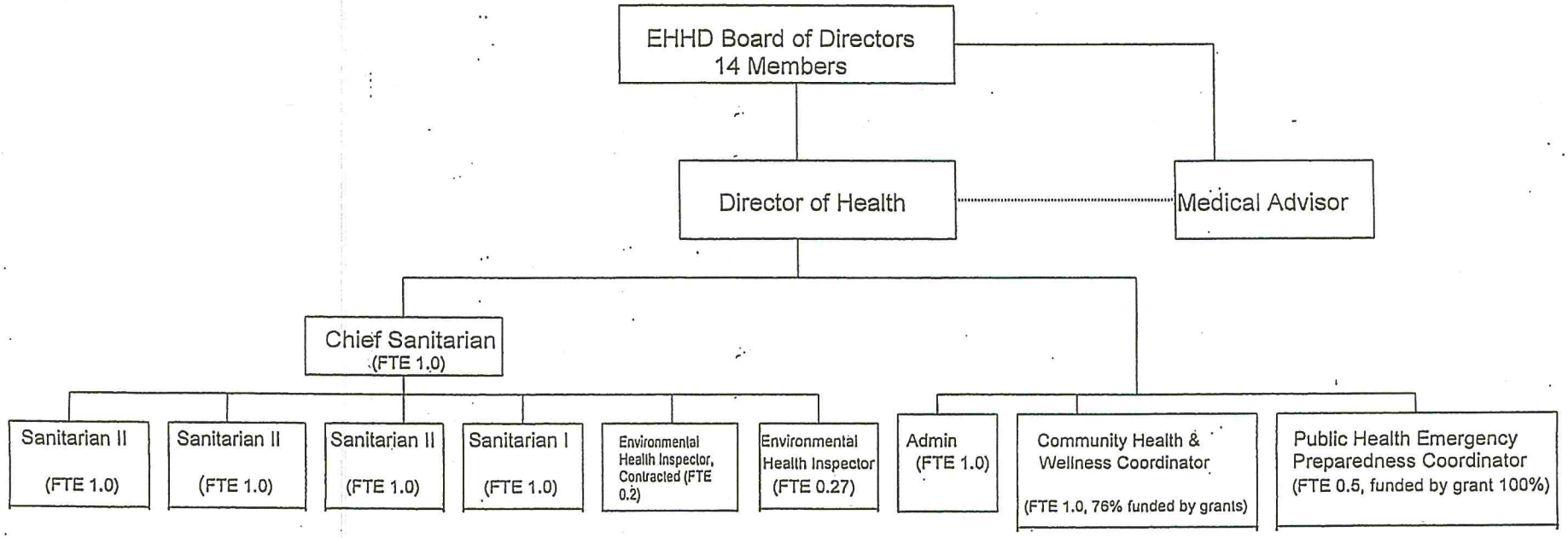
The Eastern Highlands Health District (EHHD) is one of twenty local Health Districts in the State of Connecticut. Established on June 6, 1997, it serves the towns of Andover, Ashford, Bolton, Chaplin, Columbia, Coventry, Mansfield, Tolland, Scotland and Willington with a total population of 80,738.

The District is a governmental entity authorized under Connecticut statutes for the purpose of providing local public health services. The governing authority is by a Board of Directors and the Director of Health, who acts as an agent of the State Commissioner of Public Health for the purpose of enforcing the Public Health Code.

The District services include regulatory activities in the area of environmental health, including septic system inspection and approval; well and water quality monitoring; food service; lead investigations; radon, bathing water monitoring; and public health complaint investigations. Preventing epidemics is a critical service, which includes communicable disease control involving disease surveillance and outbreak investigation. Through grants and other alternative funding, the District is expanding the number of programs it provides on a variety of public health topics that affect membership communities, such as cardiovascular health, cancer prevention and emergency preparedness. Other public health functions conducted by the District include data collection, analysis and health planning activities.

Proposed Fiscal Year 2019/2020
Eastern Highlands Health District Organizational Chart

Andover	Ashford	Bolton	Chaplin	Columbia	Coventry	Mansfield	Scotland	Tolland	Willington
Board of Selectmen Appoints One Member to District Board of Directors	Board of Selectmen Appoints One Member to District Board of Directors	Board of Selectmen Appoints One Member to District Board of Directors	Board of Selectmen Appoints One Member to District Board of Directors	Board of Selectmen Appoints One Member to District Board of Directors	Town Council Appoints Two Member to District Board of Directors	Town Council Appoints Three Member to District Board of Directors	Board of Selectmen Appoints One Member to District Board of Directors	Town Council Appoints Two Member to District Board of Directors	Board of Selectmen Appoints One Member to District Board of Directors



Fiscal Year 2019/2020 Budget Calendar

Finance Committee Budget Meeting	November 27, 2018
Finance Committee Budget Meeting	December 13, 2018
Budget Presentation to Board	December 13, 2018
Deadline for final budget estimates per By Laws	January 1, 2019
Fiscal Year 2019/2020 Budget Public Hearing	January 17, 2019 (recommended)
Budget Public Hearing Deadline per By Laws	February 1, 2019
Adoption of Budget	February 15, 2019 (If necessary)

EASTERN HIGHLANDS HEALTH DISTRICT
ESTIMATED STATEMENT OF REVENUES, EXPENDITURES AND
CHANGES IN FUND BALANCE

Roll Forward FY 2019/20

	Actual 12/13	Actual 13/14	Actual 14/15	Actual 15/16	Actual 16/17	Actual 17/18	Adopted 18/19	Estimated 18/19	Proposed 19/20	Projected 20/21	Projected 21/22	Projected 22/23	Projected 23/24	Projected 24/25
Revenues:														
Member Town Contributions	371,615	377,577	390,841	405,820	423,080	429,282	429,270	429,270	437,590	448,530	459,743	471,237	483,017	495,093
State Grant-in-Aid	152,436	151,852	149,857	142,234	133,164	149,985	123,280	133,327	123,130	123,130	123,130	123,130	123,130	123,130
Services Fees	201,608	188,798	197,796	212,942	224,874	234,393	228,280	228,280	252,591	260,169	267,974	276,013	284,293	292,822
Local Support					800	-								
Total Revenues	725,659	718,227	738,495	760,996	781,918	813,660	780,830	790,877	813,311	831,828	850,847	870,380	890,441	911,045
Expenditures:														
Salaries & Benefits	601,334	613,970	656,060	644,630	686,253	691,797	712,333	712,333	724,974	739,473	754,263	769,348	784,735	800,430
Insurance	15,338	13,826	15,607	15,607	15,599	15,599	15,800	15,800	15,800	15,800	15,800	15,800	15,800	15,800
Professional &Technical Services	38,398	12,242	14,961	13,162	47,455	46,954	47,664	54,664	48,390	48,632	48,875	49,119	49,365	49,612
Other Purchased Services & Supplies	16,990	43,157	43,382	46,162	11,713	15,879	29,840	29,840	44,840	45,064	45,290	45,516	45,744	45,972
Equipment	947	1,132	645	762	300	1,612	3,600	3,600	3,600	4,000	4,000	4,000	4,000	4,000
Sub-total Expenditures	673,007	684,327	730,655	720,323	761,320	771,841	809,237	816,237	837,604	852,970	868,228	883,784	899,644	915,814
Operating Transfers Out	82,000	142,000	-	-	-	-	3,000	23,000	3,000	6,000	9,000	12,000	15,000	17,000
Total Expenditures and Operating Transfers Out	755,007	826,327	730,655	720,323	761,320	771,841	812,237	839,237	840,604	858,970	877,228	895,784	914,644	932,814
Excess/(Deficiency) of Revenues over Expenditures	(29,348)	(108,100)	7,840	40,673	20,598	41,819	(31,407)	(48,360)	(27,293)	(27,141)	(26,381)	(25,404)	(24,203)	(21,769)
Fund Balance, July 1	384,599	355,251	247,151	254,991	295,664	316,262	358,082	358,082	309,722	282,429	255,288	228,907	203,503	179,300
Fund Balance, June 30	$355,251	$247,151	$254,991	$295,664	$316,262	$358,082	$326,675	$309,722	$282,429	$255,288	$228,907	$203,503	$179,300	$157,531

Assumptions:
Member Town increase of 2.5% per year
State Grant-in-Aid: FY19 8% below CGA budget, held flat each year after
Service Fee revenue increase of 3% annually
Salary & Benefit increases of 2% per year
Grant Deduction line for salaries held flat at $90,000 per year starting FY21
Professional & Technical increase of .5% per year
Purchased Services increase of .5% per year

Expenditures per Above	812,237	839,237	840,604	858,970	877,228	895,784	914,644	932,814
Grant Deduction	82,542	82,542	89,056	90,000	90,000	90,000	90,000	90,000
Total Expenditures	894,779	921,779	929,660	948,970	967,228	985,784	1,004,644	1,022,814
FB as a % of Total Exp	36.51%	33.60%	30.38%	26.90%	23.67%	20.64%	17.85%	15.40%

Eastern Highlands Health District
Summary of Revenues and Expenditures for FY18/19

Fund: 634 Eastern Highlands Health District
Activity: 41200

Object	Description	Adopted 18/19	Estimated 18/19	Proposed 19/20	% change	Dollar change
Revenues:						
40220	Septic Permits	40,080	40,080	52,840	31.8%	12,760
40221	Well Permits	15,960	15,960	13,890	-13.0%	(2,070)
40491	State Grant-In-Aid	123,280	133,327	123,130	-0.1%	(150)
40554	Local Support	-	-	-	-	-
40630	Health Inspec. Service Fees	4,980	4,980	3,301	-33.7%	(1,679)
40633	Health Services-Bolton	26,180	26,180	26,640	1.8%	460
40634	Health Services-Coventry	66,020	66,020	67,420	2.1%	1,400
40635	Health Services-Mansfield	137,900	137,900	140,440	1.8%	2,540
40636	Soil Testing Service	32,550	32,550	35,610	9.4%	3,060
40637	Food Protection Service	73,400	73,400	74,900	2.0%	1,500
40638	B100a Review	30,700	30,700	29,680	-3.3%	(1,020)
40639	Engineered Plan Rev	9,190	9,190	30,700	234.1%	21,510
40642	Health Services - Ashford	22,490	22,490	23,000	2.3%	510
40643	Health Services - Willington	31,180	31,180	32,090	2.9%	910
40645	Nonengineered Rev	15,340	15,340	-	-100.0%	(15,340)
40646	GroupHome/Daycare inspection	1,320	1,320	1,380	4.5%	60
40647	Subdivision Review	1,940	1,940	1,050	-45.9%	(890)
40648	Food Plan Review	2,820	2,820	2,440	-13.5%	(380)
40649	Health Services - Tolland	78,540	78,540	79,790	1.6%	1,250
40685	Health Services - Chaplin	11,930	11,930	12,150	1.8%	220
40686	Health Services - Andover	17,270	17,270	17,600	1.9%	330
40687	Health Services - Columbia	28,850	28,850	29,370	1.8%	520
40688	Health Services - Scotland	8,910	8,910	9,090	2.0%	180
	Cosmetology Inspections		-	6,800		
40999	Appropriation of Fund Balance	31,407	48,360	27,293	-13.1%	(4,114)
	Total Revenues	812,237	839,237	840,604	3.5%	28,367
Expenditures:						
51050	Grant deductions	(82,542)	(82,542)	(89,056)	7.9%	(6,514)
51601	Regular Salaries - Non-Union	584,555	584,555	602,270	3.0%	17,715
52001	Social Security	36,240	36,240	37,340	3.0%	1,100
52002	Workers Compensation	10,150	10,150	10,160	0.1%	10
52005	Unemployment Compensation	-	-		-	-
52007	Medicare	8,430	8,430	8,690	3.1%	260
52009	Salary Related Benefits	-	-		-	-
52010	ICMA (Pension)	33,980	33,980	35,020	3.1%	1,040
52103	Life Insurance	2,450	2,450	2,520	2.9%	70
52105	Medical Insurance	116,220	116,220	115,130	-0.9%	(1,090)
52117	RHS	2,210	2,210	2,260	2.3%	50
52112	LTD	640	640	640	0.0%	-
52002	Travel/Conference Fees					
52203	Dues & Subscriptions	2,000	2,000	2,000	0.0%	-
52210	Training	2,000	2,000	3,500	75.0%	1,500
52212	Mileage Reimbursement	600	600	600	0.0%	-
53120	Professional & Tech	7,120	7,120	7,120	0.0%	-
53122	Legal	2,000	9,000	2,000	0.0%	-
53125	Audit Expense	6,800	6,800	6,900	1.5%	100
53303	Vehicle Repair & Maintenance	3,200	3,200	3,200	0.0%	-
53801	General Liability	15,800	15,800	15,800	0.0%	-
53924	Advertising	1,000	1,000	1,000	0.0%	-
53925	Printing & Binding	1,000	1,000	1,000	0.0%	-
53926	Postage	1,500	1,500	1,500	0.0%	-
53940	Copier maintenance	1,000	1,000	1,000	0.0%	-
53960	Other Purchased Services	11,340	11,340	24,840	119.0%	13,500
53963	Sub-Contracted Health Serv	-	-	-	-	-
53964	Voice Communications	3,800	3,800	3,800	0.0%	-
54101	Instructional Supplies	800	800	800	0.0%	-
54214	Books & Periodicals	200	200	200	0.0%	-
54301	Office Supplies	2,000	2,000	2,000	0.0%	-
54601	Gasoline	2,600	2,600	2,600	0.0%	-
54913	Other Supplies & Materials	-	-	-	-	-
55420	Office Equipment	3,000	3,000	3,000	0.0%	-
55430	Equipment - Other	600	600	600	0.0%	-
56302	Admin. Overhead	28,544	28,544	29,170	2.2%	626
56303	Other General Expenditures	-	-	-	-	-
56312	Contingency	-	-	-	-	-
58410	Capital Nonrecurring Fund	3,000	23,000	3,000	0.0%	-
	Total Expenditures	812,237	839,237	840,604	3.5%	28,367

DEPARTMENT: EHHD LOCATION: Main Office ACTIVITY: 41200

RATIONAL OF OBJECTS BUDGET FIGURES IN BOLD

REVENUES:

40220 Septic Permits
Proposed estimate: **$52,840**

40221 Well Permits
Proposed estimate: **$13,890**

40491 State Grant-in-aid

	Population 2016	Per Capita Value	Total
Andover	3,248	1.53	4,953
Ashford	4,244	1.53	6,472
Bolton	4,916	1.53	7,497
Chaplin	2,241	1.53	3,418
Columbia	5,418	1.53	8,262
Coventry	12,439	1.53	18,969
Scotland	1,677	1.53	2,557
Tolland	14,722	1.53	22,451
Mansfield	25,912	1.53	39,516
Willington	5,921	1.53	9,030
Total	80,738		**$123,125**

40633 Health Services - Bolton

Bolton Pop.	Proposed Per Capita Contribution	Total	Dollar Increase	% increase
4,916	$ 5.420	**$26,640**	**$460**	**1.76**

40634 Health Services - Coventry

Coventry Pop.	Proposed Per Capita Contribution	Total		
12,439	$ 5.420	**$67,420**	**$1,400**	**2.12**

40635 Health Services - Mansfield

Mansfield Pop.	Proposed Per Capita Contribution	Total		
25,912	$ 5.420	**$140,440**	**$2,540**	**1.84**

40642 Health Services - Ashford

Ashford Pop.	Proposed Per Capita Contribution	Total		
4,244	$ 5.420	**$23,000**	**$510**	**2.27**

40649 Health Services - Tolland

Tolland Pop.	Proposed Per Capita Contribution	Total		
14,722	$ 5.420	**$79,790**	**$1,250**	**1.59**

40643 Health Services - Willington

Willington Pop.	Proposed Per Capita Contribution	Total		
5,921	$ 5.420	**$32,090**	**$910**	**2.92**

40685 Health Services - Chaplin

Chaplin Pop.	Proposed Per Capita Contribution	Total		
2,241	$ 5.420	**$12,150**	**$220**	**1.84**

40686 Health Services - Andover

Andover Pop.	Proposed Per Capita Contribution	Total		
3,248	$ 5.420	**$17,600**	**$330**	**1.91**

DEPARTMENT: EHHD LOCATION: Main Office ACTIVITY: 41200

RATIONAL OF OBJECTS BUDGET FIGURES IN **BOLD**

REVENUES:

40687 Health Services - Columbia

Columbia Pop.	Proposed Per Capita Contribution	Total	Dollar increase	% increase
5,418	$ 5.420	**$29,370**	**$520**	**1.80**

40688 Health Services - Scotland

Scotland Pop.	Proposed Per Capita Contribution	Total		
1,677	$ 5.420	**$9,090**	**$180**	**2.02**

40630 Health Inspection Service Fees
Proposed estimate: **$3,300**

40636 Health Services - Soil Testing
Proposed estimate: **$35,610**

40637 Food Protection Service
Proposed estimate: **$74,900**

40638 B100a Application Review
Proposed estimate: **$29,680**

40639 Plan Review Engineered Design
Proposed estimate: **$30,700**

40645 Plan Review Non-engineered Design
Proposed estimate: **$0**

40646 Group Home / Daycare Inspections
Proposed estimate: **$1,380**

40647 Subdivision Review
Proposed estimate: **$1,050**

40648 Food Plan Review
Proposed estimate: **$2,440**

XXXXX Cosmotology Inspections **$6,800**

40999 Appropriation of Fund Balance **$ 27,293**

DEPARTMENT: EHHD LOCATION: Main Office ACTIVITY: 41200

RATIONAL OF OBJECTS BUDGET FIGURE IN **BOLD ITALICS**

Expenditures:

51601 Regular Salaries - Non-Union

	FY 19/20 Proposed Appropria	FTE	FY 19/20 Grant deduct	FTE
	599,370	8.32	60,250	0.91
Longevity	**$2,900**			
Total Salaries	**$602,270**			

	Salary Deductions	60,250
	Benefit Deductions	28,806
51050 Grant Deductions	**Total Grant Deductions**	**$ 89,056**

52001 Social Security

Total Regular Salaries	Social Security Percentage (6.2%)
602,270	**$37,341**

52002 Workers compensation
Estimated Premium **$10,159**

52007 Medicare

Total Regular Salaries	Medicare Percentage (1.45%)
$ 602,270	**$8,689**

52010 ICMA (Pension Plan)

Estimated Salaries of Full-time employees		583,633
Employer percent contribution		0.06
Total estimated employer contribution	**Total**	**35,018**

52103 Life Insurance
Proposed estimate: **$2,521**

52105 Medical Insurance
Proposed estimate: **$115,130**

52117 RHS Contribution

Proposed estimate: **$2,260**

52112 LTD
Proposed estimate: **$640**

52203 Dues & Subscriptions
Proposed estimate: **$2,000**

52210 Training
Proposed estimate: **$3,500**

52212 Mileage Reimbursement
Proposed estimate: **$600**

53120 Professional and Technical Services

Medical advisor stipend		5500
website license/hosting		1120
Lead XRF inspection		500
	Total	**$7,120**

53122 Legal Services
Proposed estimate: **$2,000**

53125 Audit Expense
Proposed estimate: **$6,900**

53303 Vehicle Maintenance and Repair
Proposed estimate: **$3,200**

DEPARTMENT: EHHD LOCATION: Main Office ACTIVITY: 41200

RATIONAL OF OBJECTS BUDGET FIGURE IN BOLD ITALICS

Expenditures:

53801 General Liability Insurance

Coverage by CIRMA:
General Liability, Auto liability, Professional and Public Official Liability

Estimated premium: **$15,800**

53924 Advertising
Proposed estimate: **$1,000**

53925 Printing and Binding
Proposed estimate: **$1,000**

53926 Postage
Proposed estimate: **$1,500**

53940 Copier Maintenance
Proposed estimate: **$1,000**

53960 Other Purchased Services
Proposed estimate:

11,340	(Viewpermit users/ipad data)
13,500	Contracted Sanitarian
24,840	

53964 Voice Communications
Proposed estimate: **$3,800**

54101 Instructional Supplies
Proposed estimate: **$800**

54214 Books and Periodicals
Proposed estimate: **$200**

54301 Office supplies
Proposed estimate: **$2,000**

54601 Gasoline
Proposed estimate: **$2,600**

55420 Office equipment
Maintenance and replacement **$3,000**

55430 Equipment - Other
Field Equipment: **$600**

56302 Administrative Overhead
Propose estimate: **$29,170**
This appropriation funds support service cost provided by the Town of Mansfield such as accounting, payroll, IT and personnel support.

56312 Contigency **$0**

58410 Capital Nonrecurring Fund **$3,000**

Analysis of Service Fee Revenues

REVENUE PERFORMANCE	Actual 2004-05	Actual 2005-06	Actual 2006-07	Actual 2007-08	Actual 2008-09	Actual 2009-201	Actual 2010-11	Actual 2011-12	Actual 2012 - 13	Actual 2013-2014	Actual 2014-2015	Actual 2015-2016	Actual 2016-2017	Actual 2017-18	Budget 2018-19	Received 11/7/2018		Estimated Actuals 2018-19	Proposed 2019-20
40220 Septic Permits (New and repair permits)	40,750	56765	43885	31410	26160	31000	26100	29,295	28,455	31,845	31,655	31,285	34,400	43,880	40,080	21,135	53%	52,838	52,838
40221 Well permits	14,120	23205	19690	22695	11280	18775	13604	12,135	12,505	13,600	15,535	14,345	16,985	12,925	15,960	6,040	38%	13,892	13,892
40630 Health Inspection Services (Mortgage & Other Inspections)	12,325	0	14948	2943	32928	21,273	5,875	14,133	14,621	1,857	3,318	5,375	13,716	3,993	4,980	131	3%	3,301	3,301.30
40636 Health Services - Soil testing (Test Holes &Perc Tests)	73,680	73780	60140	46805	32229	37610	33330	31,475	33,590	32,380	32,965	39,710	33,585	41,775	32,550	14,245	44%	35,613	35,613
40637 Food Protection Service (License fees)	24,573	25735	29700	37973	41307	37630	41583	48,930	55,060	57,796	60,068	61,743	66,413	71,399	73,400	5,471	7%	73,400	74,900
40638 B100a Review	19,595	25870	22235	23420	21605	22350	21880	20,770	24,790	26,005	24,610	29,225	30,040	27,470	30,700	11,870	39%	29,675	29,675
40639 Engineered Plan Review	14,360	25605	21455	11965	10000	17130	13500	13,220	9,585	10,360	8,685	8,905	7,290	8,175	9,190	11,540	126%	29,000	30,700
40645 Nonengineered Plan Review	4,605	3235	6615	7635	5720	6285	5905	8,550	10,575	13,500	12,870	14,205	15,820	18,565	15,340	60	0%	-	-
40646 Group Home / Daycare Insp.	840	1022	1175	1740	955	695	1400	900	1,135	1,200	1,190	1,255	1,230	1,470	1,320	550	42%	1,375	1,375
40647 Subdivision Review	24,530	6455	7965	9765	4225	2340	3810	2,595	6,050	2,200	3,680	3,105	2,360	2,070	1,940	420	22%	1,050	1,050
40648 Food Plan Review	1,380	2050	2040	2485	2747	5500	5027	2,851	4,641	3,075	3,220	3,790	3,035	2,670	2,820	975	35%	2,438	2,438
XXXXX Cosmetology																			6,800
Total	230,758	243722	229848	198836	189156	200588	172014	184,854	201,007	193,818	197,796	212,943	224,874	234,392	228,280	72,437	32%	242,581	252,581

Eastern Highlands Health District

Proposed Fee Schedule
FY 19/20 (**Bold** denotes change)

Food Service Fees*	Adopted FY 14/15	Adopted FY 15/16	Adopted FY 16/17	Adopted FY 17/18	Adopted FY18/19	Proposed Changes FY 19/20	Est. Revenue net
Application Review**	$85	$85	$90	$95	$95	No change	
Class I & II Plan Review	$150	$150	$155	$175	$175	No change	
Class III & IV Plan Review	$235	$235	$240	$245	$245	No change	
Class I License	$120	$120	$125	$125	$125	No change	
Class II License	$160	$160	$165	$165	$255	No change	
Class III License	$235	$240	$245	$255	$355	No change	
Class IV License	$325	$330	$340	$355	$380	No change	
Grocery Store >10,000ft2 - Class II&III					$420	No change	
Temporary Food Event Permit	$55	$55	$55	$60	$65	No change	
Temporary Permit - samples only			$30	$30	$30	No change	
Expedited Temp food permit application review***					$20	No change	
Late License renewal (plus app fee)/operating without License					$200	No change	
CFM Process Fee (No CFM in place)					$50	No change	
Re-Inspection fee	$65	$65	$70	$85	$120	No change	
2nd Re-inspection fee	$115	$115	$120	$135	$135	No change	
Subsurface Sewage Disposal							
Permit – New	$170	$175	$185	$200	$205	No change	
Permit – Major Repair	$170	$170	$175	$185	$185	No change	
Permit - Construction by owner occupant					$275	No change	
Permit/inspection– Minor Repair	$80	$90	$95	$95	$95	No change	
Permit – Design Flow >2000 GPD	$330	$330	$350	$350	$350	No change	
Design Flow ≥ 5000 GPD/ DEP system Inspection	$440	$440	$460	$460	$460	No change	
Plan Review (per plan)	$120	$120	$125	$125	$125	No change	
Septic Tank/System Abandonment	$60	$60	$60	$60	$60	No change	
Review plans revised more than once	$35	$35	$40	$40	$40	No change	
Plan Review for Tank Replacement	$55	$55	$60	$60	$60	No change	
Soil Testing							
Percolation (perc) Test	$85	$85	$85	$85	$90	No change	
Deep Hole Test (fee includes 3 pits per site)	$100	$100	$105	$105	$105	No change	
Each Additional Pit	$30	$30	$30	$30	$30	No change	
Public Health & Subdivision Reviews						No change	
Public Health Review (assessory structure/ lot line change)	$50	$50	$50	$50	$50	No change	
Public Health Review (building addition/ change of use)	$60	$60	$65	$65	$70	No change	
Subdivision Plan Review (per lot)						No change	
(Fee includes review of one set of revisions)	$115	$115	$120	$125	$125	No change	
Subdivision Plan Revisions Reviewed (per lot)						No change	
(Fee is for each added set of revisions)	$35	$35	$40	$40	$40	No change	
Miscellaneous							
Commercial Bank Mortgage Inspection/Report	$110	$110	$115	$115	$115	No change	
Family Campground Inspection	$110	$110	$110	$110	$130	No change	
Group Home/Daycare /Other Institution Inspection	$85	$90	$95	$105	$110	No change	
Misc. Inspection/consulation fee per Sanitarian****	$65/hr	$65/hr	$65/hr	$65/hr	$80/hr	No change	
Mortgage Inspection/Report for FHA,VA	$60	$60	$60	$60	$75	No change	
Pool Inspection	$70	$75	$80	$100	$105	No change	
Private well Water Treatment Waste disposal plan review						**$50**	$1,700
Cosmotology Registration/Inspection - One or two chairs						**$80**	
Cosmotology Registration/Inspection - Three chairs or more						**$150**	$6,800
Well Permit	$105	$105	$110	$120	$120	No change	
Farmers Market Food Vendor Seasonal License Categories							
Farmer Food Vendor License - Cold samples only	no fee	no fee	no fee	no fee	no fee	**$40**	
Farmer Food Vendor License - Low Risk Food Preparation	$30	$30	$30	$30	$40	**$60**	
Non-farmer Food Vendor License - Cold samples only							
One market location	$30	$30	$35	$35	$40	**$75**	
Multiple-market locations	$45	$45	$50	$50	$60	**$90**	
Non-farmer Food Vendor License - Low Risk Food Preparation							
One market location	$45	$45	$50	$50	$75	**$90**	
Multiple-market locations	$65	$65	$70	$70	$85	**$120**	$1,500
Farmer & Non-farmer Food Vendor License - High Risk Food Preparation	$210	$210	$220	$220	$220	No change	
					Est. Net Rev.		$10,000

* License application fees waived for non-profit and municipal entities. *Late fees and re-inspection fees still apply.*

All food service fees apply to public school food operations.

**This fee will be deducted against the total plan review fee

***Application of expedited review fee is subject to written policy established by the Director

****Application of this service fee is subject to written policy established by the Director.

TABLE A

FY19 EHHD Fee Schedule with Average and Median Comparisons to Other Health Districts(1)

Service Categories(2)

	EHHD Adopted FY2019	Four Contiguous Districts Median	Four Contiguous Districts Average	Eastern Ct Median	Eastern Ct Average	ALL CT HD Median	ALL CT HD Average	5% Increase	10% Increase	15% Increase	20% Increase
Food Protection(3)											
Class I License	$ 125	$ 125	$ 137	$ 125	$ 144	$ 150	$ 153	$ 131	$ 138	$ 144	$ 150
Class II License	$ 255	$ 250	$ 246	$ 245	$ 241	$ 250	$ 249	$ 268	$ 281	$ 293	$ 306
Class III License	$ 355	$ 350	$ 333	$ 330	$ 316	$ 353	$ 353	$ 373	$ 391	$ 408	$ 426
Class IV License	$ 380	$ 350	$ 368	$ 350	$ 343	$ 403	$ 385	$ 399	$ 418	$ 437	$ 456
Temp event	$ 65	$ 70	$ 88	$ 70	$ 61	$ 60	$ 65	$ 68	$ 45	$ 75	$ 78
Re-inspection	$ 120	NA	NA	NA	NA	NA	NA	$ 126	$ 132	$ 138	$ 144
2nd re-inspection	$ 120	NA	NA	NA	NA	NA	NA	$ 126	$ 132	$ 138	$ 144
Plan review - Class I	$ 175	$ 185	$ 202	$ 200	$ 223	$ 175	$ 198	$ 184	$ 193	$ 201	$ 210
Plan review - Class II	$ 175	$ 185	$ 212	$ 200	$ 230	$ 213	$ 236	$ 184	$ 193	$ 201	$ 210
Plan review - Class III	$ 245	$ 245	$ 238	$ 245	$ 249	$ 248	$ 294	$ 257	$ 270	$ 282	$ 294
Plan review - Class IV	$ 245	$ 245	$ 238	$ 245	$ 249	$ 250	$ 249	$ 257	$ 270	$ 282	$ 294
Subsurface Sewage Disposal											
Permit - new	$ 205	$ 205	$ 209	$ 175	$ 197	$ 175	$ 212	$ 215	$ 226	$ 236	$ 246
Permit - Major repair	$ 185	$ 160	$ 180	$ 150	$ 157	$ 150	$ 161	$ 194	$ 204	$ 213	$ 222
Permit - Minor repair	$ 95	$ 100	$ 101	$ 100	$ 101	$ 100	$ 93	$ 100	$ 105	$ 109	$ 114
Permit - Design flow >2000GPD	$ 350	$ 350	NA	NA	NA	NA	NA	$ 368	$ 385	$ 403	$ 420
Percolation Test(4)											
Deep Hole Test	$ 195	$ 205	$ 165	$ 150	$ 156	$ 150	$ 156	$ 205	$ 215	$ 224	$ 234
each additional pit	$ 30	$ 53	$ 56	$ 75	$ 60	$ 75	$ 68	$ 32	$ 33	$ 35	$ 36
Subdivision Plan Review (per lot)	$ 125	$ 50	$ 129	$ 125	$ 128	$ 125	$ 134	$ 131	$ 138	$ 144	$ 150
Subdivision Plan Revisions Reviewed (per lot	$ 40	$ 125	NA	NA	NA	$ 50	$ 52	$ 42	$ 44	$ 46	$ 48
Plan review (per plan)	$ 125	$ 50	$ 124	$ 120	$ 126	$ 178	$ 184	$ 131	$ 138	$ 144	$ 150
Review plan revisions	$ 40	$ 120	NA	NA	NA	$ 50	$ 69	$ 42	$ 44	$ 46	$ 48
Plan review for minor repair	$ 60	NA	NA	NA	NA	NA	NA	$ 63	$ 66	$ 69	$ 72
B100a - assessory structure	$ 50	$ 50	$ 50	$ 50	$ 54	$ 50	$ 65	$ 53	$ 55	$ 58	$ 60
B100a - addition/use change	$ 70	$ 60	$ 77	$ 60	$ 73	$ 65	$ 75	$ 74	$ 77	$ 81	$ 84
Septic tank/system abandonment inspection	$ 60	NA	NA	NA	NA	NA	NA	$ 63	$ 66	$ 69	$ 72
Misc											
Well Permit	$ 120	$ 120	$ 119	$ 120	$ 114	$ 123	$ 122	$ 126	$ 132	$ 138	$ 144
Mortgage Inspection/letter for FHA, VA	$ 60	NA	NA	NA	NA	NA	NA	$ 63	$ 66	$ 69	$ 72
Commercial Bank Mortgage Inspection/letter	$ 115	NA	NA	NA	NA	NA	NA	$ 121	$ 127	$ 132	$ 138
Group Home inspection	$ 110	$ 120	$ 135	$ 105	$ 123	$ 100	$ 102	$ 116	$ 121	$ 127	$ 132
Daycare inspection	$ 110	$ 110	$ 126	$ 110	$ 121	$ 120	$ 130	$ 116	$ 121	$ 127	$ 132
Lead inspection per inspector per hour	$ 65	NA	NA	NA	NA	NA	NA	$ 68	$ 72	$ 75	$ 78
Family Camp ground Inspection	$ 130	$ 123	$ 119	$ 120	$ 115	$ 110	$ 113	$ 137	$ 143	$ 150	$ 156
Pool Registration/inspection	$ 105	$ 105	$ 116	$ 100	$ 111	$ 135	$ 158	$ 110	$ 116	$ 121	$ 126
cosmetology inspection - small		NA	NA	NA	NA	NA	NA	$ -	$ -	$ -	$ -
cosmetology inspection - large		NA	NA	NA	NA	NA	NA	$ -	$ -	$ -	$ -
Fee total for single lot development(5)	$ 645	$ 635	$ 452	$ 415	$ 437	$ 625	$ 674				
FY18 Health District Per Capita Rate	$ 5.31	$ 5.31	$ 6.45	$ 6.61	$ 7.29	$ 7.11	$ 8.47				

(1) Data obtained from attached documents titled, " Food Protection Program Fee Survey for All Connecticut Health Districts FY 2018", and "Survey of Fees Selected Services FY18/19 - All Connecticut Health Districts"
(2) Categories in *bold italics* are high volume, high revenue generating service areas.
(3) Many Health Districts use a range of fees based on class and seating capacity.
(4) Most Health Districts use a single fee that includes both a perc and deep hole testing.
(5) Combine cost of well, soil testing, permit, plan review, and subdivision fees

Eastern Highlands Health District
Town Contribution, CPI, Per Capita Expenditure, State Per Capita Grant - Comparisons

Fiscal Year	Town Contribution Increases Proposed %	Adopted %	CPI (1)	Town Contribution Per Capita ($)	Adopted Expenditures Per Capita (4)	State grant allocation per capita ($) Pop. < 5000	Pop. > 5000
1998	NA	NA	1.7	3.51	6.86	1.78	1.52
1999	2.85	0	2	3.51	6.93	1.78	1.52
2000	3.1	1	3.7	3.54	7.31	2.09	1.79
2001	1	1	3.2	3.58	9.42	2.32	1.99
2002	0	0	1.1	3.58	8.67	2.32	1.99
2003	3	3	2.1	3.69	8.74	1.96	1.68
2004	3	0	3.3	3.69	8.55	1.95	1.66
2005	6.77	6.77	2.5	3.94	8.91	1.95	1.66
2006	6.6	2.9	4.3	4.055	8.73	1.95	1.66
2007	3.08	0.62	2.26	4.08	8.87	1.95	1.66
2008	5.15	5.15	5	4.29	9.35	2.43	2.08
2009	5.1	5.1	-1.16	4.51	9.85	2.43	2.08
2010	0	0	1.7	4.51	9.09	1.85	1.85
2011	0	0	3.36	4.51	8.99	1.85	1.85
2012	1.1	0	1.45	4.51	8.85	1.85	1.85
2013	2.4	0	1.48	4.51	8.67	1.85	1.85
2014	3.1	2	1.89	4.6	8.83	1.85	1.85
2015	4.9	4.9	0.0	4.85	9.46	1.85	1.85
2016	5.18	3.8	1.0	5.01	9.77	1.76	1.76
2017	5.7	4.1	1.5	5.215	10.15	1.64	1.64
2018	1.5	1.5	2.5	5.295	10.06	1.85	1.85
2019	2.5	0.3		5.31	10.05	1.65	1.65
	Total % Increase (3)		59	51	47	-7.3	8.5

(1) Each number represents the percentage change from June to June for "All Urban Consumers" unless otherwise specified.

(3) Total percentage increase from June 1997 to June 2018.
(4) Figures do not include other state, federal grants, nor contracted services.

EASTERN HIGHLANDS HEALTH DISTRICT
CAPITAL NONRECURRING FUND - FUND 635
ESTIMATED STATEMENT OF REVENUES, EXPENDITURES AND
CHANGES IN FUND BALANCE

Roll Forward FY 2019/20

	Actual 12/13	Actual 13/14	Actual 14/15	Actual 15/16	Actual 16/17	Actual 17/18	Adopted 18/19	Estimated 18/19	Proposed 19/20	Projected 20/21	Projected 21/22	Projected 22/23	Projected 23/24	Projected 24/25
Revenues:														
Transfer In - General Fund	2,000						3,000	23,000	3,000	6,000	9,000	12,000	15,000	18,000
Equity Fund Transfer	80,000													
Dept of Transportation Grant		150,752												
Transfer In - Other Operating														
Surplus Vehicle proceeds							3,000	3,000	3,000	2,500	2,000	3,000	3,000	3,000
Total Revenues	82,000	150,752					6,000	26,000	6,000	8,500	11,000	15,000	18,000	21,000
Expenditures by Project:														
Automobiles	(2,925)	26,593				15,992	15,000	15,000	17,000	17,000	17,000	17,000	17,000	17,000
Computer/Office Equipment	1,000	(80)	2,209	4,828		725								
Strategic Planning Priorities:														
Strategic Plannin & CHA/CHIP	2,780	14,000	5,000						10,000	10,000	10,000	10,000		
IT Infrastructure Upgrade			38,928	17,979		17,979			6,000					
Office Reorganizing Project				20,907										
Digitizing records													5,000	5,000
Total Expenditures	855	40,513	46,137	43,714		34,696	15,000	15,000	33,000	27,000	27,000	27,000	22,000	22,000
Excess/(Deficiency) of Revenues over Expenditures	81,145	110,239	(46,137)	(43,714)		(34,696)	(9,000)	11,000	(27,000)	(18,500)	(16,000)	(12,000)	(4,000)	(1,000)
Fund Balance, July 1	60,032	141,177	251,416	205,279	161,566	161,566	126,870	126,870	137,870	110,870	92,370	76,370	64,370	60,370
Fund Balance, June 30	$141,177	$251,416	$205,279	$161,566	$161,566	$126,870	$117,870	$137,870	$110,870	$92,370	$76,370	$64,370	$60,370	$59,370

EASTERN HIGHLANDS HEALTH DISTRICT
OTHER OPERATING - FUND 636
ESTIMATED STATEMENT OF REVENUES, EXPENDITURES AND
CHANGES IN FUND BALANCE

Roll Forward FY 2019/20

	Actual 12/13	Actual 13/14	Actual 14/15	Actual 15/16	Actual 16/17	Actual 17/18	Estimated 18/19	Projected 19/20
Revenues:								
Local Support- ECHIP	$38,015	$600						
State Support - Preventive Health Block			$15,784		$15,248	$5,254	$13,546	$20,100
State Support - Cardiovascular Disease Prevention								
State Support - Women's Healthy Heart								
State Support - Bioterrorism Response								
State Support - Bioterrorism Response-Base	51,728	54,694	54,887	58,908	58,569	55,456	56,011	56,050
State Support - H1N1 Planning/Preparedness								
State Support - H1N1 Administration								
State Support - Community Transformation Grant	87,126	104,068	11,593					
State Support - Comprehensive Cancer Control Grant	14,751	10,000						
State Support- Policy/Environ. Change for Chronic Disea	11,101	16,279		17,024	4,386	13,604	7,205	
Local Support - Safe Routes Grant								
Local Support - Be Well Program Mansfield	48,031	52,365	53,936	55,741	56,707	61,064	60,743	60,750
Local Support - Be Well Program Tolland	5,733	8,148	7,333	7,903	6,886	7,579	8,140	7,500
Cooperative Grant - CT Chapter of American Planning			25,031	72,969				
Cooperative Grant - Putting on "AIRS"								
Cooperative Grant - Lyme Disease Grant								
Cooperative Grant -Lead Poisoning	2,500	7,919	4,858	5,428	7,817			
Cooperative Grant - ACHIEVE	6,915	498	3,629	228	3,451	5,000	15,552	1,000
Cooperative Grant - CRI Cities Readiness Initiatives				5,622	378			
MRC Capacity Building Award		1,161	3,056	2,479				
MRC Region 4			129	8,598	58		11,214	5,000
Citizen Corps Program		1,500	(31)					
Community Based Wellness Service		69	5,431					
	265,900	257,301	185,636	234,902	153,500	147,956	172,411	150,400
Expenditures by Project:								
Salaries & Benefits	167,523	171,132	148,572	170,608	132,149	114,068	105,171	91,744
Professional &Technical Services	3,000	3,050	7,063	28,538	8,981	6,540	1,724	1,504
Other Purchased Services & Supplies	95,378	83,119	30,000	35,756	12,070	27,348	65,516	57,152
Equipment					300			
Transfer Out								
Total Expenditures	265,900	257,301	185,636	234,902	153,500	147,956	172,411	150,400
Excess/(Deficiency) of Revenues over Expenditures								
Fund Balance, July 1								
Fund Balance, June 30								

EASTERN HIGHLANDS HEALTH DISTRICT
FUND BALANCE ANALYSIS

FY 2016/17 - Projected FY 2024/25

	Actual 16/17	Actual 17/18	Adopted 18/19	Estimated 18/19	Projected 19/20	Projected 20/21	Projected 21/22	Projected 22/23	Projected 23/24	Projected 24/25
General Fund										
Operating Expenditures	761,320	771,841	812,237	839,237	840,604	858,970	877,228	895,784	914,644	932,814
Grant Deduction	86,938	91,253	82,542	82,542	89,056	90,000	90,000	90,000	90,000	90,000
Total Expenditures	848,258	863,093	894,779	921,779	929,660	948,970	967,228	985,784	1,004,644	1,022,814
Fund Balance	316,262	358,082	326,675	309,722	282,429	255,288	228,907	203,503	179,300	157,531
FB as a % of Total Expenditures	37.28%	41.49%	36.51%	33.60%	30.38%	26.90%	23.67%	20.64%	17.85%	15.40%
Capital Non-Recurring Fund										
Total Expenditures	-	34,696	15,000	15,000	33,000	27,000	27,000	27,000	22,000	22,000
Fund Balance	161,566	126,870	117,870	137,870	110,870	92,370	76,370	64,370	60,370	59,370
FB as a % of Total Expenditures	0.00%	365.67%	785.80%	919.13%	335.97%	342.11%	282.85%	238.41%	274.41%	269.86%
All Funds										
Total Expenditures	848,258	897,789	909,779	936,779	962,660	975,970	994,228	1,012,784	1,026,644	1,044,814
Fund Balance	477,828	484,952	444,545	447,592	393,299	347,658	305,277	267,873	239,670	216,901
FB as a % of Total Expenditures	56.33%	54.02%	48.86%	47.78%	40.86%	35.62%	30.70%	26.45%	23.34%	20.76%
Service Fees & State Grant Revenue	358,038	384,378	351,560	361,607	375,721	383,299	391,104	399,143	407,423	415,952
Target Fund Balance - 50% of Service Fees & State Grant Revenue	179,019	192,189	175,780	180,804	187,861	191,649	195,552	199,572	203,712	207,976
General Fund - Fund Balance	316,262	358,082	326,675	309,722	282,429	255,288	228,907	203,503	179,300	157,531
Variance	137,243	165,893	150,895	128,918	94,568	63,638	33,355	3,931	(24,412)	(50,445)

Temporary Food Event Permit Program

	FY06/07	FY07/08	FY08/09*	FY09/10	FY10/11	FY11/12	FY12/13	FY13/14	FY14/15	FY15/16	FY16/17	FY17/18**
Temp Food Vendor Permits Issued	77	71	89	158	185	165	186	163	172	198	164	167
Farmers Market Vendor Permits Issued	0	0	50	61	52	56	51	50	63	66	70	78
Total Permits issued	77	71	139	219	237	221	213	213	235	264	234	245
Farmers Market Inspections Conducted	NA	NA	NA	42	105	81	70	132	109	168	151	109
Total Temp Food Inspections Conducted	NA	NA	NA	45	139	119	96	160	142	198	170	129
Missed inspections (estimated potential)	NA	NA	NA	NA	151	127	160	135	139	168	145	147

* The figures split between "temp food permits" and "farmer market permits" is estimated.
**We experienced a material field staff shortage during this year

Many Farmer Markets started FY08/09 and thereafter.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Environmental Health Section

EHS Circular Letter 2018-37

TO: Local Directors of Health
Certified Food Inspectors
Interested Parties

FROM: Tracey Weeks, MS, RS
Coordinator, Food Protection Program

DATE: December 20, 2018

SUBJECT: **FDA Food Code Adoption Update**

Background
In 2018 legislation was passed that revised Section 19a-36h of the Connecticut General Statutes to read:

> *(a) Not later than January 1, 2019, the commissioner shall adopt and administer by reference the United States Food and Drug Administration's Food Code, as amended from time to time, and any Food Code Supplement published by said administration as the state's food code for the purpose of regulating food establishments.*
>
> *(b) The commissioner may adopt regulations, in accordance with the provisions of chapter 54, to implement the provisions of this section and sections 19a-36i to 19a-36m, inclusive.*

To this end, regulations to implement the FDA Food Code have been submitted and are currently in the formal regulation review process. (See EHS Circular Letter 2018-30.) The regulations are necessary to implement the FDA Food Code and provide enforcement mechanisms to local health officials.

Current Status
Because the regulations to implement the FDA Food Code are still in the regulation review process, it is not possible that they will be approved by January 1, 2019. **Therefore, on January 1, 2019, the current food regulations: 19-13-B42; 19-13-B40; 19-13-B48; and 19-13-B49 will still be in effect and enforceable by local certified food inspectors.** The FDA Food Code **will not** automatically become effective on January 1, 2019.

Unfortunately, it is not possible to predict the date the draft regulations to implement the FDA Food Code will become approved due to the various steps and required approvals that are part of the regulatory review process. However, as this has been a priority for the agency, we are hopeful that the regulations will be approved in 2019.

Certified food inspectors who wish to become certified to enforce the FDA Food Code when the regulations to implement the Code are approved, should:

- Continue to work on completing the required FDA online courses
- View the recorded webinar CT's New Food Establishment Laws on TRAIN
- View the recording of the live webinar, *The New Food Inspection Form Training,* that was broadcast on 12/19/18
- Read Guide 3B in Annex 7 of the 2017 Food Code, *Instructions for Marking the Food Establishment Report*
- Continue to read the 2017 FDA Food Code

NOTE: A limited # of single copies of the 2017 FDA Food Code can be ordered at no cost at https://www.fda.gov/Food/ResourcesForYou/Consumers/ucm239035.htm (refer to publication # **IFS17**)

Certified food inspectors will receive a letter extending their certification date through December 31, 2019. Once the regulations are approved and the FDA Food Code becomes effective and enforceable, new certificates will be sent to those certified food inspectors who meet the criteria to enforce the new Code.

Summary

The 2017 FDA Food Code will not automatically become effective on January 1, 2019. It will become effective when the regulations to implement it are approved. Until that time, certified food inspectors will continue to enforce the current Connecticut food regulations using the existing food establishment inspection report forms.

The Food Protection Program will continue to send updates as necessary.

If you have questions regarding this notice, please contact the Food Protection Program at the number below or email us at DPH.FoodProtectionProgram@ct.gov.

Suzanne Blancaflor, MS, MPH, Chief, Environmental Health Section

Robert L. Miller

5

From: Robert L. Miller
Sent: Monday, December 17, 2018 11:04 AM
To: Derrik M. Kennedy
Cc: Elizabeth Paterson (home)
Subject: RE: Values & Your Department
Attachments: StrategicPlan2013-2017 Final - Copy.pdf

Hi Derrik – I have leveraged your "Five Guiding Values" initiative to engage the health district staff in a discussion how these values relate to the work we do, and to the established goals and mission of the health district (See attached). The discussion took place last week during a regular staff meeting.

Out of the discussion came many considerations, observations, and other comments. Below are the salient points :

- Ethics – Is an essential precondition to the work that HD staff conduct as local code enforcers. Violation of this trust, real or perceived, would result in the gravest of harm to our capacity and effectiveness.
- Balance- Recent changes to promote internal work equity has made "balance" challenging in some cases..."it is not always about the numbers". The HD in many cases has little control over the worksite due to our decentralized structure. Nonetheless, the HD spearheads employee wellness programming, and works routinely to promote both group/team and individual balance.
- Development – Relates directly to most of the work conducted by the health district. There many examples of this both in terms of required and voluntary continuing professional education and enrichment. It was noted that this value can support Balance and job satisfaction.
- Service – "This is why HD staff take this job." Service is at the core of what we do here at Health District, particularly as it relates to preventing illness and promoting wellness. We cannot be effective in this mission without treating residents, and the regulated community with empathy, compassion, and transparency.
- Stewardship – This is not open to interpretation. The over guiding comment here is that this is a cornerstone of local public service. It does not matter for which department you work.

Yours in Health,
Rob

Robert L. Miller, MPH, RS
Director of Health
Eastern Highlands Health District
4 South Eagleville Road
Storrs, CT 06268
860-429-3325
860-429-3321 (Fax)
Twitter: @RobMillerMPH
www.ehhd.org

EHHD
Eastern Highlands Health District

Preventing Illness and Promoting Wellness in the Communities We Serve

Mansfield Town Government

Five Guiding Values

1. **Ethics**
   Responding to the call for positive, exemplary community service, statutes, regulations, charter, ordinances, and policies guide our daily activities and performance. Work performed by us outside the limits of these guidelines is a violation of the public and our colleague's trust. There is no tolerance for unethical behavior or practices. If change is desired or needed, work within the bounds of accepted procedures to promote change.

2. **Balance**
   You should work to live, not live to work. The workplace should be set up to assist you in being the best employee and the best person you can be. We all work differently and have different habits to complete our best work. The workplace should not limit work styles nor limit ability to be the best you. Understanding and promoting healthy, active lifestyles will return exemplary work product.

3. **Development**
   Everyone should strive for and be supported to attain the highest level of knowledge in their field. Continued education and training make the organization safer, smarter, and more interconnected. We should all have the opportunity for development and growth, striving for achievement and advancement within the organization. The return on investment in our development, to the resident, leads to a more efficient and effective government that provides the most services for the least amount of taxes.

4. **Service**
   Our work in government is about helping others. Holding a government position means that you chose to work on behalf of our residents. We should strive to be great at customer service, ensuring everyone's visit and experience with Town Staff is exemplary and positive. We should strive to make positive change in our communities, whether that be through service or being an employee and department of excellence, always striving for perfection.

5. **Stewardship**
   We are stewards of the people's money. Residents provide the financial resources for us to deliver consistent and reliable services. Residents expect us to consistently exceed their expectations. We are paid by resident tax dollars and should treat that resource as precious and scarce. While delivering the best services possible to our community, the use of tax dollars should be specific and responsible. Misuse of public funds is antithetical to these five guiding values and will not be tolerated.

Robert L. Miller

From: Jeffrey Catlett <jcatlett@manchesterct.gov>
Sent: Thursday, January 3, 2019 1:13 PM
To: Charles Brown; Shane Lockwood; Byron Kennedy; Andrea Boissevain; Jeffrey Catlett; Robert L. Miller; Mark Cooper; Donna Culbert; Steven Huleatt; Jennifer Kertanis; Raymond Sullivan; Maura Esposito; Neal Lustig; Scott Sjoquist; Michael Pascucilla; dknauf@darienct.gov
Subject: FW: Notice of Event

To all:

Just a heads up. This invite was sent to *Fairfield County* legislators, municipal directors of health, and First Selectman and Mayors to discuss the idea of regionalization of municipal health departments. Interesting that DPH is a co-presenter.

Jeffrey Catlett, MPH, R.S.
Director of Health
Town of Manchester
phone (860) 647-3171

From: McKenzie, Lillian [mailto:Lillian.McKenzie@cga.ct.gov]
Sent: Thursday, January 03, 2019 9:14 AM
To: McKenzie, Lillian
Cc: Rep. Santiago, Ezequiel; maritza.bond@bridgeportct.gov
Subject: Notice of Event

NOTICE OF ROUNDTABLE DISCUSSION

HOSTS: Rep. Ezequiel Santiago, Maritza Bond- Director of Health- Bridgeport, CT Department of Public Health

DATE: Thursday, January 17th, 2019

LOCATION: State Capitol, Room 310 (Old Approps)

On behalf of Representative Ezequiel Santiago, we are gathering Fairfield County legislators, municipal directors of health, and First Selectman and Mayors to discuss the idea of regionalization of municipal health departments. We will begin at 9:30am with presentations from the Bridgeport Health Department and Connecticut Department of Public Health. Please join us to offer your perspective and ideas on this topic. **Please RSVP at this link by January 14th** if you will be able to attend.

Sincerely,

Lillian McKenzie
Outreach Coordinator
House Democrats Office
860-240-0182

The Regionalization of Public Health Services: A Review

Prepared by

Kristina Ramdial, Jonathan Noel

for the Advocacy Committee of the Connecticut Public Health Association

Connecticut Public Health Association

Promoting Public Health in Connecticut Since 1916

Suggested citation: Ramdial K, Noel J. The Regionalization of Public Health Services: A Review. Hartford, CT: Connecticut Public Health Association. 2018.

Executive Summary:

In Fall 2016, the Connecticut Department of Public Health (CT DPH) released a proposal to consolidate Connecticut's local health agencies into 8 regions by 2020. Intentions of the proposal were to promote equity, secure local and federal grants, improve emergency response, and provide every Connecticut resident access to public health services (Health). Despite the promotion of public health regionalization in Connecticut, there is little information on how regionalization may impact population health outcomes. Because of the gap in the literature, a systematic review of the peer-reviewed literature was conducted to determine if public health regionalization is a cost-efficient method for improving population health outcomes.

Regionalization can be described as the addition of regional structure to supplement local government agencies, in some cases leading to consolidation of services (Koh, Elqura, Judge, & Stoto, 2008). Efficient delivery of services, sharing of specialized resources, better trained personnel with the capacity for specialized skills, a lower turnover rate and higher levels of coverage are the expected results that might appeal to the public health field.

The regionalization of public health services has been implemented to varying degrees in the U.S. and abroad. For example, in 2004, vaccine production issues were resolved in Massachusetts by creating a regional vaccine clinic. Contrary to expectations, autonomy was respected amongst new leadership. In Connecticut, the economic impact of regionalization was simulated, and there appeared to be a potential increase in spending on public health services, with departments serving larger populations having a tendency to overspend on local services (Bates & Santerre, 2013). An analysis of local health districts (LHDs) in Florida concluded that while LHDs varied in size, services offered, and population served, economies of scale were seen in many public health activities. For smaller LHDs however, having higher costs at lowers volumes of service meant that participation may be limited, and specialization of services would not be as beneficial when constrained by smaller budgets. In Nebraska, most counties did not have health departments before a 2001 regionalization plan helped provide services to these areas. The consolidation of LHDs in Ohio suggested public health expenditures were reduced without sacrificing the provision or improvement of services.

The available evidence suggests that regionalization of public health services can decrease public health costs through economies of scale and improve population health outcomes. However, there is no evidence suggesting that one form of regionalization is inherently more efficient or effective than another. Indeed, stakeholder buy-in is likely necessary for any regionalization plan to be effective. Conversely, forced regionalization lacks stakeholder buy-in; may lead to a higher demand of services; and may lead to an overspending on public health services. Due diligence is needed by all involved parties before any regionalization plan is implemented.

Introduction

In 1950, Joe Mountin, founder of the United States (U.S.) Centers for Disease Control and Prevention (CDC), promoted a concept for regionalization of public health and hospital services. He favored the collaboration of medical and health facilities and the integration of hospitals and health departments. He believed that preventative and curative medicine had reached the stage where they were no longer separable and thought it necessary to bring them together functionally (Grant, 1953). The organization of public health services into regions, defined by geographical boundaries, population needs, residential type, or other methods, is a concept being implemented across the U.S., neighboring countries, and the world (Tidwell, 2011). Reasons for regionalizing public health services vary from area to area. Some states, such as Massachusetts, implemented regionalization schemes to improve emergency preparedness, while the Caribbean Community and Common Market (CARICOM) approached the idea from a standpoint of regulation of medicinal resources and health technology in resource-constrained environments (Preston et al., 2016).

A common argument for the regionalization of medical services is that such actions will be more resource efficient (Koh et al., 2008). If each area of a region contributed a set of unique services, all areas of the region could benefit from these services without duplication or overlap. Additionally, the creation of larger public health regions could address larger population areas and optimize service allocation. Moreover, matters of safety and health may often fall outside of the restrictions of city and town lines, and municipal services may benefit from coordination in order to address those matters.

In 2009, Connecticut's Governor's Council for Local Public Health Regionalization was formed to provide a practical regional approach for defining the local public health infrastructure. Members reviewed past efforts in other states to enhance the quality and equity of public health services. A proposal was put forth recommending regionalization of public health services, increasing certain fee structures, and decreasing per capita reimbursements from the state to each department of health region. Several municipalities expressed their concerns with this initial proposition. Many towns were satisfied with their current services, and saw no need for change. Others had already regionalized some services and did not want to erase their progress. There were also concerns regarding increased cost and a fear for decreased quality of service (Dixon, 2009).

By 2016, still without any major action to regionalize Connecticut's public health infrastructure en masse, Hartford officials began to consider the consolidation for their own services, with the intention of tapping into the spending savings that regionalization was to offer. Across the state, several programs consolidated. The Regional Performance Incentive Program, a capital source to encourage towns and regions to collaborate, was showing success, and the Nutmeg Network opened the opportunity to share resources, which produced savings (Sterns, 2016). There had also been removals of previous statutes which prevented towns, cities and boards of education from collaborating.

In Fall 2016, the Connecticut Department of Public Health (CT DPH) released a proposal to consolidate Connecticut's 73 local health agencies in to 8 regions by 2020 in an effort to offer more efficient services

to a larger number of people. Prior to this proposal, some towns have voluntarily formed inter-municipal health districts (e.g., the Torrington Area Health District includes 18 municipalities) (Fitch). Under the proposed bill, Litchfield County would absorb these districts into a 29-town region. Likewise, Hartford would join into a region of 28 towns and cities for the Hartford county region. An alternative to this plan was to have districts follow county boundaries, but Connecticut's five largest cities, Hartford, Bridgeport, Waterbury, New Haven and Stamford, would maintain their existing individual health departments (Benson). Funding for the new districts would initially depend on the population of the district and the budget of each municipality, requiring each municipality to contribute 1.5% of their budget to the regional fund, and the commissioner of public health would approve the program and budget of each district (Fitch). Later amendments, made in March 2017 (i.e. HB5754 and HB7170,) would have required each district to receive $1.85 per person covered from state coffers.

The public health regionalization proposals made in 2016 and 2017 were largely panned. The City of Stamford explained that HB7170 as written did not provide sufficient representation for larger cities and the potential economic impact to municipalities needed to be evaluated. There was also concern that the bill did not provide an adequate process for defining regional health district boundaries (Jankowski, 2017). What many refer to as a top-down approach did not seem appropriate to address the specific needs of an area, allow flexibility in the management of services, and ensure accountability from all parties involved (Henry, 2017).

Despite ongoing discussions of regionalization and consolidation of services in Connecticut, there is little information on how regionalization may impact the population's health. Because of this gap, a systematic review of the peer-reviewed literature was conducted to determine if public health regionalization can improve the general health of the population while also being cost efficient. The review includes evaluations of state and national attempts at regionalization within multiple sub-fields of public health.

Methods

For the present study, regionalization was defined as the addition of a regional structure to supplement local government agencies, which may lead to consolidation of services or agencies (Koh et al., 2008). We broadened the definition by providing examples of its iterations: creating an intermediary administrative structure with the responsibility for organizing and delivering health care services to a defined population, or guiding the decentralization of services to optimize their impact (Simpson, 2011). The definition also includes the act of negotiation and agreement processes between all parties involved, with attention to the needs of the area served (Sancho, Geremia, Dain, Geremia, & Leao, 2017). Following the National Association of County and City Health Officials (NACCHO), Local Health Departments (LHDs) were defined as a governmental public health presence at the local level, which may be a locally governed health department, a branch of the state health department, a state-created district or region, a department governed by and serving a multi-county area, or any other arrangement that has governmental authority and is responsible for public health functions at the local level ("Operational Definition Booklet," 2005).

SCOPUS, PubMed, and Google Scholar were searched. The search terms "regionalization AND public health" were used to locate articles relating the two topics. The search terms "Health AND (region OR district)" were used to locate articles on health service organization. There were no date restrictions because this information has not been previously reviewed. Article reference lists were reviewed to identify additional articles that were not in the search results. Studies were selected if they contained information on (1) reorganization of the delivery of health services, (2) had studied the effects of regionalization or reorganization of the delivery of services, or (3) pertained specifically to the pros and cons of regionalization public health services. Studies were excluded if they were unavailable in English, or were an editorial, opinion, or review article.

Results

General Impact of Regionalization

Regionalization is described by Koh et al. (2008) as an addition of regional structure to supplement local government agencies, in some cases leading to consolidation of services (Koh et al., 2008). Efficient delivery of services, sharing of specialized resources, better trained personnel with the capacity for specialized skills, a lower turnover rate and higher levels of coverage are the expected results that might appeal to the field of public health. Such results are obtained because regionalized structures allow for more training and advancement opportunities, which produce better trained personnel, and are more cost-effective due to a reduction of service duplication. Becoming a part of a larger region may also allow each incorporated area to dedicate funds to the development and maintenance of a select few services, which would be their contribution to the region, instead of having funds spread across all potential service areas. This was thought to increase the likelihood that higher quality services would be available to all areas within the covered region.

Regionalization for Preparedness

Several areas within the U.S. have implemented regionalization plans with the motive of becoming better prepared for disaster and emergency situations. Six papers were found on this topic.

Because approximately 25% of the U.S. population lives in areas that surround state lines, regionalization would limit the confusion between federal, state, and local jurisdiction in times of emergency, as was needed during and after Hurricane Katrina (Katz, Staiti, & McKenzie, 2006). Furthermore, only 25% of U.S. local public health jurisdictions are able to provide 60% or more of the essential services needed to respond to a terrorist event and protect community health, with departments serving more residents often having a higher performance score (Stoto, 2008).

Regionalization has enhanced the response to emerging infectious diseases (Stoto, 2008). Regional surveillance aided the characterization of the West Nile Virus; regional epidemiology offices aided the investigation of potential cases of severe acute respiratory syndrome (SARS); and regionalization aided a

response to a Hepatitis A outbreak. The lack of comprehensive coordination, which regionalization can provide, may have contributed to the delays in the responses to these outbreaks.

In Massachusetts, the Massachusetts Department of Public Health (MA DPH) funds a regional coordinator and distributes preparedness funds to a fiscal agent in each state sub-region (Koh et al., 2008). Centralizing surveillance and communication has improved emergency preparedness, and Massachusetts has begun to standardize relevant equipment across regions as well. In 2004, vaccine production issues were resolved in Massachusetts by creating a regional vaccine clinic. Autonomy was respected amongst new organizational leadership, and with no formal governmental leadership assigned, the power dynamic that might produce tension was not apparent.

The University of North Carolina (UNC) Preparedness and Emergency Response Learning Center (PERLC) program serves North Carolina, Virginia, and West Virginia, helping to meet the needs of the public health workforce by providing epidemiology field training programs, distance learning tools, trainings for preparedness staff, and other resources (Horney & Wilfert, 2014). The project was able to leverage improvements on other projects related to preparedness, including the sharing of expertise and staff that would have otherwise been difficult to accomplish as smaller, independent projects. The UNC PERLC has also developed a survey to understand the impact of regionalization of public health workforces, particularly services provided by the Public Health Regional Surveillance Teams (PHRSTs) to North Carolina's LHDs (Horney, Markiewicz, Meyer, & Macdonald, 2011). Compared to Massachusetts, a significant improvement in networking and coordination of services within the PHRSTs was noted. Perceived quality of assistance varied, as did the package of services, support, and training provided by the PHRSTs. Needs assessments and resource development and provision were noted benefits of the North Carolina preparedness programs, but similar impacts in other participating states were not addressed.

Regionalization of Public Health in Connecticut

One paper was identified that focused on Connecticut. The economic impact of public health regionalization was simulated using data from several Connecticut communities. It was noted that regionalization appeared to increase spending on public health services, and departments serving larger populations would have a tendency to overspend on local services (Bates & Santerre, 2013). Overspending would primarily occur during the transition from local to regional health organization, and the financial resources would likely be pulled from education and other municipal services.

Regionalization of Public Health in Florida

One paper was identified that focused on economies of scale and regionalization in Florida. An analysis of LHDs in Florida questioned whether the concepts of economies of scale and economies of scope were seen in the delivery of public health services (Bernet & Singh, 2015). While LHDs varied in size, services offered, and population served, the study found that economies of scale were seen in many public health activities. LHD specialization, where each LHD within a region specializes in a different service

but shares the service region-wide, also reduced costs while eliminating duplicative efforts. For smaller LHDs however, economies of scale posed difficulties. Having higher costs at lowers volumes of service means that small LHDs might not be able to participate to the same extent as larger LHDs, and specialization of services would not be as beneficial when constrained by smaller, more limited budgets. For example, smaller LHDs might lack sufficient bargaining power to negotiate fair rates for specialized services when partnering with larger LHDs. Breadth of services provided was not associated with variations in the cost of providing service, which suggests that no economies of scope were achieved and that the range of public health services offered would not be limited to financial factors. The study concluded that consolidation of service production could result in a net improvement of health of the population within the confines of the original budget.

Regionalization of Public Health in Other States

Other states also have experience implementing public health regionalization plans. Three papers are discussed here.

In Nebraska, most counties did not have health departments before multicounty departments were established in 2001 (Stoto, 2008). This regionalization plan has helped Nebraska provide essential public health services to areas that would otherwise lack these resources.

A study on the consolidation of LHDs in Ohio was conducted to determine whether there were subsequent changes in spending and service quality. The results suggested that LHD consolidation had financial advantages, including reduced public health expenditures without sacrificing the ability to provide public health services (Hoornbeek et al., 2015). Furthermore, consolidation enabled the improvement of services, especially for smaller cities, who may have otherwise been restricted in their access or unable to provide higher quality services for their residents.

A study of health districts and county health departments in Georgia was conducted to gauge whether multicounty health districts could serve as "Quality Improvement Collaboratives" and address the issue of meeting health problems and the demands of accreditation while working with limited resources (Livingood et al., 2012). The Quality Improvement Collaborative (QIC) regional public health model substantially improved accreditation standards of public health agencies; improved cross-jurisdictional sharing of resources; and aided in capacity building of smaller local health departments. The perception of local agencies ability to provide 10 essential public health services was substantially lower than perceptions of the same capabilities for regional agencies.

Regionalization of Public Health in Brazil

A large number of articles addressed regionalization and decentralization of services in Brazil. Five papers are discussed here.

Since the 1980's, Brazil has planned to decentralize the government provision of healthcare to optimize capacity, rationalize care, influence economies of scale, integrate municipal services, and overcome access barriers (Ribeiro, Tanaka, & Denis, 2017). Territorial organization alternatives have reinforced local management autonomy at times, and federal regulation at others. In the early 2000's, federal healthcare legislation and court rulings created criteria for health regions, regional-centric planning instruments, negotiation and management of care services, and integration of healthcare networks. Health regionalization requires the establishment of complex relationships within the government and within regions (Sancho et al., 2017). Incentives addressing autonomy and cooperation were used to institutionalize the new governing structures. Regionalized healthcare services reduced operational costs, and impacted innovation, performance management, and services provided. Notable negative effects were the lack of tools for establishing governmental and structural agreements. Acknowledgment of these challenges were reflected in Brazil's efforts to establish a governing model that had legal and institutional security, thereby improving efficiency in the regionalization process.

Recent strategies in Brazil were aimed to reinforce federal relations while allowing local powers to maintain responsibilities of setting priorities. Decentralized decision making, planning, and resource allocations lie in the hands of state and municipal governments (Ribeiro et al., 2017). The criteria for the demarcation of health regions include cultural, social, and economic factors, as well as consideration of existing communication and transportation infrastructure. To reinforce this idea, the Organizational Contract for Public Action (Contrato Organizativo da Ação Pública, COAP) was created. Under control of the Sistema Único de Saúde (SUS), COAP helped create healthcare networks for each region by defining responsibilities, health targets, performance assessments, and budgets. COAP also defined control, enforcement, and integrated implementation of regional actions.

While COAP aided in the institutionalization of the health region as a healthcare organizational structure, such a contract does not ensure meaningful cooperation between tiers of government nor does it ensure effective regional-level organization (Goya, Andrade, Pontes, Tajra, & Barreto, 2017). In Ceará, Brazil, the Ministry of Health was engaged in a contract with local and regional officials; however, there was no political or technical consensus regarding how the contract would be used. This lead to discrepancies in the interpretation of which powers lied with which parties. Based on this experience, procedures were developed to institutionalize the COAP goals by implementing ombudsmen and HÓRUS in municipalities, sharing state workforce information, and increasing transparency regarding the regional health budget. Despite these initiatives, operational procedures for the regions remained weakly developed. The SUS is challenged by the distribution of power and responsibility amongst the three governing sections of a region, and COAP is being modified to adjust for these unaddressed structural grey areas.

Reis et al. (2017) noted that the main challenge moving forward for the SUS is the need to redefine responsibilities of federal entities (Reis, Soter, Furtado, & Pereira, 2017). They emphasized the need for municipally integrated systems guided by the needs of the population. Access to care and financing could be addressed with regionally based modules of integrated care that are under public regulation.

Regionalization of Health Services in Other Countries

A portion of the literature addressed regionalization in other countries. Two papers discussed Singapore as well as a grouping of Barbados, Guyana, Jamaica, and Trinidad and Tobago.

In Singapore, who was ranked as the world's 6th most successful health care system by the World Health Organization, regionalization took the form of a shared database (George et al., 2015). The Regional Health System (RHS) database was a framework for population healthcare management that allowed the sharing of health information across healthcare services. Such knowledge was thought to aid in coordinating care across services, planning of effective population-level health interventions, and promoting programs that allow optimization of health service resources. Regionalization of information access facilitated a better understanding of the health of the population and the most effective use of resources for public health services.

The Caribbean Community and Common Market (CARICOM), consisting of Barbados, Guyana, Jamaica, and Trinidad and Tobago, implemented the Caribbean Regulatory System (CRS) (Preston et al., 2016). CARICOM used the CRS to leverage existing platforms to centralize cooperation, governance and infrastructure, and build human resource capacity amongst themselves. The anticipated benefits of the CRS were: pooling of limited resources, standardized rules and processes, information sharing, increased availability of safe, effective and high-quality medicines, improved market control of medicines, improved efficiency at which resources are allocated, reduced regulatory burdens, and improved human resource capacity for regulation enforcement. Challenges included division of power amongst the members of CARICOM, conflicting or incongruous goals, and the inability of each part of the region to contribute equally.

Discussion

Regionalization of public health services has been implemented to varying degrees in the U.S. and abroad. In emergency preparedness, regionalization may ensure more efficient use of resources that transcend geopolitical boundaries. However, regionalization might also risk a power struggle between local and regional agencies, which may lead to confusion in the event of a disaster. Economies of scale can reduce service costs and increase the quality and variety of services within regionalized health districts, and although health outcomes were not addressed, increased service quality will likely improve population health measures. In the CARICOM countries, regionalization provided strength in numbers for the provision of medical, technological, and regulatory resources.

The findings of the peer-reviewed literature are consistent with similar research published elsewhere. NACCHO released a comprehensive paper on the benefits of regionalizing public health services (Tidwell, 2011). North Dakota regionalized in response to resource constraints and saw increased efficiency. Kansas implemented 'functional regionalization,' in which LHDs of each county are separate but cooperate within a region to provide public health services. In their model, the state health department assisted with assessment, planning, legality, financial issues and communication. In Massachusetts,

regionalization through a state-funded structure has shown results of economies of scale and increased funding. Nebraska's regionalization allowed for autonomy and choice in selection of county partners within a region.

The Center for Sharing Public Health Services published a case study in 2014 about the Eastern Highlands Health District, based in Mansfield, Connecticut. Formed in 1997, this district now provides public health services to about 2% of the population of Connecticut. The region was experiencing high staff turnover, and in some cases, the quality of services offered suffered. Towns sought to increase the scope and quality of public health services while reducing expenses and intended to do so by pooling resources. This allowed them to establish a full-time public health staff, provide competitive salaries to skilled employees, and raise the level of professionalism to the provision of public health services. It is estimated that the centralized model has helped the town of Coventry save 30%-35% in costs by helping to form and participate in the health district. Some towns were apprehensive about losing autonomy in the merge, and there was an adjustment period for frequent inspections and other methods of imposing the same standard across the board that some found intrusive initially. The Connecticut Department of Health held workshops to facilitate the transition; state law helped dictate how the changes would occur; and the appointment of town representatives were steps taken with the intention of directing the new structure into a form that fit all its towns (Services, 2014).

Regionalization has also been proposed as a solution to socioeconomic disparities in the U.S. (Koh et al., 2008). Income and race already play roles in the uneven distribution of local public goods and services. Regionalization of municipal services have addressed some disparities between economically variable areas and might thereby be used as an example to address health disparities based on income, geography, and population density. Efficient use of resources and building economies of scale, two motivations previously referred to when considering public health regionalization, have been the primary motivating factors in the regionalization of municipal services such as police, fire, education, and wastewater.

As an expansion of its Project Public Health Ready (PPHR), NACCHO identified four approaches to achieving emergency preparedness that incorporates the concept of regionalization. Networking was described as the most informal quality of regionalization, which allows for the sharing of preparedness information between organizations (Koh et al., 2008). This interaction can involve contact sharing or pooling of educational materials. The second approach was Coordinating, which described departments in each region working together to plan meetings, trainings, and exercises related to preparedness. Standardizing is the approach to creating uniformity across departments, via an adoption of tools, press releases, and response procedures. Reponses might still be controlled by individual departments, but procedure would be determined as a region. Finally, Centralizing suggests that planning and response resources such as notification systems, web portals, training or even epidemiologic support would fall under one regional entity.

Factors and algorithms for determining an optimal method for assigning regional boundaries were explored in a comparative study from 1979 (Thomas, 1979). The 'implicit enumeration' algorithm was

appropriate for problems of relatively small size only. Constraints on region population size, number of hospitals per region, and other factors limited the number of combinations to be considered, allowing the algorithm to function more efficiently. The 'greedy modern' algorithm produced solutions for populations of any size and was conceptually the simplest of the three. It has also been used in other efforts to define health region boundaries. The efficiency of the 'max-flow/min-cut' algorithm was influenced by the number of counties and regions, as well as the density of the county to county patient flow matrix. It was very efficient in portioning states into multi-county regions. In terms of proportion of patients using health services in their regions, the 'max-flow/min-cut' algorithm produced slightly superior solutions that the other two algorithms. The paper concluded that the 'max-flow/min-cut' and 'greedy' algorithms had greater general applicability than the 'implicit enumeration' algorithm. The 'greedy' algorithm used less computer time for areas with relatively dense patient flow matrices while the 'max-flow/min-cut' algorithm identify a slightly superior solution.

Limitations

The primary limitation of this review is the coverage of available information. Additional search terms and databases may have increased the number of relevant articles included. The concept of regionalization can be implemented to many different degrees and might not always be titled as such, which may have led to an oversight of relevant studies that may not have been shown using the search terms of this study. Moreover, non-peer-reviewed reports produced by government agencies, non-governmental organizations, and consultant firms were explicitly excluded from the results. While these sources may be informative, they may also lack the scientific rigor of the peer-reviewed literature.

Conclusions

The available evidence suggests that regionalization of public health services can decrease public health costs through economies of scale and improve population health outcomes. However, there is no evidence suggesting that one form of regionalization is inherently more efficient or effective than another. Indeed, stakeholder buy-in is likely necessary for any regionalization plan to be effective. Conversely, forced regionalization lacks stakeholder buy-in; may lead to a higher demand of services; and may lead to an overspending on public health services. Due diligence is needed by all involved parties before any regionalization plan is implemented.

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Public Health Preparedness and Local Health Section

MEMORANDUM

DATE: December 21, 2018 OPHPR 2018- 018

TO: Directors of Health
Mass Dispensing Area (MDA) Leads/Local Health Preparedness Coordinators
HCC Coordinators

FROM: Lisa Bushnell, Strategic National Stockpile Coordinator
Epidemiologist II

RE: Restructuring Mass Dispensing Areas (MDAs) in Connecticut

On November 15, 2018 the Department of Public Health (DPH) Office of Public Health Preparedness and Response (OPHPR) conducted a presentation entitled, "Restructuring MDAs in Connecticut" on the monthly Directors of Health webinar hosted by the DPH Office of Local Health Administration. This presentation was shared with Directors of Health and any staff who attended the webinar. As it was not widely distributed, we are sharing the slides (attached) and access to recording so you are fully informed of the contents and nature of the presentation. The webinar presentation can be accessed via TRAIN CT at https://www.train.org/connecticut (course #1071215, access code OLHA1234).

It was noted by our regional Centers for Disease Control and Prevention (CDC) Medical Countermeasures (MCM) Specialist that Connecticut was doing a large amount of MCM work. The ability to demonstrate MCM readiness requires each MDA to have well-established public health emergency preparedness plans and be able to demonstrate operational readiness by conducting required drills and exercises. The CDC requested that DPH reduce the number the MDAs in the state.

To begin exploring MDA restructuring, I conducted research to determine the number of state-designated CRI jurisdictions across the country. The attached slides provide you with the data I collected and a summary of my findings. Also attached are the results of a survey sent to all MDAs regarding the date of their latest Dispensing Full Scale Exercise (FSE). An additional

column was added to the survey results that includes information on whether or not an MDA met the CDC's Dispensing FSE requirement for the period 7/1/12 to 6/30/17. MCM Operational Readiness Reviews (ORRs) were conducted by Anna Sigler between the fall of 2015 through late spring of 2016. If an MDA conducted a Dispensing FSE after their MCM ORR and exercise documentation was not found in our MCM ORR file or in the MCM ORR Final Report it is listed as no and marked with an asterisk (*). The information contained in this attachment can serve to inform your process of selecting MDA leads within your region.

To assist you, as you explore the process of restructuring, the DPH OPHPR will be hosting regularly scheduled conference calls. The calls will serve as a forum for raising questions and sharing information across regions. The calls will be held on the following dates:

Monday, January 7th,	11am
Thursday, January 17th	1pm (before the OLHA DOH call)
Wednesday, January 30th	9am
Thursday, February 14th	1pm (before the OLHA DOH call)
Tuesday, February 26th	11am
Thursday, March 14th	1pm (before the OLHA DOH call)
Monday, March 25th	9am (if needed)

The conference call telephone number is 1-866-759-9983 and the participant code is 26142240#.

Questions can be directed to Lisa Bushnell at lisa.bushnell@ct.gov or at 860 509-7397.

cc: E. Blaschinski, MBA, RS, COO
F. Provenzano, PHP&LHS
PHP&LHS staff

att

Survey Results (self-reported) from CT's Mass Dispensing Area leads

Mass Dispensing Area Name	MDA #	Date of last DISPENSING FULL SCALE EXERCISE that met MCM ORR criteria? (self-reported survey data)	DPH record of Dispensing FULL SCALE EXERCISE between 7/1/12-6/30/17
REGION 1			**4 of 7 = YES**
Greenwich	MDA 1	January 2010	
Stamford/ Darien	MDA 2	April 16, 2016	yes
Norwalk	MDA 3	October 2007	
WWHD	MDA 4	May 2005	
Fairfield	MDA 10	May 20, 2015	yes
Bridgeport	MDA 11	5 years ago (Need to identify date)	yes
Stratford	MDA 12	June 2014	yes
REGION 2			**5 of 9 = YES**
NVHD	MDA 13	June 2018	No per 2016 MCM ORR conducted on 1/28/16*
Milford/Orange	MDA 17	March 31, 2017	yes
West Haven	MDA 18	June 2017	No per 2016 MCM ORR conducted on 11/18/15*
New Haven	MDA 19	April 14, 2016	yes
QVHD	MDA 20	only Regional	
East Shore	MDA 21	October 2014	yes
Meriden	MDA 22	March 2017	yes
Wallingford	MDA 23	July 10, 2018	No per 2016 MCM ORR conducted on 4/8/16*
CT River Area	MDA 39	April 14, 2014	yes

Mass Dispensing Area Name	MDA #	Date of last DISPENSING FULL SCALE EXERCISE that met MCM ORR criteria? (self-reported survey data)	DPH record of Dispensing FULL SCALE EXERCISE between 7/1/12-6/30/17
REGION 3			**4 of 13 = YES**
FVHD	MDA 24	2009-2010	
BBHD	MDA 25	April 15, 2016	yes
Southington	MDA 26	11/2016 with WHBD	No per 2016 MCM ORR conducted on 4/8/16*
New Britain	MDA 27	2009 H1N1	
CCHD	MDA 28	October 13, 2018	No per 2016 MCM ORR conducted on 4/8/16*
WHBHD	MDA 29	Feb 2018	No per 2016 MCM ORR conducted on 4/8/16*
Hartford	MDA 30	June 2011	
Windsor	MDA 31	February 2018	yes
East Hartford	MDA 32	May 2017	yes
Manchester / Glastonbury	MDA 33	October 2016	yes
North Central	MDA 34	Our MDA didn't perform an FSE yet	
Chatham	MDA 35	2009 H1N1	
Middletown / Cromwell	MDA 36	April 2014	No per 2016 MCM ORR conducted on 2/18/16*

Mass Dispensing Area Name	MDA #	Date of last DISPENSING FULL SCALE EXERCISE that met MCM ORR criteria? (self-reported survey data)	DPH record of Dispensing FULL SCALE EXERCISE between 7/1/12-6/30/17
REGION 4			**3 of 4 = YES**
Ledge Light	MDA 37	October 22, 2017	yes
Uncas	MDA 38	2009 H1N1 (3 drive-thru flu vaxx clinics done 2015, 2016, 2017 but had fewer than 50 cars)	No per 2016 MCM ORR conducted on 1/14/16*
EHHD	MDA 40	April 16, 2016	yes
Northeast	MDA 41	October 1, 2017	yes
REGION 5			**1 of 8 = YES**
Danbury	MDA 5	2013	No per 2016 MCM ORR conducted on 6/13/16*
Bethel	MDA 6	June 2, 2012	
Newtown	MDA 7	Nov 2006 (planned exercise with seasonal flu) and Nov 2009 (real life with H1N1)	
New Milford	MDA 8	April 2013 Regional distrib ex. April 2014 - CT Statewide SNS FSE. May 2016 participated in MDA #9 POD Drill & MCM FSE	No per 2016 MCM ORR conducted on 5/10/16*
Torrington	MDA 9	October 5, 2015	yes
Pomperaug	MDA 14	February 2018	No per 2016 MCM ORR conducted on 4/26/16*
Waterbury	MDA 15	Feb 2017 Real Event	No per 2016 MCM ORR conducted on 2/4/16*
Chesprocott	MDA 16	December/2016 - CHD hosted an 'exercise day' with FE and TTX components that met MCM ORR components.	No per 2016 MCM ORR conducted on 4/28/16*

*** FSEs conducted after the 2015-2016 MCM ORRs by Anna Sigler and prior to June 30, 2017 may have fulfilled the FSE exercise requirement. Last project period MCM ORRs and Final Reports available upon request.**

Robert L. Miller

From: Robert L. Miller
Sent: Tuesday, January 8, 2019 7:11 AM
To: EHHD-Staff
Subject: Jeff Polhemus

Hello Everyone – Some of you are aware that for a few years now Jeff has been taking engineering classes. It is with very mixed feelings that I inform you that Jeff will be leaving the health district to pursue is goal to become an engineer. He is enrolled as a full-time student for this spring semester. His last full time day with us will be January 18, 2019, while staying on with us on a part-time basis for a number of months to help with the transition.

Needless to say that Jeff will be sorely missed by all that have had the pleasure of working with one of the most effective, dedicated, local environmental health professionals in the State of Connecticut.

I have no doubt that each of you will wholeheartedly join me in wishing Jeff the best of luck in his new pursuits.

Robert L. Miller, MPH, RS
Director of Health
Eastern Highlands Health District
4 South Eagleville Road
Storrs, CT 06268
860-429-3325
860-429-3321 (Fax)
Twitter: @RobMillerMPH
www.ehhd.org

EHHD
Eastern Highlands Health District

Preventing Illness and Promoting Wellness in the Communities We Serve

Robert L. Miller

From:	Robert L. Miller
Sent:	Wednesday, January 2, 2019 11:16 AM
To:	'Deb Walsh'; Elizabeth Paterson (home); Derrik M. Kennedy; Town Administrator (townadministrator@columbiact.org); Robert DeVito (r.devito27@gmail.com); 'Steve Werbner'
Cc:	Joshua S. Putman; Robert L. Miller; Millie C. Brosseau
Subject:	FW: Brian Clinton

Greetings Personnel Committee Members – Please see the below email for your information regarding the resignation of our Community Health and Wellness Coordinator, effective 1/16/19.

This office will be working with Mansfield HR to get this job opportunity posted. You will be copied on the job announcement at that time.

Sincerely,
Rob

Robert L. Miller, MPH, RS
Director of Health
Eastern Highlands Health District
4 South Eagleville Road
Storrs, CT 06268
860-429-3325
860-429-3321 (Fax)
Twitter: @RobMillerMPH
www.ehhd.org

EHHD
Eastern Highlands Health District

Preventing Illness and Promoting Wellness in the Communities We Serve

From: Robert L. Miller
Sent: Tuesday, December 18, 2018 4:37 PM
To: Brian Clinton <ClintonB@ehhd.org>; Derek N. May <MayDN@ehhd.org>; Diane L. Collelo <ColleloDL@ehhd.org>; EHHDIntern <EHHDIntern@ehhd.org>; Glenn H. Bagdoian <bagdoiangh@ehhd.org>; Holly D. Hood <HoodHD@ehhd.org>; Jeffrey W. Polhemus <polhemusjw@ehhd.org>; Lynette S. Swanson <SwansonLS@ehhd.org>; Millie C. Brosseau <MBrosseau@ehhd.org>; Robert L. Miller <MillerRL@ehhd.org>; Sherry L. McGann <McGannSL@ehhd.org>
Subject: Brian Clinton

Hello Everyone – It is with mixed feelings that I let you know that Brian has submitted his letter of resignation. He is moving on to a new and exciting opportunity teaching full-time at Quinebaug Valley Community College (where he will get his summers off!) His last with us will be January 16, 2019.

When you see him please join me in wishing Brian the best in his new endeavor.

Rob

Robert L. Miller, MPH, RS
Director of Health
Eastern Highlands Health District
4 South Eagleville Road
Storrs, CT 06268
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EHHD
Eastern Highlands Health District

Preventing Illness and Promoting Wellness in the Communities We Serve

New Haven Register 1/5/18

ELLEN ANDREWS

Public health has a free-rider problem

Public health is the best deal on the planet. It's how residents of other countries live longer, healthier lives than Americans at half the cost. But Connecticut expects our under-funded public health system to solve this intractable health problem while all the savings go to the inefficient health care system that created the problem.

Free rider is an unflattering economic term. Anyone who gets a benefit without paying their fair share is a free rider. For example, in student group projects there is always one free rider who doesn't do any work but who still benefits from everyone else's effort and gets the group grade. Connecticut spends only $29 per person, less than most states, on public health but $9,859 on health care services, more than most states. The health care system, that treats sickness, is a free rider on the efforts of public health professionals who keep us all well.

Public health is under appreciated. We all know health care providers and the critical services they provide to make us better. But we don't necessarily recognize all the hardworking public health professionals who keep entire populations healthy. We should thank public health when we eat in clean restaurants, drink clean water, are treated in safe health care facilities, and don't get an infection from a haircut or pedicure. Public health's responsibilities include tracking and preventing deadly epidemics, promoting healthy behaviors like quitting smoking, exercise, and healthy eating, vaccination programs, and protection from environmental health hazards.

There is a growing recognition that the impact of health care services on outcomes is limited. Studies estimate that health care services account for only 10 percent of premature deaths, while public health factors account for 60 percent. Public health has led efforts to address the social determinants of health, tackling problems such as inadequate housing, unhealthy food, building safe and supportive neighborhoods, poverty and inadequate education. It has taken awhile, but the health care system is coming to recognize the importance of social determinants in health.

There is still a great deal of work to do, as health care leaders tend to think of population health in terms of their insured members or their patients, while public health officials are concerned with all of us, especially those without links to health insurance or providers. Health care systems are beginning to understand that writing a prescription for a patient who can't afford to fill it won't help, discharging a homeless patient back to the streets won't work, and if patients can't afford healthy food, it will be harder to heal.

Unfortunately, recognition of social determinants by health care systems so far has been limited to new payment models pushing financial incentives to make referrals to already strained public health and community resources. But when costs go down, payers, health care systems and providers split up all the savings. There is no compensation for the increased responsibility laid upon public health and community resources, which just adds to the imbalance.

At a recent meeting of local health directors, we learned about exciting new tools to connect public health and health care systems. When I asked about the free rider problem, there were a lot of nodding heads in the audience. The answer was that public health should do it anyway because it's the right thing to do. Unfortunately, that's not sustainable. Connecticut's public health professionals are already doing more with less. Expecting them to also solve our over-funded health care system's cost problems, without new resources, is not realistic. Public health is a public good. To lower health costs and keep people well, we have to invest in public health.

Ellen Andrews, PhD, is the executive director of the CT Health Policy Project. Follow her on Twitter @CTHealthNotes. This column first appeared on CTNewsJunkie.com.

Letters: 300-word limit, signed and phone number included. We reserve right to edit for space and clarity. Send to New Haven Register, HAVE YOUR SAY, 100 Gando Dr., New Haven, 06513; or email to letters@nhregister.com.

2018-2019 Influenza Season Update for Week 1*

(The week ending on Saturday, January 5, 2019)

Key Points

- ✓ Classification of Connecticut geographic activity remains at **widespread**** for week 1.
- ✓ Influenza activity has rapidly increased in Connecticut during the past several weeks.
- ✓ Influenza A viruses are the predominate type circulating; very few flu B viruses are now being reported.
- ✓ The U.S. Centers for Disease Control and Prevention (CDC) recent reports on the percentage of people nationally seeing their health care provider with influenza-like-illness (ILI) has increased to 4.1%, above the national baseline of 2.2% for elevated ILI activity.
- ✓ There is still time for you and your family to obtain your flu vaccine and take steps to prevent influenza-related illness and hospitalization: https://portal.ct.gov/DPH/Immunizations/Seasonal-Influenza

The Department of Public Health (DPH) uses multiple surveillance systems to monitor circulating flu viruses throughout the year. Data are updated with available information each week starting in October and ending in May. Consider current week data preliminary due to delays in reporting and confirmation.

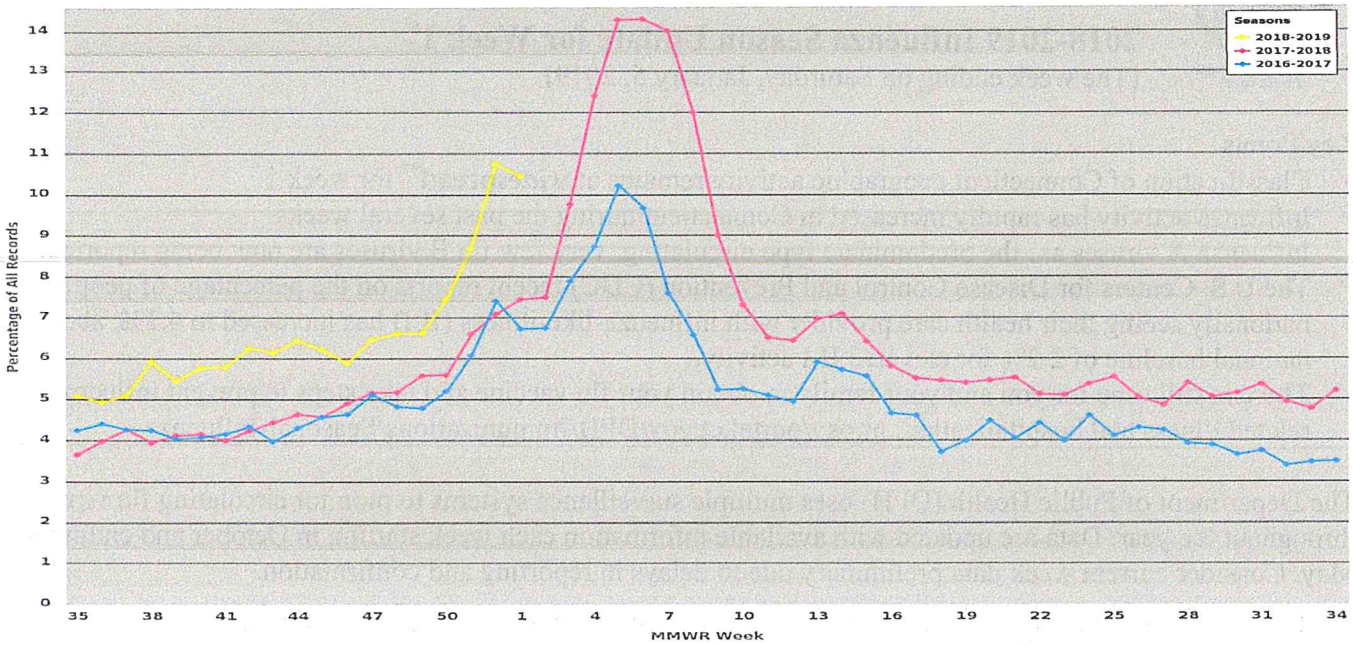
- The percentage of statewide emergency department visits attributed to the "fever/flu syndrome" has decreased slightly from 10.8% in week 52 to 10.4% in week 1 (Figure 1). Caution should be used when comparing the 2018-2019 EpiCenter syndromic surveillance data to 2016-2017 and 2017-2018 Hospital Emergency Department Syndromic Surveillance System data†.
- The percentage of outpatient visits with influenza-like illness (ILI) is currently 5.1%, above the level of 1%, generally considered the minimum threshold for elevated influenza-associated visits in the outpatient setting in Connecticut (Figure 2).
- To date, a total of 377 hospitalized patients with laboratory-confirmed influenza admitted between August 26 and January 5, 2019 have been reported. Of these, 333 were associated with type A (subtype unspecified), 25 influenza A (2009 H1N1), 6 influenza A (H3N2), and 13 influenza B viruses (Figures 3 & 4).
- Two flu-associated death which occurred in week 1were reported resulting in a total of 6 deaths reported through week 1 in Connecticut. Five flu-associated deaths were associated with influenza A (unspecified) and 1 with influenza B. Of the 6 total reported flu-associated deaths, 4 occurred in persons >65 years of age, 1 in a person 50-64 years of age, and 1 in a person 25-49 years of age.
- A total of 1,039 influenza positive laboratory tests have been reported during the current season (August 26 – January 5, 2019): Hartford County (342), New Haven (314), Fairfield (172), Middlesex (62), New London (48), Litchfield (43), Tolland (29), Windham (23) and 6 in currently unknown counties. Of the positive reports, 878 were influenza A (subtype unspecified), 98 influenza A (2009 H1N1), 11 influenza A (H3N2), and 52 influenza B (Figures 5 & 6).

** Week numbers refer to the Morbidity and Mortality Weekly Report calendar used by the Centers for Disease Control and Prevention (CDC) for national disease surveillance.*

*** Definitions for the estimated levels of geographic spread of influenza activity available at: http://www.cdc.gov/flu/weekly/overview.htm*

† The EpiCenter system replaced the Hospital Emergency Department Syndromic Surveillance System; 18 additional emergency department facilities send data to the EpiCenter.

Figure 1. Percentage of Statewide Emergency Department Visits Attributed to "Fever/Flu Syndrome", 2016-17, 2017-18, 2018-19*



*Caution should be used when comparing EpiCenter surveillance data to 2016-17 and 2017-18 Hospital Emergency Department Syndromic Surveillance system data.

Figure 2. Outpatient Influenza-Like Illness Surveillance Network (ILINet), Percentage of Patients with Influenza-Like Illness (ILI); 2016-17, 2017-18, 2018-19

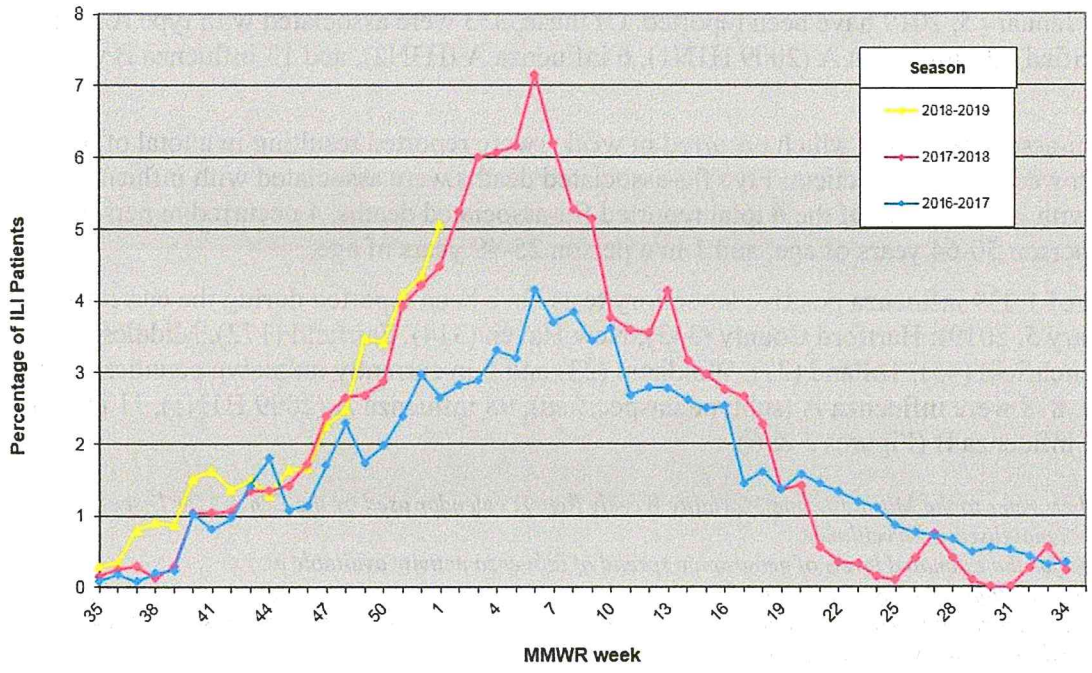


Figure 3. Hospitalized Patients (n = 377) with Positive Lab Tests by Subtype & Week, Connecticut, through 1/5/2019

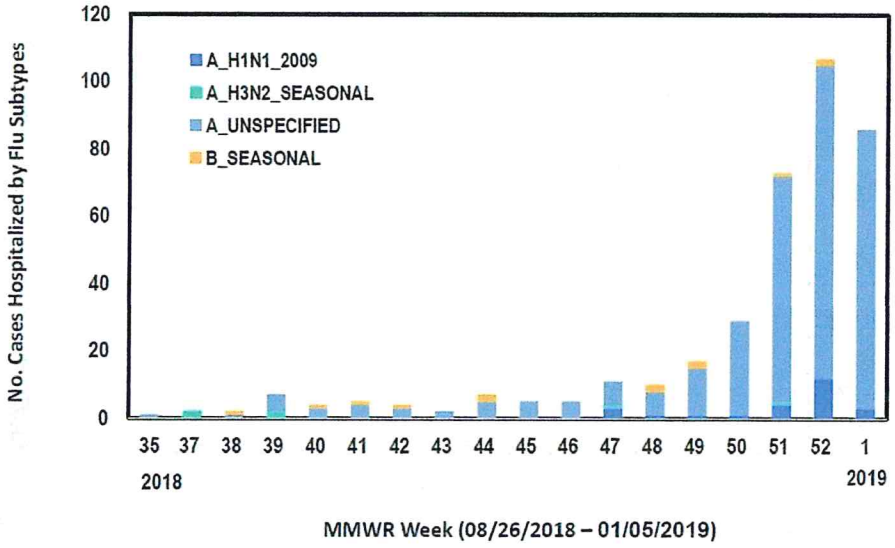


Figure 4. Hospitalized Patients (n=377) with Positive Laboratory Tests by Influenza Subtype and Age Group, Connecticut, through 1/5/2019

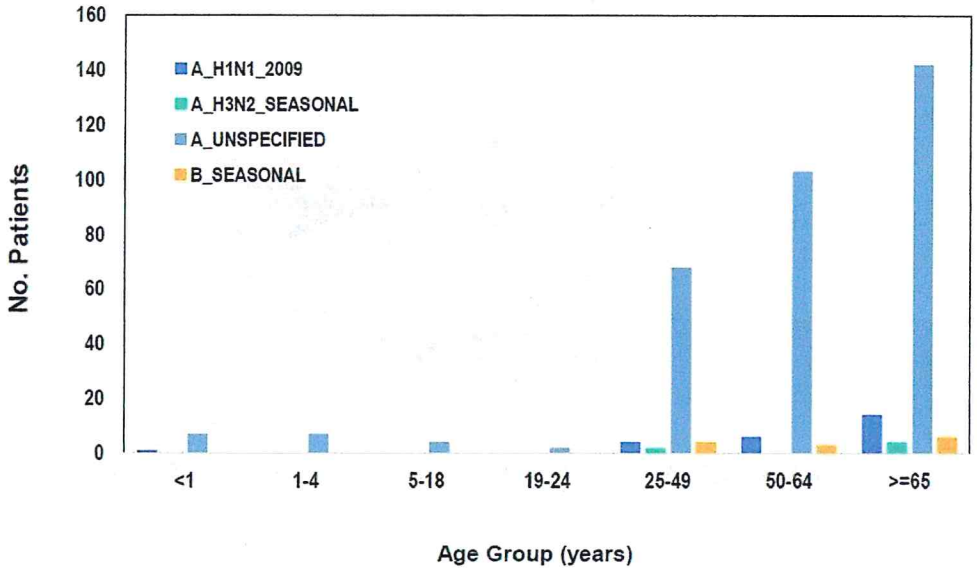


Figure 5. Positive Laboratory Tests (n = 1039) by Influenza Subtype and Week, Connecticut, through 1/5/2019

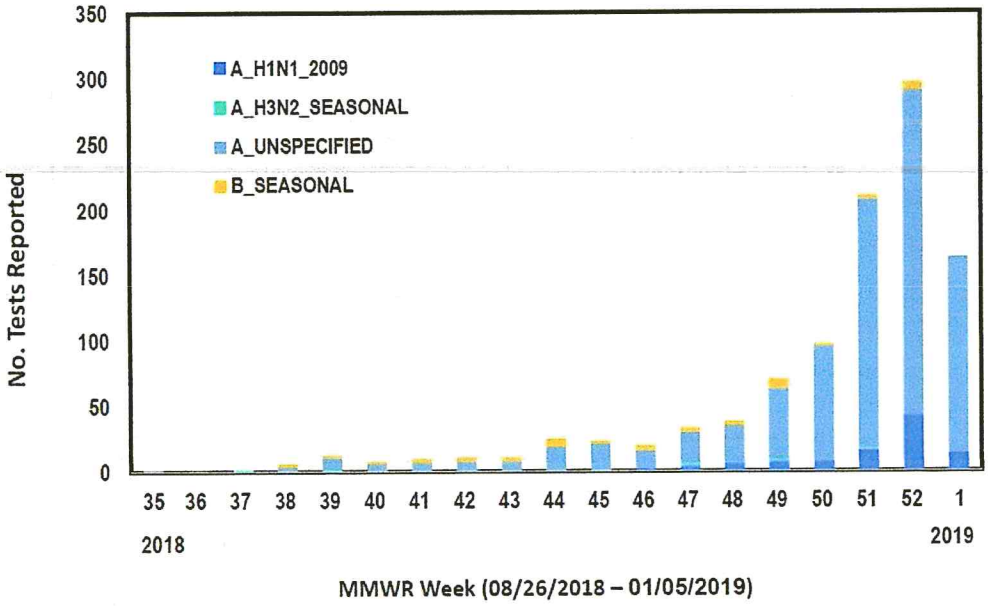
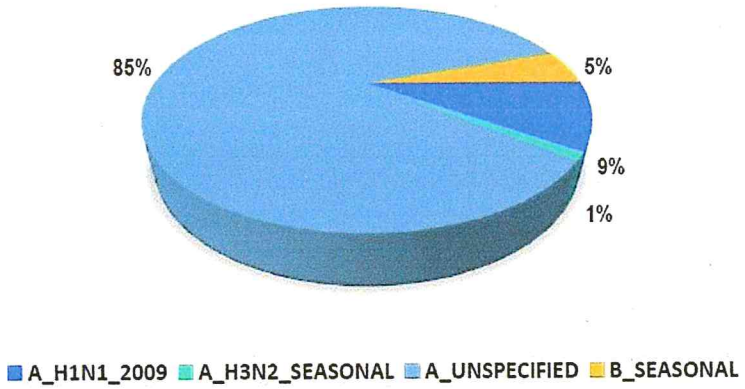


Figure 6. Proportion of Cumulative Positive Laboratory Tests (n = 1039) by Influenza Subtype, Connecticut, through 1/5/2019



Influenza Surveillance System Definitions

The EpiCenter System: This system receives near real-time reports on ED visits from all 38 licensed, hospital emergency departments in Connecticut. Data include a description of the chief complaint, or reason for visit, including fever/flu. The EpiCenter system replaced the Hospital Emergency Department Syndromic Surveillance system (HEDSS). During 2017-2018, 18 additional emergency department facilities began sending data to the EpiCenter, and caution should be used when comparing EpiCenter surveillance data to historical HEDSS data.

Sentinel Provider Surveillance: Reporting of influenza-like illness (ILI) is conducted through a statewide network of volunteer outpatient providers known as ILINet. The proportion of patients exhibiting ILI is reported to the DPH on a weekly basis. ILI is defined as a cough and/or sore throat in the absence of a known cause, and the presence of a fever $\geq 100^{\circ}$ F.

Influenza-associated Hospitalizations and/or Deaths: Providers are required to report influenza-associated hospitalizations and influenza-associated deaths, they are not required to report any positive influenza test results. Data collected describe the more serious illnesses associated with influenza infections.

Laboratory Surveillance. In Connecticut, positive influenza results are reportable by the laboratory conducting the test. Rapid antigen results are only reportable by laboratories with electronic file reporting. These results are used to determine what types, subtypes, and strains are circulating.

To my Local Health Colleagues:

As you are well aware, whenever there is a change in the Governorship there is typically change in leadership at Connecticut's many agencies. As is the case, I was informed on Friday shortly before noon that Governor-elect Lamont decided to appoint someone else for Health Commissioner. I was assured that this was not a reflection of our collective work under my leadership, but rather a decision made based on the Governor-elect's desire to move in a different direction. Never one to shy away from the truth, I will share that it was harder to hear the news than I had anticipated; after spending the last 3-1/2 years here, I know that I fully comprehend the things we need to do to move Public Health in Connecticut forward and was looking to continue steering this amazing agency and championing the great work you all do to keep Connecticut as healthy and safe as possible.

While we have not uniformly agreed about the strategy nor my vision to collectively maximize our public health clout, I hope that I was able to convey respect and an understanding of the difficulties and limitations that Local Health faces daily; remember, I was right there with you 4 years ago. But even so, I am certain that a few of our Local Health colleagues will be happy upon receiving this news, and that is fine because we can't please everyone. But by and large, you are some of the most sincere and dedicated professionals who are looking to achieve the best for your communities and until we speak with one voice, despite our differences, or we will not advance Public Health in Connecticut. None is better positioned than each of you to be the voices of the many "invisible" residents who live in Connecticut. If I could leave you with a suggestion: support the next Public Health Commissioner, think collaboratively and work together, and be the best possible advocates for your communities.

Each Health Department or Health District, including DPH, is more than an agency; we create the conditions in which people can be the healthier version of themselves. We should all be proud of our work, the many things we have accomplished, and the success that lays ahead for each of you. DPH is such an amazing place that I would not rule out working here in another capacity if I get to be that lucky. With this being my second tour at DPH, let's see how the adage "third time's the charm" holds up!

So even though as of today the next step in my career is uncertain, I am committed to working in the best interest for our state up until the last minute of my tenure. I do not yet know who the nominee for the next Commissioner is nor when my final day will be, but I will share those details with you once I learn of them. I only ask for one big fat favor: no regrets, no "sorry" emails , no goodbye parties, and no presents. I hope you understand that this not out of an ungrateful soul, but it is difficult for me to handle goodbyes and this is a big one! I have so enjoyed every minute of my time here and have no regrets. I got to work with people I admire and led 700-plus colleagues who do incredible work. I informed Governor Malloy of the Governor-elect's decision by email, to which he immediately called me to express not only his gratitude for my service but was highly complementary of our work...your work.

If you wish to reach out to me once I leave, here is my personal email as well as my mobile number: raulpinomd@gmail.com and (860) 692-4658.

Raul

Raul Pino MD/MPH
Commissioner
Connecticut Department of Public Health
410 Capitol Avenue
Hartford, CT 06134
Phone - 860-509-7101
raul.pino@ct.gov

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

January 7, 2019

Robert L. Miller, Director of Health
Eastern Highlands Health District
4 South Eagleville Road
Mansfield, CT 06268

Dear Mr. Miller:

On behalf of the Connecticut Department of Public Health, thank you for participating in the recent Statewide Influenza Campaign, held on December 1st and 8th, 2018. Please also extend our appreciation to your staff and volunteers, whose hard work was instrumental in making these flu clinics a success.

The clinics, held during National Influenza Vaccination Week, helped promote the importance of being protected against the influenza virus. They also increased access to influenza vaccine for those most at risk, including the uninsured, underinsured, and lower income families.

Your efforts to promote public health programs, such as these flu clinics, and enhance your public health emergency preparedness capabilities are valued and critical to ensuring the health of our state. Thank you for partnering with us on this important initiative.

Sincerely,

Raul Pino, M.D., M.P.H
Commissioner

Cc: Elizabeth Paterson, Chairman, Eastern Highlands Health District

Connecticut Department of Public Health

Connecticut Epidemiologist

Volume 39, No. 1 January 2019

Reportable Diseases, Emergency Illnesses and Health Conditions, and Reportable Laboratory Findings Changes for 2019

As required by Conn. Gen. Stat. §19a-2a and Conn. Agencies Regs. §19a-36-A2, the Commissioner of the Department of Public Health (DPH) is required to declare an annual list of Reportable Diseases, Emergency Illnesses and Health Conditions, and Reportable Laboratory Findings. The list of Reportable Diseases, Emergency Illnesses and Health Conditions has two parts: (A) reportable diseases; and (B) reportable emergency illnesses and conditions. An advisory committee, consisting of public health officials, clinicians, and laboratorians, contribute to the process. There is 1 modification to the healthcare provider list only; 2 additions and 5 modifications to the laboratory list only; and 2 additions to both the physician and laboratory lists. No changes have been made to emergency illnesses or health conditions.

Reportable disease forms can be found on the DPH "Forms" webpage at: https://portal.ct.gov/DPH/Communications/Forms/Forms.

Changes to the List of Reportable Diseases, Emergency Illnesses and Health Conditions

Part A: Reportable Diseases

HIV—acute cases

Reporting of acute HIV cases has been modified. Acute HIV cases will be reported as Category 1 diseases, which require a telephone call to the DPH immediately on the day of recognition or strong suspicion.

Changes to the List of Reportable Laboratory Findings

Candida spp, blood isolates only

Laboratory reporting of *Candida* species from blood specimens only has been added. Laboratories should submit all *Candida* spp. blood isolates to the State Public Health Laboratory for speciation and antifungal susceptibility testing. Reporting for *Candida auris* remains unchanged; *Candida auris* from all sites and any potential *Candida auris* misidentifications should still be reported.

Enterotoxigenic Escherichia coli (ETEC)

Laboratory reporting of Enterotoxigenic *E. coli* (ETEC) has been added. This addition will allow DPH to estimate the number of ETEC positive tests typically identified by multiplex PCR GI panels that include ETEC and to conduct follow-up activities.

Group B Streptococcus (GBS)

Laboratory reporting of Group B *Streptococcus* has been modified. Laboratories should submit infant (<1 year of age) GBS isolates to the State Public Health Laboratory.

Hepatitis A

Laboratory reporting of Hepatitis A (HAV) has been modified. Laboratories should report (when available), nucleic acid/RNA test results and total bilirubin level conducted within 7 days of a positive test. These changes will align HAV surveillance with the national HAV case definition.

Hepatitis C

Laboratory reporting of Hepatitis C virus (HCV) has been modified. All labs are required to report HCV genotype results, either by paper or electronically. Laboratories are encouraged to develop policies consistent with CDC guidance for reflex HCV RNA testing following an initial reactive HCV antibody test.

Influenza

Laboratory reporting of influenza has been modified. Laboratories should report positive influenza results to the DPH only. Dual reporting to local health

(Continued on page 4)

In this issue...

REPORTABLE DISEASES, EMERGENCY ILLNESSES and HEALTH CONDITIONS - 2019

PART A: REPORTABLE DISEASES

Physicians, and other professionals are required to report using the Reportable Disease Confidential Case Report form (PD-23), other disease specific form or authorized method (see page 4 for additional information). Forms can be found on the DPH "Forms" webpage or by calling 860-509-7994. Mailed reports must be sent in envelopes marked "CONFIDENTIAL." Changes for 2019 are in **bold font** .

Category 1 Diseases: Report immediately by telephone (860-509-7994) on the day of recognition or strong suspicion of disease for those diseases marked with a telephone (☎). On evenings, weekends, and holidays call 860-509-8000. These diseases must also be reported by mail within 12 hours.

Category 2 Diseases: All other diseases not marked with a telephone must be reported by mail within 12 hours of recognition or strong suspicion of disease.

Acquired Immunodeficiency Syndrome (1,2)
Acute flaccid myelitis
☎ **Acute HIV infection**
☎ Anthrax
Babesiosis
***Borrelia miyamotoi* disease**
☎ Botulism
☎ Brucellosis
California group arbovirus infection
Campylobacteriosis
Candida auris
Carbon monoxide poisoning (3)
Chancroid
Chickenpox
Chickenpox-related death
Chikungunya
Chlamydia (*C. trachomatis*) (all sites)
☎ Cholera
Cryptosporidiosis
Cyclosporiasis
Dengue
☎ Diphtheria
Eastern equine encephalitis virus infection
Ehrlichia chaffeensis infection
Escherichia coli O157:H7 gastroenteritis
Gonorrhea
Group A Streptococcal disease, invasive (4)
Group B Streptococcal disease, invasive (4)
Haemophilus influenzae disease, invasive (4)
Hansen's disease (Leprosy)
Healthcare-associated Infections (5)
Hemolytic-uremic syndrome (6)
Hepatitis A
Hepatitis B:
- acute infection (2)
- HBsAg positive pregnant women

Hepatitis C:
- acute infection (2)
- positive rapid antibody test result

HIV-1 / HIV-2 infection in: (1)
- persons with active tuberculosis disease
- persons with a latent tuberculous infection (history or tuberculin skin test ≥5mm induration by Mantoux technique)
- persons of any age
- pregnant women

HPV: biopsy proven CIN 2, CIN 3 or AIS or their equivalent (1)
Influenza-associated death (7)
Influenza-associated hospitalization (7)
Legionellosis
Listeriosis
Lyme disease
Malaria
☎ Measles
☎ Melioidosis
☎ Meningococcal disease
Mercury poisoning
Mumps
Neonatal bacterial sepsis (8)
Neonatal herpes (≤ 60 days of age)
Occupational asthma
☎ Outbreaks:
- Foodborne (involving ≥ 2 persons)
- Institutional
- Unusual disease or illness (9)

Pertussis
☎ Plague
Pneumococcal disease, invasive (4)
☎ Poliomyelitis
Powassan virus infection
☎ Q fever
☎ Rabies
☎ Ricin poisoning
Rocky Mountain spotted fever
Rubella (including congenital)
Salmonellosis
☎ SARS-CoV
Shiga toxin-related disease (gastroenteritis)
Shigellosis
Silicosis
☎ Smallpox
St. Louis encephalitis virus infection
☎ Staphylococcal enterotoxin B pulmonary poisoning
☎ *Staphylococcus aureus* disease, reduced or resistant susceptibility to vancomycin (1)
Staphylococcus aureus methicillin-resistant disease, invasive, community acquired (4,10)
Staphylococcus epidermidis disease, reduced or resistant susceptibility to vancomycin (1)
Syphilis
Tetanus
Trichinosis
☎ Tuberculosis
☎ Tularemia
Typhoid fever
Vaccinia disease
☎ Venezuelan equine encephalitis virus infection
Vibrio infection (*parahaemolyticus, vulnificus*, other)
☎ Viral hemorrhagic fever
West Nile virus infection
☎ Yellow fever
Zika virus infection

FOOTNOTES:

1. Report only to State.
2. As described in the CDC case definition.
3. Includes persons being treated in hyperbaric chambers for suspected CO poisoning.
4. Invasive disease: from sterile fluid (blood, CSF, pericardial, pleural, peritoneal, joint, or vitreous) bone, internal body sites, or other normally sterile site including muscle.
5. Report HAIs according to current CMS pay-for-reporting or pay-for-performance requirements. Detailed instructions on the types of HAIs, facility types and locations, and methods of reporting are available on the DPH website: https://portal.ct.gov/DPH/Infectious-Diseases/HAI/Healthcare-Associated-Infections-and-Antimicrobial-Resistance.
6. On request from the DPH and if adequate serum is available, send serum from patients with HUS to the DPH Laboratory for antibody testing.
7. Reporting requirements are satisfied by submitting the Hospitalized and Fatal Cases of Influenza-Case Report Form in a manner specified by the DPH.
8. Clinical sepsis and blood or CSF isolate obtained from an infant ≤ 72 hours of age.
9. Individual cases of "significant unusual illness" are also reportable.
10. Community-acquired: infection present on admission to hospital, and person has no previous hospitalizations or regular contact with the health-care setting.

How to report: The PD-23 is the general disease reporting form and should be used if other specialized forms are not available. The PD-23 can be found on the DPH "Forms" webpage (https://portal.ct.gov/DPH/Communications/Forms/Forms). It can also be ordered by writing the Department of Public Health, 410 Capitol Ave., MS#11FDS, P.O. Box 340308, Hartford, CT 06134-0308 or by calling the Epidemiology and Emerging Infections Program (860-509-7994). Specialized reporting forms are available on the DPH "Forms" webpage or by calling the following programs: Epidemiology and Emerging Infections Program (860-509-7994) - Hospitalized and Fatal Cases of Influenza, Healthcare Associated Infections (860-509-7995) - National Healthcare Safety Network, HIV/AIDS Surveillance (860-509-7900) - Adult HIV Confidential Case Report form, Immunizations Program (860-509-7929) - Chickenpox Case Report (Varicella) form, Occupational Health Surveillance Program (860-509-7740) - Physician's Report of Occupational Disease, Sexually Transmitted Disease Program (860-509-7920), and Tuberculosis Control Program (860-509-7722). National notifiable disease case definitions are found on the CDC website.

Telephone reports of Category 1 disease should be made to the local Director of Health for the town in which the patient resides, and to the Epidemiology and Emerging Infections Program (860-509-7994). Tuberculosis cases should be directly reported to the Tuberculosis Control Program (860-509-7722). For the name, address, or telephone number of the local Director of Health for a specific town contact the Office of Local Health Administration (860-509-7660).

For public health emergencies on evenings, weekends, and holidays call 860-509-8000.

departments will be facilitated through a shared database (CTEDSS) maintained by DPH.

Yersinia (not pestis)

Laboratory reporting of *Yersinia* (not pestis) has been modified to require submission of *Yersinia* (not pestis) isolates, or stool specimens if no isolate is recovered for positive culture-independent testing results, to the State Public Health Laboratory for confirmation/isolation of the organism.

Changes to Both Lists

Borrelia miyamotoi

Reporting of *Borrelia miyamotoi* has been added. *B. miyamotoi* is an emerging tick-borne pathogen, which has been identified in *Ixodes scapularis* ticks in Connecticut. State surveillance will assist in characterizing the incidence, epidemiology, and clinical spectrum of *B. miyamotoi* disease in Connecticut.

Powassan virus

Reporting of Powassan virus has been added. Powassan virus is a tick-borne arbovirus, which has been identified in *Ixodes* species ticks and in humans in Connecticut. State surveillance will contribute to national surveillance to better understand the epidemiology of the infection.

Persons Required to Report Reportable Diseases, Emergency Illnesses and Health Conditions

1. Every health care provider who treats or examines any person who has or is suspected to have a reportable disease, emergency illness or health condition shall report the case to the local director of health or other health authority within whose jurisdiction the patient resides and to the Department of Public Health.
2. If the case or suspected case of reportable disease, emergency illness or health condition is in a health care facility, the person in charge of such facility shall ensure that reports are made to the local director of health and Department of Public Health. The person in charge shall designate appropriate infection control or record keeping personnel for this purpose.
3. If the case or suspected case of reportable disease, emergency illness or health condition is not in a health care facility, and if a health care provider is not in attendance or is not known to have made a report within the appropriate time, such report of reportable disease, emergency illness or health condition shall be made to the local director of health or other health authority within whose jurisdiction the patient lives and the Department of Public Health by:
   A. the administrator serving a public or private school or day care center attended by any person affected or apparently affected with such disease, emergency illness or health condition;
   B. the person in charge of any camp;
   C. the master or any other person in charge of any vessel lying within the jurisdiction of the state;
   D. the master or any other person in charge of any aircraft landing within the jurisdiction of the state;
   E. the owner or person in charge of any establishment producing, handling, or processing dairy products, other food or non-alcoholic beverages for sale or distribution;
   F. morticians and funeral directors

Persons Required to Report Reportable Laboratory Findings

The director of a laboratory that receives a primary specimen or sample, which yields a reportable laboratory finding, shall be responsible for reporting such findings within 48 hours to the local director of health of the town in which the affected person normally resides. In the absence of such information, the reports should go to the town from which the specimen originated and to the Department of Public Health.

IMPORTANT NOTICE

Persons required to report must use the Reportable Disease Confidential Case Report Form PD-23 to report Reportable Diseases, Emergency Illnesses and Health Conditions on the current list unless there is a specialized reporting form or other authorized method available. The director of a clinical laboratory must report laboratory evidence suggestive of reportable diseases using the Laboratory Report of Significant Findings Form OL-15C or other approved format by the DPH. Reporting forms can be found on the DPH "Forms" webpage: (https://portal.ct.gov/DPH/Communications/Forms/Forms) or by calling 860-509-7994. Please follow these guidelines when submitting reports:

- Mailed documents must have "CONFIDENTIAL" marked on the envelope.
- All required information on the form must be completed, including name, address, and phone number of person reporting and healthcare provider, infectious agent, test method, date of onset of illness, and name, address, date of birth, race, ethnicity, gender, and occupation of patient.
- Send one copy of completed report to the DPH via fax (860-509-7910), or mail to: Connecticut Department of Public Health, 410 Capitol Ave., MS#11FDS, P.O. Box 340308, Hartford, CT 06134-0308.
- Unless otherwise noted, send one copy of the completed report to the Director of Health of the patient's town of residence.
- Keep a copy in the patient's medical record.

Raul Pino, MD, MPH
Commissioner of Public Health

Matthew L. Cartter, MD, MPH
State Epidemiologist

Lynn Sosa, MD
Deputy State Epidemiologist

Epidemiology and Emerging Infections	860-509-7995
Healthcare Associated Infections	860-509-7995
HIV & Viral Hepatitis	860-509-7900
Immunizations	860-509-7929
Sexually Transmitted Diseases (STD)	860-509-7920
Tuberculosis Control	860-509-7722

Connecticut Epidemiologist

Editor: Matthew L. Cartter, MD, MPH

Assistant Editor & Producer:
Starr-Hope Ertel

REPORTABLE LABORATORY FINDINGS—2019

The director of a clinical laboratory must report laboratory evidence suggestive of reportable diseases (see page 4 for additional information. The Laboratory Report of Significant Findings form (OL-15C) can be found on the DPH "Forms" webpage or by calling 860-509-7994. Changes for 2019 are in **bold font**.

Anaplasma phagocytophilum by PCR only
Babesia: ☐ IFA IgM (titer) _____ IgG (titer) _____
☐ Blood smear ☐ PCR ☐ Other _____
☐ *microti* ☐ *divergens* ☐ *duncani* ☐ Unspeciated
Bordetella pertussis (titer) _____
☐ Culture (1) ☐ Non-pertussis *Bordetella* (1) (specify) _____
☐ DFA ☐ PCR
Borrelia burgdorferi (2)
Borrelia miyamotoi
California group virus (3) spp _____
Campylobacter (3) spp _____ ☐ Culture ☐ PCR ☐ EIA
Candida auris (1,4)
***Candida* spp. [blood isolates only]:** _____ **(1,3)**
Carbapenem-resistant *Acinetobacter baumannii* (CRAB) (1,5)
Carbapenem-resistant Enterobacteriaceae (CRE) (1,3,5)
Genus _____ spp _____
Carboxyhemoglobin ≥ 5% _____% COHb
Chikungunya virus
Chlamydia trachomatis (test type) _____
Clostridium difficile (6)
Corynebacterium diphtheria (1)
Cryptosporidium spp (3) _____ ☐ PCR ☐ DFA ☐ EIA
☐ Microscopy ☐ Other: _____
Cyclospora spp (3) _____ ☐ PCR ☐ Microscopy ☐ Other: _____
Dengue virus
Eastern equine encephalitis virus
Ehrlichia chaffeensis by PCR only
Enterotoxigenic *Escherichia coli* (ETEC) ☐ Culture ☐ PCR
Escherichia coli O157 (1) ☐ Culture ☐ PCR
Giardia spp (3) _____
Group A *Streptococcus*, invasive (1,5) ☐ Culture ☐ Other _____
Group B *Streptococcus*, invasive (1,5) ☐ Culture ☐ Other _____
Haemophilus ducreyi
Haemophilus influenzae, invasive (1,5) ☐ Culture ☐ Other _____
Hepatitis A virus (HAV): ☐ IgM anti-HAV (7) ☐ **NAAT Positive (7)**
ALT _____ **Total Bilirubin** _____ ☐ Not Done
Hepatitis B HBsAg ☐ Positive ☐ Negative (8)
☐ IgM anti-HBc ☐ HBeAg (2) ☐ HBV DNA (2)
anti-HBs (8) ☐ Positive (titer) _____ ☐ Negative
Hepatitis C virus (HCV) **(9) ☐ Antibody** _____
☐ PCR/NAAT/RNA _____ **☐ Genotype specify** _____
Herpes simplex virus (infants ≤ 60 days of age)
☐ Culture ☐ PCR ☐ IFA ☐ Ag detection
HIV Related Testing (report only to the State) (10)
☐ Detectable Screen (IA)
Antibody Confirmation (WB/IFA/Type-diff) (10)
HIV 1 ☐ Positive ☐ Neg/Ind HIV 2 ☐ Positive ☐ Neg/Ind
☐ HIV NAAT (or qualitative RNA) ☐ Detectable ☐ Not Detectable
☐ HIV Viral Load (all results) (10) _____ copies/mL
☐ HIV genotype (10)
☐ CD4 count: _____ cells/uL; _____% (10)
HPV (report only to the State) (11)
Biopsy proven ☐ CIN 2 ☐ CIN 3 ☐ AIS
or their equivalent, (specify) _____
Influenza virus: **(report only to State)** ☐ Rapid antigen (2) ☐ RT-PCR
☐ Type A ☐ Type B ☐ Type Unknown
☐ Subtype _____
Lead poisoning (blood lead ≥10 µg/dL <48 hrs; 0-9 µg/dL monthly) (12)
☐ Finger stick level _____ µg/dL ☐ Venous level _____ µg/dL

Legionella spp _____
☐ Culture ☐ DFA ☐ Ag positive
☐ Four-fold serologic change (titers) _____
Listeria monocytogenes (1) ☐ Culture ☐ PCR
Mercury poisoning
☐ Urine ≥ 35 µg/g creatinine _____ µg/g
☐ Blood ≥ 15 µg/L _____ µg/L
Mumps virus (13) (titer) _____ ☐ PCR
Mycobacterium leprae
Mycobacterium tuberculosis Related Testing (1)
AFB Smear ☐ Positive ☐ Negative
If positive ☐ Rare ☐ Few ☐ Numerous
NAAT ☐ Positive ☐ Negative ☐ Indeterminate
Culture ☐ *Mycobacterium tuberculosis*
☐ Non-TB mycobacterium. (specify *M.* _____)
Neisseria gonorrhoeae (test type) _____
Neisseria meningitidis, invasive (1,5)
☐ Culture ☐ Other _____
Neonatal bacterial sepsis (3,14) spp _____
Plasmodium (1,3) spp _____
Poliovirus
Powassan virus
Rabies virus
Rickettsia rickettsii
Rubella virus (13) (titer) _____
Rubeola virus (Measles) (13) (titer) _____ ☐ PCR
St. Louis encephalitis virus
Salmonella (1,3) (serogroup & type) _____ ☐ Culture ☐ PCR
SARS-CoV (1) ☐ IgM/IgG
☐ PCR _____ (specimen) ☐ Other _____
Shiga toxin (1) ☐ Stx1 ☐ Stx2 ☐ Type Unknown
☐ PCR ☐ EIA
Shigella (1,3) (serogroup/spp) _____ ☐ Culture ☐ PCR
Staphylococcus aureus, invasive (5) ☐ Culture ☐ Other _____
☐ methicillin-resistant ☐ methicillin-sensitive
Staphylococcus aureus, vancomycin MIC ≥ 4 µg/mL (1)
MIC to vancomycin _____ µg/mL
Staphylococcus epidermidis, vancomycin MIC ≥ 32 µg/mL (1)
MIC to vancomycin _____ µg/mL
Streptococcus pneumoniae
☐ Culture (1,5) ☐ Urine antigen ☐ Other (5) _____
Treponema pallidum ☐ RPR (titer) _____ ☐ FTA ☐ EIA
☐ VDRL (titer) _____ ☐ TPPA
Trichinella
Varicella-zoster virus, acute
☐ Culture ☐ PCR ☐ DFA ☐ Other _____
Vibrio (1,3) spp _____ ☐ Culture ☐ PCR
West Nile virus
Yellow fever virus
Yersinia, not *pestis* (1 ,3) spp _____ ☐ Culture ☐ PCR
Zika virus

BIOTERRORISM possible disease indicators (15)

Bacillus anthracis (1)	*Brucella* spp (1)
Burkholderia mallei (1)	*Burkholderia pseudomallei* (1)
Clostridium botulinum	*Coxiella burnetii*
Francisella tularensis	Ricin
Staphylococcus aureus - enterotoxin B	Variola virus (1)
Venezuelan equine encephalitis virus	
Viral agents of hemorrhagic fevers	*Yersinia pestis* (1)

1. Send isolate/specimen to DPH Laboratory. **For GBS, send isolate for cases <1 year of age.** For *Salmonella*, *Shigella*, *Vibrio*, **and Yersinia (not pestis)** tested by non-culture methods, send isolate if available; send stool specimen if no isolate available. For Shiga toxin-related disease, send positive broth or stool specimen.
2. Only laboratories with electronic file reporting are required to report positive results.
3. Specify species/serogroup/serotype.
4. Include samples from all sites.
5. Sterile site: sterile fluids (blood, CSF, pericardial, pleural, peritoneal, joint, or vitreous), bone, internal body site (lymph node, brain, heart, liver, spleen, kidney, pancreas, or ovary), or other normally sterile site including muscle. For CRE and CRAB, also include urine or sputum; for CRAB also include wounds.
6. Upon request from the DPH, report all *C. difficile* positive stool samples.
7. Report peak ALT and **Total Bilirubin** results if conducted within one week of HAV positive test, if available. Otherwise, check "Not Done".
8. Negative *HBsAg* and *all* anti-HBs results only reportable for children ≤ 2 years old.
9. **Report positive Antibody, and all RNA and Genotype results. Negative RNA results only reportable by electronic reporting. For HCV test result reporting, contact (860) 509-7768 for specific form.**
10. Report all HIV antibody, antigen, viral load, and qualitative NAAT results. HIV genotype (DNA sequence) and all CD4 results are only reportable by electronic file.
11. Upon request from the DPH, send fixed tissue from the diagnostic specimen for HPV typing.
12. Report results ≥ 10 µg/dL within 48 hours to the Local Health Department and DPH; submit ALL lead results at least monthly to DPH only.
13. Report *all* IgM positive titers, only report IgG titers considered significant by laboratory performing the test.
14. Report all bacterial isolates from blood or CSF from infants ≤ 72 hours of age.
15. Call the DPH, weekdays 860-509-7994; evenings, weekends, and holidays 860-509-8000.

From: Robert L. Miller
Sent: Friday, December 14, 2018 1:25 PM
To: 'Andover Superintendant'; 'Ashford Superintendant'; 'Bolton Superintendant'; 'Chaplin Superintendant'; 'Columbia Superintendant'; 'Coventry Superintendant'; 'Frances Baran (fbaran@scotlandes.org)'; 'Mansfield Superintendant (k-8)'; 'Region 8 Superintendent'; 'supt@eosmith.org'; 'Tolland Superintendent'; 'Kelly Lyman'; 'Willington Superintendant'
Cc: Millie C. Brosseau; Jeffrey W. Polhemus
Subject: FY 19/20 Expense Reminder

Greetings School Superintendents – As you begin work to develop your operating budgets, this is a friendly reminder that an annual licensing fee for school food service operations took effect on July 1, 2018.

The annual licensing fee *per school* will be either $355 or $380, depending on the class definition that each school food operation falls within. Specifically, if you have an child care program licensed by the CT Office of Early Childhood operating out of a school, *and* kitchen operations support that program, then the higher fee rate will apply.

Please let me know if you have any questions.

Yours in Health,
Rob

Robert L. Miller, MPH, RS
Director of Health
Eastern Highlands Health District
4 South Eagleville Road
Storrs, CT 06268
860-429-3325
860-429-3321 (Fax)
Twitter: @RobMillerMPH
www.ehhd.org

EHHD
Eastern Highlands Health District

Preventing Illness and Promoting Wellness in the Communities We Serve

From: Allyson Schulz <aschulz@qualityperspectives.com>
Sent: Wednesday, December 26, 2018 10:19 PM
To: Derek N. May
Cc: Robert L. Miller
Subject: RE: FYI : EHHD MRC Thank You

Very nice, Derek! You and Brian have made significant strides with EHHD MRC this year – thank you for all your hard work!

Best,

Allyson

From: Derek N. May [mailto:MayDN@ehhd.org]
Sent: Wednesday, December 26, 2018 4:01 PM
To: 'aschulz@qualityperspectives.com'; 'Brittany Otto'; 'Linda Colangelo'
Subject: FYI : EHHD MRC Thank You

FYI end of year message sent to our EHHD MRC volunteers today.

From: Brian Clinton
Sent: Wednesday, December 26, 2018 3:56 PM
To: Derek N. May <MayDN@ehhd.org>
Subject: EHHD MRC Thank You

medical reserve corps

December 26, 2018

To EHHD Medical Reserve Corps (EHHD MRC):

We at the Eastern Highlands Health District want to offer our sincerest thanks and appreciation for your time, effort, and work put forth with the Medical Reserve Corps program during 2018. Your commitment to making our communities safer and healthier is very much appreciated. We are extremely fortunate to have outstanding volunteers who lead by example and step-up when called upon.

Here are some of the events that the EHHD MRC has helped with in 2018:

- Hosted a health screening table at the Ashford Spring Jamboree.
- Conducted four sessions of "Until Help Arrives" in Ashford, Coventry, Willimantic, and Coventry.
- Welcomed several new members into the EHHD MRC.
- Staffed the Medical Aid Station Team (MAST) at the Hartford Marathon
- Supported the Region 4 drive-through flu clinic/infectious disease exercise in New London.

- Staffed two seasonal flu clinics in Mansfield and Coventry.

We look forward to working with each of you in 2019 and to continuing to increase the capability and capacity of our EHHD MRC units. This upcoming year be on the lookout for more Until Help Arrives workshops, assisting UConn with a Radiological Emergency Preparedness Drill, vaccination clinics, and more.

Best wishes to you and your families for a wonderful and Happy New Year!

Brian Clinton, MA, MCHES
Community Health and Wellness Coordinator
Medical Reserve Corps Coordinator
Eastern Highlands Health District
4 South Eagleville Rd.
Mansfield, CT 06268
Main Office: 860.429.3325
FAX: 860.429.3321