CATTARAUGUS COUNTY BOARD OF HEALTH

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Public Health
Prevent. Promote. Protect.
Cattaraugus County
Health Department
Established 1923

MINUTES
March 7, 2018

The 863rd meeting of the Cattaraugus County Board of Health was held at The Point Restaurant, 800 East State Street, Olean, New York on March 7, 2018.

The following members were present:

Dr. Joseph Bohan	Theresa Raftis
Dr. Giles Hamlin	Mayor David Smith
Sondra Fox, RN	Jim Snyder, Legislator Chair
Richard Haberer	Kathryn Cooney Thrush, NP, MSN

Also present were:
Kevin D. Watkins, MD, MPH, Public Health Director
Eric Firkel, County Attorney
Dr. Gil Witte, Medical Director
Richard Helmich, Legislator
Robert Neil, Legislator
Donna Vickman, Legislator
Scott Anderson, West Valley Deputy General Manager
Brian Bower, West Valley Site Director, Nuclear Plant
Christopher Ellman, Sheriff Deputy
Mark Kless, Public, Co-Owner of Kless Boys Full Service
Matt Kless, Public, Co-Owner of Kless Boys Full Service
Joe Pillitere, West Valley Communication Director
Lynne Moore, Director of Nursing
Dave Porter, Hearing Officer
Raymond Jordan, Sr. Public Health Sanitarian
Debra Lacher, Secretary to Public Health Director
Colette Lulay-Pound, Administrative Officer
Eric Wohlers, Environmental Health Director

The meeting was called to order by Dr. Bohan. The roll was called and a quorum declared. Legislator Snyder made a motion to approve the minutes of the Board of Health (BOH) meeting held on February 7, 2018, it was seconded by Mayor Smith and the motion was unanimously approved.

Dr. Bohan informed the Board that there would be a change in the order of the agenda due to an enforcement matter.

Mr. Porter presented **Docket #17-030 Kless Boys Full Service, LLC, 12248 Route 16, Yorkshire, N.Y. 14173. Violation New York State Public Health Law Section 1399-CC Sale of Cigarettes to a person under eighteen years of age.**

An Administrative Hearing was held 2-13-18 where respondents requested to be heard at the 3-7-18 BOH meeting, which Dr. Kevin Watkins approved.

Recommendation: The civil compromise offered to be changed to a $300.00 fine and a $50.00 surcharge for a total of $350.00 to be paid on or before 3-30-18. A $10.00 per day per diem will be levied for every day not in compliance after 3-30-18.

Mark Kless introduced himself and his brother Matt and expressed their opinions regarding this docket and their investment into their local community.

Dr. Bohan thanked the Kless Brothers for all they have done for the community, and asked them what percentage of their employees took the freThanks, I'll have Wohlersd to e State Certified Tobacco Sales Training course offered by the Health Department. Mr. Kless stated that they have 17-18 employees and none of them have taken the training due to the high turnover, and that it was not a viable option. Legislator Neil stated he stands with the Kless Brothers, and hopes the Board can help them solve this problem.

Dr. Bohan introduced Scott Anderson, Deputy General Manager of CH2M HILL BWXT West Valley, LLC, as the guest speaker. Mr. Anderson reported that they value safety at their facility which is historically high (1.33 injuries per 100 people at the site- 4 injuries on site in the last year, no serious injury noted). Milestones that have been achieved includes completion of the relocation of 275 High Level Radioactive Waste (HLW) Canisters and 3 non-conforming HLW canisters to long term interim storage. Processing, shipping, and disposing of legacy waste continues. Demolishing, and removing the main plant process building and the vitrification facility, is 50% complete. Work will continue until all legacy waste has been removed, at this point the process is 90% complete with approximately 24 shipments remaining, with planned completion set for September 2018. Mr. Wohlers asked what disposal sites were being utilized for the disposal of the waste. Mr. Anderson answered there are three disposal options available: a federal facility in Nevada, called Nevada National Security Site, one in Texas called Waste Control Specialists, and a third in Utah called Energy Solutions. The main plant process has undergone 82% deactivation, with a planned completion of mid to late summer. The site went on well water in 2015, and recently put in a new water conditioning system approved by the County in mid-February. This spring, West Valley will be refurbishing an off-site rail shipment process and hope to have rail cars active by the end of the summer. This will be a much more cost effective way to ship right from the site instead of trucking items which requires loading and offloading.

Mr. Brian Bower added that in 2010 a decision was made to move forward with decommissioning the West Valley Site. This site is owned by New York State, but the Department of Energy was contracted do work on the site. There are three underground tanks that hold high level radioactive waste, and two disposal areas that need to be cleaned up yet. Each of those facilities are under a different complex regulatory system. The Department of Energy is in the process of releasing a supplemental environmental impact statement for the phase II scoping session, and meetings will be held on March 19, 20, and 21st for those in the community who want further information.

Dr. Bohan asked if there has been any leakage from the tanks into the ground. Mr. Bower confirmed that there was a ground water plume, due to a leak that occurred in 1969. In 2010 a subservice barrier wall was installed to prevent further contamination. Ground water levels are kept intentionally low, that way, if there was ever a leak the water would be pulled into the captured wells instead of leaving.
Legislator Snyder asked how many employees worked at the plant and if funding was 100% federal. Mr. Bower responded approximately 300 employees. Work that is currently being done, funding is primarily 90% federal, and 10% state. When the project moves forward with removing the contaminated soils, there will be a shift of 50% federal and 50% state responsibility. Dr. Bohan asked about security at the facility, Mr. Bower replied that he was not at liberty to discuss security.

DIRECTORS REPORT: Dr. Watkins reported that during the week ending February 24th the influenza activity level was categorized as geographically widespread. This is the twelfth consecutive week that widespread activity has been reported. There were (13,703) laboratory-confirmed influenza reports in NYS, which is a 25% decrease over the week prior to Feb. 24th. Of the (161) specimens tested at Wadsworth Center, (123) were positive for influenza. (88) were Influenza A (H3N2), (12) were influenza A (H1N1) and (23) were influenza B (Yamagata). The number of patients hospitalized with laboratory-confirmed influenza in NYS was (1,702) a 21% decrease over the week prior to Feb. 24th. There has been (5) influenza-associated pediatric death in NYS reported this season.

Cattaraugus County has reported a total of (421) laboratory confirm cases of influenza; (202) or 48% were influenza A; (217) or 52% were influenza B, (2) influenza were type non-specific. There has been no influenza-associated pediatric deaths in Cattaraugus County. In Cattaraugus County there has been (13,811) vaccines given to Cattaraugus County residents during this influenza season. (1,633) given by the Health Department, (8,313) given by providers, (3,965) given by local pharmacies.

An interim report on the 2017-2018 Influenza Vaccine Effectiveness was recently released and distributed to those in attendance. As speculated, the vaccine effectiveness was better than what was reported in Austria back in October 2017 when reports indicated that the vaccine was only 10% effective against the influenza A (H3N2) strain.

Table one, page 182 gives an overview of the study sites, sex, age group, race and ethnicity and health status of the 4,562 participants. Table two, page 183 shows that of the 4,562 participants, 1,712 were positive for influenza; of that group, 741 or 43% received the 2017-2018 influenza vaccine.
After adjusting for study site, age group, sex, race/ethnicity, self-rated general health, number of days from illness onset to enrollment, and week of illness onset. (3-week intervals):
The Overall Vaccine Effectiveness was 36% against all influenza virus types.
Vaccine Effectiveness for all ages was 25% against influenza A(H3N2) virus.
Vaccine Effectiveness for all ages was 67% against influenza A(H1N1) virus.
Vaccine Effectiveness for all ages was 42% against influenza B virus infection.
Overall Vaccine Effectiveness (VE) varied by age group; statistically significant protection was found among children aged 6 months through 8 years (VE = 59%) and adults aged 18–49 years (VE = 33%), whereas no statistically significant protection was observed in other age groups.

Influenza vaccine is our first line of defense against the influenza virus and it is still recommended for those six months and older despite the vaccine effectiveness, it is used to keep people out of the hospital and to prevent deaths. Dr. Witte added that if you get the vaccine it does not prevent you from getting influenza, however the illness will be less severe.

Dr. Watkins shared that health authorities in Japan have approved a new flu medication that is called baloxavir marboxil (Xofluza), that aims to stop the influenza virus within one day. The drug works by inhibiting cap-dependent endonuclease, (which the flu virus relies on to duplicate in the human body), therefore, it blocks the flu virus's ability to use the host cell for replication. That's a different mechanism from oseltamivir (Tamiflu), which blocks the virus's neuraminidase enzyme, preventing its escape from the host cell.

Xofluza has not been approved by FDA yet, but it does look like it is on fast track for approved next year. The drug is given as a one-time dose regime and is reported to effectively kill the flu virus within 24 hours, while Tamiflu takes 72 hours. Reports indicates that although the virus is killed 24 hours after taking Xofluza, the symptoms can remain for up to 7-10 days.

March is colorectal cancer awareness month, in New York State, colorectal cancer is one of the most frequently diagnosed cancers and the second leading cause of cancer deaths among men and women combined. Each year, over (4,600) men and about (4,700) women are diagnosed with colorectal cancer and about (1,600) men and about (1,700) women in New York State die from this disease. It is estimated that one in 20 people will develop colorectal cancer sometime in their life.
In Cattaraugus County the average annual incidence of colorectal cancer for men is 23.2 compared to women which is 25.6, and the annual mortality rate is 8.6% for men and 8.2% for women.

A handout was provided to all in attendance with colorectal cancer incidence by zip code for Cattaraugus County. For men living in Gowanda, Limestone, and Salamanca, colorectal cancer was observed nearly 50% higher than what would have been expected for men in those areas. Other zip code where colorectal cancer were observed to be 15-49% higher than expected for men included Franklinville, Olean, and Randolph. For women, Franklinville appears to be an area of concern as colorectal cancer was observed nearly 50% high than what would have been expected for women in those areas. Other zip code where colorectal cancer were observed to be 15-49% higher than expected for women include Gowanda, Cuba, Olean, Randolph, and Salamanca.

The risk factors include age, family history and hereditary conditions, personal health history, obesity, physical inactivity, diet, and other lifestyle factors such as smoking, or alcohol intake.

NURSING DIVISION REPORT: Mrs. Moore reported the homecare census is currently (300) patients with (10) patients under the Medicaid Obstetrical and Maternal Services (MOMS) program. The lead program currently has (33) children being followed. The second lead coalition meeting was held February 15th and there was a good turnout. Some of the participants included the Seneca Nation, Southern Tier Health Care System, Healthy Families, and Allegany County Health Department.

In February, the communicable disease program had (17) Chlamydia cases, (5) Hepatitis C cases, (1) Lyme disease case, (1) Strep A case, (2) Strep B cases, and (2) haemophilus influenza cases. HIV testing was completed including (11) in Olean, (2) in Machias, (6) in Salamanca with no positives at any site.

There is (1) patient scheduled to receive the rabies pre exposure vaccine, and (1) patient that received the rabies post-exposure prophylaxis after being bitten by a barn cat. Patti Williams retired as of February 27th, and Shawna Trudeau has taken over the immunization program.

The department still has (150) doses of influenza vaccine available with (20) high dose flu vaccines, and (25) pediatric doses.

Mrs. Moore shared that the department will start some new marketing campaigns to increase the homecare census, which will include participating in the home show, and an upcoming YMCA event.

Dr. Bohan welcomed Colette Lulay-Pound, as the new administrative officer for the Health Department.

ENVIRONMENTAL HEALTH DIVISION REPORT: Mr. Wohlers stated that every local health department is given a list of licensed tobacco retail outlets within their County and they are required to provide one compliance check a year to all of those establishments. If a sale is made to a minor, the state regulations requires that the establishment then be checked at least (3) times a year to follow-up on their sales record.

In preparation for upcoming festivals, mailings have gone out to all temporary food vendors, and organizers regarding the food manager training requirements. Staff is getting a few questions from restaurant managers about the training but everything seems to be going fairly smoothly.
To be in compliance with accreditation guidelines, the environmental health division has developed several new polices and will need the policies approved by the governing body. These polices will be mailed to the Board of Health member for review and hopefully approved at the April Board meeting.

Next week the department will co-host a water operator training course with the American Water Works Association in Springville. At the end of the month the State will hold its yearly environmental health summit meeting in Albany that we plan to attend. The focus for the meeting will be on the harmful algae blooms toxins that are affecting lakes, and reservoirs. Currently, there is not enough certified laboratories in NYS that are qualified to conduct these algae bloom toxin tests and the State is actively recruiting labs to become certified.

Mr. Wohlers informed the Board that there was another appropriation in the State budget to improve water quality through the targeted replacement of aging septic systems in communities across New York. Through a collaboration between the State Departments of Environmental Conservation and Health, and the Environmental Facilities Corporation, the state will support the new program in 31 counties.

Through this program, the state will provide funds to counties to reimburse eligible property owners for a portion of the cost of replacing failing septic systems and installing more environmentally effective systems. Eligible property owners can be reimbursed up to 50 percent of eligible costs up to $10,000. Cattaraugus County is eligible to receive a total of $75,000 in the first year funding allocation of this program.

Ms. Raftis requested that Mr. Wohlers send the details of this program to her next week as she wants to make sure they are providing the correct paperwork to individuals who apply for bank loans for this purpose. Mr. Wohlers added that a 12-member Drinking Water Quality Council has been created to ensure all New Yorkers have access to clean drinking water. The Council will address a wide range of emerging water quality issues, and solicit outside industry experts to complement the expertise of council members where appropriate.

Legislator Snyder, stated that the Seneca Nation of Indians are deeply concerned about a proposed fracking project being done in Coudersport, Pa. Mr. Wohlers responded that his research shows that the fracking is not occurring in Coudersport, but the proposal is to build a new hydro-fracturing wastewater treatment plant where others could haul their fracking waste water to this new facility which would treat it and then discharge hundreds of thousands of gallons of fracking wastewater into the Allegheny River. Legislator Snyder stated the Seneca's are holding a hearing in Salamanca to discuss the environmental and health risk of this proposed project at the end of this month and Mr. Wohlers confirmed his planned attendance.

ENFORCEMENT REPORT: Discussion continued on Docket #17-030, Kless Boys Full Service, LLC. Section 1399-ee of the Public Health Law allows tobacco retailers a reduced penalty for a sale-to-minor violation if the clerk who made the sale previously attended a State Certified Tobacco Sales Training course and holds a valid certificate of completion. Ms. Raftis asked if the certified training course was available on-line. Mr. Wohlers responded that the course is not offered on-line but the training is offered twice a year at the County building in Olean, free of charge.

Instead of sending 17 employees to Olean the Kless Brothers could have the employees meet at the Town Hall of Yorkshire and the department could send staff over to provide the training.

Legislator Vickman encouraged the board to remember that these business owners are in Northern Cattaraugus County and that they are very vital to our County tax base. She suggested that the department find some place for them to have this training whether it is at the Health Department in Machias or at the Machias Nursing Home. Dr. Bohan suggested that a letter be sent at some point in time after the BOH order, offering to send a representative to train their employees. Mr. Wohlers stated that this offer has been made in the past and it was rejected, but that the department will reach out to the business owners again.

A motion was made by Mrs. Fox to accept Mr. Porter's recommendation, the motion was seconded by Dr. Hamlin, and unanimously approved.

Docket #17-028:

Respondent: Jennifer Dietl, 112 ½ South 2nd Street, Olean, NY 14760 Violation sanitary code of the Cattaraugus County Health District Chapter 2 Part 24.2.5. Respondent failed to submit a completed animal confinement verification form and proof of rabies vaccination for her dog when directed to do so following a biting incident (x2).

Recommendation: Pay a $150.00 fine and provide proof of dog vaccination by a veterinarian by 3-30-18. A $10.00 per day per diem will be levied for every day not in compliance after 3-30-18.

A motion to accept the recommendation was made by Mayor Smith, seconded by Dr. Hamlin and unanimously approved.

Docket #18-006

Respondent: Aaron Davis, 618 Irving Street, Olean, NY 14760. Violation sanitary code of Cattaraugus County Health District Chapter 2 Part 4.2.5. Respondent failed to provide proof of current rabies vaccine for his dog when directed to do so following a biting incident.

Recommendation: Pay a $150.00 fine and provide proof of dog vaccination by a licensed veterinarian by 3-30-18. A $10.00 per day per diem will be levied for every day not in compliance after 3-30-18.

A motion to accept this recommendation was made by Mrs. Fox, seconded by Mayor Smith, and unanimously approved.

There being no further business to discuss, a motion to adjourn was made by Mr. Haberer, and seconded, by Dr. Hamlin, and unanimously approved.

Respectfully submitted,

Kevin D. Watkins, M.D.

Kevin D. Watkins, M.D., M.P.H.
Secretary to the Board of Health

Interim Estimates of 2017–18 Seasonal Influenza Vaccine Effectiveness — United States, February 2018

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In the United States, annual vaccination against seasonal influenza is recommended for all persons aged ≥6 months (*1*). During each influenza season since 2004–05, CDC has estimated the effectiveness of seasonal influenza vaccine to prevent laboratory-confirmed influenza associated with medically attended acute respiratory illness (ARI). This report uses data from 4,562 children and adults enrolled in the U.S. Influenza Vaccine Effectiveness Network (U.S. Flu VE Network) during November 2, 2017–February 3, 2018. During this period, overall adjusted vaccine effectiveness (VE) against influenza A and influenza B virus infection associated with medically attended ARI was 36% (95% confidence interval [CI] = 27%–44%). Most (69%) influenza infections were caused by A(H3N2) viruses. VE was estimated to be 25% (CI = 13% to 36%) against illness caused by influenza A(H3N2) virus, 67% (CI = 54%–76%) against A(H1N1)pdm09 viruses, and 42% (CI = 25%–56%) against influenza B viruses. These early VE estimates underscore the need for ongoing influenza prevention and treatment measures. CDC continues to recommend influenza vaccination because the vaccine can still prevent some infections with currently circulating influenza viruses, which are expected to continue circulating for several weeks. Even with current vaccine effectiveness estimates, vaccination will still prevent influenza illness, including thousands of hospitalizations and deaths. Persons aged ≥6 months who have not yet been vaccinated this season should be vaccinated.

Methods used by the U.S. Flu VE Network have been published previously (*2*). At five study sites,* patients aged ≥6 months seeking outpatient medical care for an ARI with cough within 7 days of illness onset were enrolled. Study enrollment began after local surveillance identified increasing weekly influenza activity or one or more laboratory-confirmed cases of influenza per week for 2 consecutive weeks. Patients were eligible for enrollment if they 1) were aged ≥6 months on September 1, 2017, and thus were eligible for vaccination; 2) reported an ARI with cough with onset ≤7 days earlier; and 3) had not been treated with influenza antiviral medication (e.g., oseltamivir) during this illness. After obtaining informed consent from patients or from parents or guardians for their children, participants or their proxies were interviewed to collect demographic data, information on general and current health status and symptoms, and 2017–18 influenza vaccination status. Nasal and oropharyngeal swabs (or nasal swabs alone for children aged <2 years) were collected to obtain respiratory specimens; nasal and oropharyngeal swabs were placed together in a single cryovial with viral transport medium. Specimens were tested at U.S. Flu VE Network laboratories using CDC's real-time reverse transcription polymerase–chain reaction (rRT-PCR) protocol for detection and identification of influenza viruses. Participants (including children aged <9 years, who require 2 vaccine doses during their first vaccination season) were considered vaccinated if they received ≥1 dose of any seasonal influenza vaccine ≥14 days before illness onset, according to medical records and registries (at the Wisconsin site); medical records and self-report (at the Washington site); or self-report only (at the Michigan, Pennsylvania, and Texas sites). VE against all influenza virus types combined and against viruses by type/subtype was estimated as 100% x (1 - odds ratio).† Estimates were adjusted for study site, age group, sex, race/ethnicity, self-rated general health, number of days from illness onset to enrollment, and week of illness (3-week intervals) using logistic regression. Interim VE estimates for the 2017–18 season were based on patients enrolled through February 3, 2018.

Among the 4,562 children and adults with ARI enrolled at the five study sites from November 2, 2017, through February 3, 2018, a total of 1,712 (38%) tested positive for influenza virus by rRT-PCR, including 1,392 (81%) influenza A viruses and 323 (19%) influenza B viruses (Table 1). Among 1,340 subtyped influenza A viruses, 1,143 (85%) were A(H3N2) viruses and 208 (16%) were A(H1N1)pdm09

* The U.S. Flu VE Network sites and the dates enrollment began are as follows: Kaiser Permanente Washington (Seattle, Washington) (November 27, 2017); Marshfield Clinic Research Institute (Marshfield, Wisconsin) (December 26, 2017); University of Michigan School of Public Health (the School of Public Health partnered with the University of Michigan Health System, Ann Arbor, and the Henry Ford Health System, Detroit, Michigan) (December 4, 2017); University of Pittsburgh Schools of the Health Sciences (the Schools of the Health Sciences partnered with the University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania) (November 29, 2017); and Baylor Scott & White Health, Texas A&M University Health Science Center College of Medicine (Temple, Texas) (November 2, 2017).

† 100% x (1 - odds ratio [ratio of odds of being vaccinated among outpatients with influenza-positive test results to the odds of being vaccinated among outpatients with influenza-negative test results]).

viruses. Most (98%) influenza B viruses belonged to the B/Yamagata lineage. The proportion of patients with influenza differed by study site, sex, age group, race/ethnicity, self-rated health status, and interval from illness onset to enrollment (Table 1). The percentage of patients who were vaccinated ranged from 45% to 59% among study sites and differed by sex, age group, race/ethnicity, and self-rated health status.

Among ARI patient participants, 43% of those with influenza had received the 2017–18 seasonal influenza vaccine, compared with 53% of influenza-negative participants (Table 2). After adjusting for study site, age group, sex, race/ethnicity, self-rated general health, number of days from illness onset to enrollment, and week of illness onset (3-week intervals), VE against medically attended ARI caused by all influenza virus types combined was 36% (CI = 27%–44%). VE for all ages was 25% (CI = 13% to 36%) against medically attended ARI caused by A(H3N2) virus infection, 67% (CI = 54%–76%) against influenza A(H1N1)pdm09 virus infection, and 42% (CI = 25%–56%) against influenza B virus infection. VE point estimates against medically attended influenza for all virus types varied by age group; statistically significant protection against medically attended influenza was found among children aged 6 months through 8 years (VE = 59%; CI = 44%–69%) and adults aged 18–49 years (VE = 33%; CI = 16%–47%), whereas no statistically significant protection was observed in other age groups.

As of February 3, 2018, a total of 257 influenza A(H3N2) viruses from U.S. Flu VE Network participants had been characterized by CDC; 240 (93%) belonged to either genetic group 3C.2a (226 viruses) or the related subgroup 3C.2a1 (14), whereas 17 (7%) belonged to group 3C.3a. Genetic group 3C.2a includes the A/Hong Kong/4801/2014 reference virus representing the A(H3N2) component of the 2017–18 Northern Hemisphere influenza vaccines (*3*).

Discussion

Early and widespread influenza activity during the 2017–18 influenza season provided the opportunity to estimate interim VE against several circulating influenza viruses, including the predominant A(H3N2) virus. These interim estimates reflect ongoing challenges with the A(H3N2) vaccine component since the 2011–12 season. The interim estimate of 25% VE against A(H3N2) viruses this season indicates that vaccination provided some protection, in contrast to recently reported, nonsignificant interim estimates of 17% from Canada and 10% from Australia (*4*,*5*) and is similar to final (32%) VE estimates in the United States against A(H3N2) viruses during 2016–17[§] (*6*). However, among children aged 6 months through 8 years, the interim estimates against any influenza and A(H3N2) virus infection were higher; the risk for A(H3N2) associated medically-attended influenza illness was reduced by more than half (59%) among vaccinated children. Also, with interim VE estimates of 67% and 42% against influenza A(H1N1)pdm09 and B viruses, respectively, vaccination provided substantial protection against circulating A(H1N1)pdm09 viruses, as well as moderate protection against influenza B viruses predominantly belonging to the B/Yamagata lineage, the second influenza type B component included in quadrivalent vaccines. CDC continues to recommend influenza vaccination while influenza viruses are circulating in the community; several more weeks of influenza activity are likely. Influenza vaccination has prevented thousands of hospitalizations during previous seasons when influenza A(H3N2) viruses were predominant, including during the 2014–15 season when interim VE estimates were similar to those reported here. Appropriate use of influenza antiviral medications for treatment of severely ill persons or persons at high risk for complications from influenza who develop influenza symptoms is important, especially among older adults, who currently have the highest hospitalization rates (*3*).

VE estimates against A(H3N2) viruses have been lower than estimates against A(H1N1)pdm09 and B viruses for several years (*7*). Although there is no definitive evidence for antigenic drift of viruses circulating this season compared with cell culture–propagated reference viruses representing the A(H3N2) vaccine component (*3*), challenges with antigenic characterization of recent A(H3N2) viruses, many of which could not be characterized using traditional hemagglutination inhibition assays, have required the use of additional virus neutralization assays to assess antigenic characteristics. Multiple factors might be contributing to the reported VE against A(H3N2) viruses this season. Immune responses to vaccination differ by age and previous infection or vaccination history and can affect vaccine protection; higher VE against A(H3N2) viruses among young children suggests that vaccination might provide better protection against circulating A(H3N2) viruses to this age group. Also, genetic changes in the vaccine virus hemagglutinin protein that arise during passage in eggs might result in a vaccine immune response that is less effective against circulating viruses (*8*,*9*). Human serologic data indicate decreased inhibition of circulating cell culture–propagated A(H3N2) viruses compared with egg-propagated viruses among persons vaccinated with egg-based vaccines.[¶] Additional studies are needed to assess whether VE against circulating A(H3N2) viruses varies by vaccine type, including comparisons between egg-based and

[§] https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2017-06/flu-03-ferdinands.pdf.

[¶] http://apps.who.int/iris/bitstream/10665/259275/1/WER9242.pdf?ua=1.

TABLE 1. Selected characteristics for 4,562 enrolled outpatients with medically attended acute respiratory illness and cough, by influenza test result status and seasonal influenza vaccination status — U.S. Influenza Vaccine Effectiveness Network, United States, November 2, 2017–February 3, 2018

	Test result status			Vaccination status*		
	Influenza-positive	Influenza-negative		Vaccinated		
Characteristic	No. (%)	No. (%)	p-value†	No. enrolled	No. (%) vaccinated	p-value†
Overall	**1,712 (38)**	**2,850 (62)**	—	**4,562**	**2,259 (50)**	—
Study site						
Michigan	264 (35)	491 (65)		755	422 (56)	<0.001
Pennsylvania	330 (41)	480 (59)		810	376 (46)	
Texas	572 (42)	806 (58)	<0.001	1,378	614 (45)	
Washington	195 (27)	518 (73)		713	420 (59)	
Wisconsin	351 (39)	555 (61)		906	427 (47)	
Sex						
Male	735 (39)	1,133 (61)	0.03	1,868	865 (46)	<0.001
Female	977 (36)	1,717 (64)		2,694	1,394 (52)	
Age group (yrs)						
6 mos–8	359 (33)	739 (67)		1,098	535 (49)	<0.001
9–17	288 (49)	300 (51)		588	204 (35)	
18–49	561 (36)	989 (64)	<0.001	1,550	642 (41)	
50–64	288 (39)	454 (61)		742	436 (59)	
≥65	216 (37)	368 (63)		584	442 (76)	
Race/Ethnicity§						
White	1,169 (37)	2,020 (63)		3,189	1,659 (52)	<0.001
Black	161 (43)	218 (58)	0.004	379	150 (40)	
Other race	144 (33)	287 (67)		431	217 (50)	
Hispanic	231 (42)	317 (58)		548	225 (41)	
Self-rated health status						
Fair or poor	75 (31)	168 (69)		243	135 (56)	<0.001
Good	377 (35)	695 (65)	<0.001	1,072	559 (52)	
Very good	618 (36)	1,087 (64)		1,705	875 (51)	
Excellent	639 (42)	898 (58)		1,537	687 (45)	
Illness onset to enrollment (days)						
<3	856 (48)	940 (52)		1,796	866 (48)	0.23
3–4	589 (35)	1,082 (65)	<0.001	1,671	829 (50)	
5–7	267 (24)	828 (76)		1,095	564 (52)	
Influenza test result¶						
Negative	—	2,850	—	2,850	1,518 (53)	—
Influenza B positive	323	—	—	323	132 (41)	—
B/Yamagata	260	—	—	260	112 (43)	—
B/Victoria	5	—	—	5	2 (40)	—
B lineage pending	58	—	—	58	18 (31)	—
Influenza A positive	1,392	—	—	1,392	610 (44)	—
A(H1N1)pdm09	208	—	—	208	60 (29)	—
A(H3N2)	1,143	—	—	1,143	530 (46)	—
A subtype pending	52	—	—	52	23 (44)	—

* Defined as having received ≥1 dose of influenza vaccine ≥14 days before illness onset. A total of 102 participants who received the vaccine ≤13 days before illness onset were excluded from the study sample.

† The chi-square statistic was used to assess differences between the numbers of persons with influenza-negative and influenza-positive test results, in the distribution of enrolled patient and illness characteristics, and in differences between groups in the percentage vaccinated.

§ Enrollees were categorized into one of four mutually exclusive racial/ethnic populations: white, black, other race, and Hispanic. Persons identifying as Hispanic might have been of any race. Persons identifying as white, black, or other race were non-Hispanic. Race/ethnicity data were missing for 15 enrollees.

¶ Fourteen patients had coinfection with influenza A and influenza B, making the sum 1,726, or 14 greater than the total number of influenza-positive patients.

non–egg-based vaccines. CDC will continue to monitor VE through the remainder of the season and is investigating these factors. In addition, many efforts are under way to improve selection and development of candidate vaccine viruses that are optimal for vaccine production and provide protection against a majority of circulating viruses.

These interim VE estimates underscore the need for influenza antiviral treatment for any patient with suspected or confirmed influenza who is hospitalized, has severe or progressive illness, or is at high risk for complications from influenza, regardless of vaccination status or results of rapid, point-of-care influenza

TABLE 2. Number and percentage receiving 2017–18 seasonal influenza vaccine among 4,562 enrolled outpatients with medically attended acute respiratory illness and cough, by influenza test result status, age group, and vaccine effectiveness against all influenza A and B and against virus types A(H3N2), A(H1N1)pdm09 and B — U.S. Influenza Vaccine Effectiveness Network, United States, November 2, 2017–February 3, 2018

	Test result status				Vaccine effectiveness*	
	Influenza-positive		Influenza-negative		Unadjusted	Adjusted
Influenza type/Age group	Total	No. (%) vaccinated	Total	No. (%) vaccinated	% (95% CI)	% (95% CI)
Influenza A and B						
Overall	**1,712**	**741 (43)**	**2,850**	**1,518 (53)**	**33 (24 to 41)**	**36 (27 to 44)†**
Age group (yrs)						
6 mos–8	359	127 (35)	739	408 (55)	56 (42 to 66)	59 (44 to 69)†
9–17	288	100 (35)	300	104 (35)	0 (-41 to 29)	5 (-38 to 34)
18–49	561	198 (35)	989	444 (45)	33 (17 to 46)	33 (16 to 47)†
50–64	288	159 (55)	454	277 (61)	21 (-6 to 42)	17 (-15 to 40)
≥65	216	157 (73)	368	285 (78)	23 (-14 to 47)	18 (-25 to 47)
Influenza A(H3N2)						
Overall	**1,143**	**530 (46)**	**2,850**	**1,518 (53)**	**24 (13 to 34)**	**25 (13 to 36)†**
Age group (yrs)						
6 mos–8	200	79 (40)	739	408 (55)	47 (27 to 61)	51 (29 to 66)†
9–17	203	75 (37)	300	104 (35)	-10 (-60 to 24)	-8 (-62 to 29)
18–49	395	155 (39)	989	444 (45)	21 (-1 to 37)	20 (-4 to 38)
50–64	198	115 (58)	454	277 (61)	11 (-24 to 37)	12 (-26 to 39)
≥65	147	106 (72)	368	285 (78)	25 (-16 to 51)	17 (-35 to 49)
Influenza A(H1N1)pdm09						
Overall	**208**	**60 (29)**	**2,850**	**1,518 (53)**	**64 (52 to 74)**	**67 (54 to 76)†**
Age group (yrs)						
<18	105	22 (21)	1,039	512 (49)	73 (56 to 83)	78 (63 to 87)†
18–64	84	26 (31)	1,443	721 (50)	55 (28 to 72)	51 (20 to 70)†
≥65	19	12 (63)	368	285 (78)	50 (-31 to 81)	34 (-96 to 78)
Influenza B						
Overall	**323**	**132 (41)**	**2,850**	**1,518 (53)**	**39 (23 to 52)**	**42 (25 to 56)†**
Age group (yrs)						
<18	127	46 (36)	1,039	512 (49)	42 (14 to 60)	36 (1 to 58)†
18–64	151	53 (35)	1,443	721 (50)	46 (23 to 62)	50 (28 to 66)†
≥65	45	33 (73)	368	285 (78)	20 (-62 to 60)	25 (-62 to 66)

Abbreviation: CI = confidence interval.

* Vaccine effectiveness was estimated as 100% x (1 - odds ratio [ratio of odds of being vaccinated among outpatients with influenza-positive test results to the odds of being vaccinated among outpatients with influenza-negative test results]); odds ratios were estimated using logistic regression.

† Statistically significant at the p<0.05 level.

diagnostic tests.** CDC recommends antiviral medications as an adjunct to vaccination, and their potential public health benefit is increased in the context of low VE. A CDC health update issued December 27, 2017, regarding treatment with antiviral medications is available at https://emergency.cdc.gov/han/han00409.asp. Clinicians should be aware that influenza activity is widespread, and influenza should be considered as a possible diagnosis in all patients with acute respiratory illness.

The findings in this report are subject to at least four limitations. First, vaccination status included self-report at four of five sites. End-of-season VE estimates based on updated documentation of vaccination status might differ from interim estimates. Second, information from medical records and immunization registries is needed to evaluate VE by vaccine type and for fully vaccinated versus partially vaccinated children, as well as to evaluate the effects of previous season vaccination and timing of vaccination; end-of-season analysis of VE by vaccine type and effects of partial or previous season vaccination is planned. Third, an observational study design

** A complete summary of guidance for antiviral use is available at https://www.cdc.gov/flu/professionals/antivirals/summary-clinicians.htm. Groups at high risk for influenza complications include the following: children aged <2 years; adults aged ≥65 years; persons with chronic pulmonary conditions (including asthma); persons with cardiovascular disease (except hypertension alone); persons with renal, hepatic, or hematologic (including sickle cell) disease; persons with metabolic disorders (including diabetes mellitus); persons with neurologic and neurodevelopmental conditions (including disorders of the brain, spinal cord, peripheral nerves and muscles, such as cerebral palsy, epilepsy [seizure disorders], stroke, intellectual disability [mental retardation], moderate to severe developmental delay, muscular dystrophy, or spinal cord injury); persons with immunosuppression, including that caused by medications or by human immunodeficiency virus infection; women who are pregnant or ≤2 weeks postpartum; persons aged <19 years who are receiving long-term aspirin therapy; American Indian/Alaska Natives; persons with morbid obesity (i.e., body-mass index ≥40); and residents of nursing homes and other chronic-care facilities.

Summary

What is already known about this topic?

Effectiveness of seasonal influenza vaccine can vary by season and has generally been higher against influenza A(H1N1)pdm09 and B viruses than against A(H3N2) viruses.

What is added by this report?

So far this season, influenza A(H3N2) viruses have predominated, but other influenza viruses are also circulating. Based on data from 4,562 children and adults with acute respiratory illness enrolled during November 2, 2017–February 3, 2018, at five study sites with outpatient medical facilities in the United States, the overall estimated effectiveness of the 2017–18 seasonal influenza vaccine for preventing medically attended, laboratory-confirmed influenza virus infection was 36%.

What are the implications for public health practice?

CDC continues to monitor influenza vaccine effectiveness. Influenza vaccination is still recommended; vaccination reduces the risk for influenza illnesses and serious complications. Treatment with influenza antiviral medications, where appropriate, is especially important this season.

has greater potential for confounding and bias relative to randomized clinical trials. However, the test-negative design is widely used in VE studies and has been used by the U.S. Flu VE Network to estimate VE for previous influenza seasons. Finally, small sample sizes in some age groups resulted in wide confidence intervals, and end-of-season VE estimates could change as additional patient data become available or if there is a change in circulating viruses late in the season. It is also important to note that the VE estimates in this report are limited to the prevention of outpatient medical visits rather than more severe illness outcomes, such as hospitalization or death; data from studies measuring VE against more severe outcomes will be available at a later date.

Annual monitoring of VE supports ongoing efforts to improve influenza vaccines. Although more effective vaccines are needed, vaccination prevents a substantial burden of influenza-related illness annually. During the 2014–15 season, when VE against medically attended illness caused by any influenza virus was less than 20%, vaccination was estimated to prevent 11,000–144,000 influenza-associated hospitalizations and 300–4,000 influenza-associated deaths (https://www.cdc.gov/flu/about/disease/2014-15.htm). Small increases in VE can substantially affect the number of hospitalizations prevented during a severe season (*10*). Although interim estimates suggest that vaccination has prevented some influenza-related illness this season, influenza vaccines with improved effectiveness are needed to substantially reduce the incidence of disease.

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Conflict of Interest

No conflicts of interest were reported.

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SHIONOGI

XOFLUZA™ (Baloxavir Marboxil) Tablets 10mg/20mg Approved for the Treatment of Influenza Types A and B in Japan

Osaka, Japan, February 23, 2018 - Shionogi & Co., Ltd. (Head Office: Osaka; President & CEO: Isao Teshirogi, Ph.D.; hereafter "Shionogi") announced that XOFLUZA™ (generic name: baloxavir marboxil) tablets 10mg/20mg was approved today by the Ministry of Health, Labour and Welfare for the treatment of Influenza Types A and B. As the cap-dependent endonuclease inhibitor XOFLUZA™ suppresses the replication of influenza viruses by a mechanism different from existing anti-flu drugs, XOFLUZA™ was designated for Sakigake procedure with priority review by the Ministry of Health, Labour, and Welfare of Japan in October 2015. Shionogi filed for approval to manufacture and sell XOFLUZA™ in October 25, 2017.

As the treatment with XOFLUZA™ requires only a single oral dose regardless of age, it is very convenient, and is expected to improve adherence. XOFLUZA™ is expected to be a new treatment option that can improve the quality of life in influenza patients. Shionogi will launch the product immediately after the National Health Insurance (NHI) price listing.

Shionogi's research and development targets infectious disease as one of its priority areas, and Shionogi have positioned "protecting people from the threat of infectious diseases" as one of its social mission targets. Shionogi strives constantly to bring forth innovative drugs for the treatment of infectious diseases, to protect the health of patients we serve.

Forward-Looking Statements

This announcement contains forward-looking statements. These statements are based on expectations in light of the information currently available, assumptions that are subject to risks and uncertainties which could cause actual results to differ materially from these statements. Risks and uncertainties include general domestic and international economic conditions such as general industry and market conditions, and changes of interest rate and currency exchange rate. These risks and uncertainties particularly apply with respect to product-related forward-looking statements. Product risks and uncertainties include, but are not limited to, completion and discontinuation of clinical trials; obtaining regulatory approvals; claims and concerns about product safety and efficacy; technological advances; adverse outcome of important litigation; domestic and foreign healthcare reforms and changes of laws and regulations. Also for existing products, there are manufacturing and marketing risks, which include, but are not limited to, inability to build production capacity to meet demand, unavailability of raw materials and entry of competitive products. The company disclaims any intention or obligation to update or revise any forward-looking statements whether as a result of new information, future events or otherwise.

For further information, contact:
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Colorectal Cancer Incidence by ZIP code , Cattaraugus County, 2005-2009

Source: New York State Cancer Registry

Primary ZIP Code	Post Office	Included ZIP Codes	Males			Females		
			Number of Cases Observed	Number of Cases Expected	Percent Difference from Expected	Number of Cases Observed	Number of Cases Expected	Percent Difference from Expected
14009	Arcade*		5	7.6	Very sparse data	8	7.3	Within 15% of expected
14042	Delevan	14173	1	6.3	Very sparse data	5	5.5	Very sparse data
14065	Freedom*	14060, 14029, 14133	6	3.1	Very sparse data	1	2.4	Very sparse data
14070	Gowanda*	14041	16	8.7	More than 50% above expected	13	9.1	15 to 49% above expected
14101	Machias		5	3.5	Very sparse data	4	3.9	Very sparse data
14129	Perrysburg	14168	1	2.5	Very sparse data	5	2.1	Very sparse data
14138	South Dayton*		3	2.2	Very sparse data	2	2.0	Very sparse data
14141	Springville*		10	11.3	Within 15% of expected	9	12.2	15 to 50% below expected
14171	West Valley		1	3.2	Very sparse data	3	2.5	Very sparse data
14706	Allegany	14778	9	9.8	Within 15% of expected	11	10.1	Within 15% of expected
14719	Cattaraugus	14766	6	5.2	Very sparse data	5	4.3	Very sparse data
14726	Conewango Valley*	14751	2	2.2	Very sparse data	3	1.8	Very sparse data
14727	Cuba*	14786	6	8.3	Very sparse data	11	7.8	15 to 49% above expected
14729	East Otto		1	1.3	Very sparse data	1	1.0	Very sparse data

Primary ZIP Code	Post Office	Included ZIP Codes	Males			Females		
			Number of Cases Observed	Number of Cases Expected	Percent Difference from Expected	Number of Cases Observed	Number of Cases Expected	Percent Difference from Expected
14731	Ellicottville		2	3.2	Very sparse data	2	2.6	Very sparse data
14737	Franklinville*		8	6.0	15 to 49% above expected	10	5.2	More than 50% above expected
14738	Frewsburg*		4	5.9	Very sparse data	7	5.9	15 to 49% above expected
14741	Great Valley		3	3.3	Very sparse data	2	2.5	Very sparse data
14743	Hinsdale		2	3.3	Very sparse data	2	2.7	Very sparse data
14747	Kennedy*	14732	3	3.6	Very sparse data	2	2.8	Very sparse data
14748	Kill Buck		0	0.9	Very sparse data	3	0.7	Very sparse data
14753	Limestone		9	2.1	More than 50% above expected	2	1.8	Very sparse data
14755	Little Valley		6	4.2	Very sparse data	5	3.5	Very sparse data
14760	Olean	14788	36	28.1	15 to 49% above expected	39	31.5	15 to 49% above expected
14770	Portville*	14721	2	4.7	Very sparse data	4	4.3	Very sparse data
14772	Randolph	14730, 14783	8	6.1	15 to 49% above expected	7	5.3	15 to 49% above expected
14779	Salamanca		18	10.9	More than 50% above expected	15	11.2	15 to 49% above expected

Notes

- Incidence data are provisional, November 2011.
- *This ZIP Code crosses county boundaries. The values provided are for the entire ZIP Code, not just the portion in this county.

	Cattaraugus County Health Department			
	Policy Title:	Assignment of Risk Categories for Food Service Establishments		
	Policy #:	FS-P-1	**Effective Date:**	4/5/18
	Date Reviewed:		**Next Review Date:**	1/1/21

Purpose:

The purpose of this policy is to establish a standardized, objective method for the assignment of RISK CATEGORIES for food service operations. Consistent assignment of RISK CATEGORIES by the Environmental Health Division is necessary to ensure fairness when determining permit fees and to facilitate enforceability of "Food Protection Manager Training" requirements.

Applicability:

This policy shall apply to all types of public food service operations (FOOD SERVICE ESTABLISHMENTS, MOBILE FOOD SERVICE ESTABLISHMENTS, and TEMPORARY FOOD SERVICE ESTABLISHMENTS) permitted by the Environmental Health Division.

Religious, fraternal and charitable organizations (typically fire halls & churches) that have been granted a limited PERMISSION TO OPERATE a food service operation are excluded from this policy.

Policy:

1. Each public food service operation permitted by the Environmental Health Division shall be assigned one of the following three RISK CATEGORIES:

    - Low Risk – establishments which serve primarily non-potentially hazardous/Temperature Controlled for Safety (TCS) foods (i.e. foods that do not need refrigeration), or potentially hazardous/TCS foods requiring little to no processing (pre-cooked or no-cook foods) prior to service. Examples of common "low-risk" foods include hot dogs, pre-cooked hamburgers/sausage, pizza with only cheese and pepperoni toppings, popcorn, candy and most baked goods.

    - Medium Risk - establishments which serve potentially hazardous/TCS foods (i.e. foods that do require refrigeration) which require limited processing (cook-and-serve) on site to the general population. Examples of common "medium-risk" foods include hamburgers/sausage cooked from raw products, specialty pizzas, barbecue chicken, fish fries, deli sandwiches/subs, and any cooked vegetable-based dishes.

    - High Risk - establishments which serve potentially hazardous/TCS foods requiring significant processing (multiple cooking, cooling, and reheating steps), which transport hot/cold ready-to-eat meals off site for service (caterers), or that serve meals to highly-susceptible populations (small children, elderly or the infirmed). Examples of common "high-risk" foods include many soups, roasted/smoked meats, potato/pasta salads and any food items that are prepared ahead of time and reheated prior to service.

    These RISK CATEGORIES shall be used to determine annual permit fees (in accordance with the current Environmental Health fee schedule), inspection frequency, and to determine whether or not the operation requires a manager/supervisor who has completed the "Food Protection Manager Training" course pursuant to the "Board Of Health Ordinance: Certified Food Protection Manager Training Verification".

2. Each public food service permit issued by the Environmental Health Division will be assigned a RISK CATEGORY using the standardized RISK CATEGORY WORKSHEET. The RISK CATEGORY WORKSHEET shall be the sole method of determining the RISK CATEGORY of food service permits.

   The RISK CATEGORY WORKSHEET must be completed whenever:

   - A new food service operation permit is issued
   - A food service operator makes significant menu changes that increase or decrease the complexity of the food handling/foods served
   - A Public Health Sanitarian finds that a permit holder is conducting food service operations not allowed under their current RISK CATEGORY

3. Each public food service permit will be issued with a permit condition indicating the assigned RISK CATEGORY and restricting the establishment to foods/processes allowed under said RISK CATEGORY. These permit conditions will be clearly printed on the front of each food service permit issued by the Environmental Health Division. Standard language to be applied to each permit follows in the tables below:

Food Service Establishment Operations

Risk Category	*Standard Permit Conditions*
High Risk	High Risk Food Service Establishment – This permit qualifies the holder to conduct an unlimited amount of public food service of any complexity at their establishment. Please note that certain types of high risk foods which require a scheduled process still require prior approval from your local Health Department (i.e. yogurt/cheese making, fermented foods, and reduced oxygen packaging).
Catering	Catering – This permit add-on qualifies the holder to conduct an unlimited amount of food service operations of any complexity off site within Cattaraugus County, in addition to public food service at their establishment.
Medium Risk	Medium Risk Food Service Establishment – This permit qualifies the holder to conduct an unlimited amount of food service of limited complexity at their establishment. Food items requiring substantial post-cook processing (i.e. cooling/reheating), raw or undercooked fish/shellfish/crustacea, and the transport of food off site for service is prohibited.
Low Risk	Low Risk Food Service Establishment – This permit qualifies the holder to conduct an unlimited amount of food service of minimal complexity at their establishment. Food items are restricted to non-Temperature Controlled for Safety (TCS) foods requiring little to no processing and commercially prepared TCS foods which do not require cooking prior to service.

Mobile Food Service Establishment Permits

Risk Category	*Standard Permit Conditions*
High Risk	High Risk Food Service Establishment – This permit qualifies the holder to conduct an unlimited amount of public food service of any complexity at their designated commissary and/or from their mobile food unit. Please note that certain types of high risk foods which require a scheduled process still require prior approval from your local Health Department (i.e. yogurt/cheese making, fermented foods, and reduced oxygen packaging).
Medium Risk	Medium Risk Food Service Establishment – This permit qualifies the holder to conduct an unlimited amount of food service of limited complexity at their designated commissary and/or from their mobile food unit. Food items requiring substantial post-cook processing (i.e. cooling/reheating), raw or undercooked fish/shellfish/crustacea are prohibited.
Low Risk	Low Risk Food Service Establishment – This permit qualifies the holder to conduct an unlimited amount of food service of minimal complexity at their designated commissary and/or from their mobile food unit. Food items are restricted to non-TCS foods requiring little to no processing and commercially prepared TCS foods which do not require cooking prior to service.

Temporary Food Service Establishment Permits

Risk Category	*Standard Permit Conditions*
High Risk	High Risk Food Service Establishment – This permit qualifies the holder to conduct an unlimited amount of public food service of significant complexity at their temporary food operation, and any pre-approved food prep locations. Please note that certain types of high risk foods which require a scheduled process are still prohibited unless pre-approved by the Health Department (i.e. yogurt/cheese making, fermented foods, and reduced oxygen packaging).
Medium Risk	Medium Risk Food Service Establishment – This permit qualifies the holder to conduct an unlimited amount of food service of limited complexity at their temporary food operation, and any pre-approved food prep locations. Food items requiring substantial post-cook processing (i.e. cooling/reheating), raw or undercooked fish/shellfish/crustacea are prohibited.
Low Risk	Low Risk Food Service Establishment – This permit qualifies the holder to conduct an unlimited amount of food service of minimal complexity at their temporary food operation, and any pre-approved food prep locations. Food items are restricted to non-TCS foods requiring little to no processing and commercially prepared TCS foods which do not require cooking prior to service.

	Cattaraugus County Health Department			
	Policy Title:	Assignment of Risk Categories for Food Service Establishments		
	Policy #:	FS-P-1	**Effective Date:**	4/5/18
	Date Reviewed:		**Next Review Date:**	1/1/21

Procedures:

New Food Service Establishments & Mobile Food Service Establishments

1. During the pre-operational inspection, the assigned Public Health Sanitarian shall review the proposed menu with the permit applicant. The permit applicant must complete the RISK CATEGORY WORKSHEET, with assistance from the Public Health Sanitarian if necessary. The RISK CATEGORY WORKSHEET must be signed and dated by both the permit applicant and the Public Health Sanitarian after completion.

2. The Public Health Sanitarian shall note the establishment's RISK CATEGORY on the pre-operational inspection report and on the permit application.

3. The assigned Environmental Health Division clerical staff preparing the establishment's permit shall include the appropriate standard language from the tables above on the FOOD SERVICE ESTABLISHMENT's or MOBILE FOOD SERVICE ESTABLISHMENT's Permit to Operate.

4. The RISK CATEGORY WORKSHEET will be kept on file with the Environmental Health Division until the establishment's permit becomes inactive, or a more recent RISK CATEGORY WORKSHEET is completed.

Significant Menu Changes by Existing Food Service Establishments & Mobile Food Service Establishments

1. The food service operation permit holder must contact the Environmental Health Division whenever there is a significant menu change that may not be covered under their current RISK CATEGORY.

2. The assigned Public Health Sanitarian shall review the proposed menu with the permit holder. The permit holder must complete the RISK CATEGORY WORKSHEET, with assistance from the Public Health Sanitarian if necessary. The RISK CATEGORY WORKSHEET must be signed and dated by both the permit applicant and the Public Health Sanitarian after completion.

3. The Public Health Sanitarian shall notify the Senior Public Health Sanitarian and the appropriate clerical staff of the change. A new permit indicating the appropriate RISK CATEGORY will be issued for the remainder of the permit cycle. If the change in RISK CATEGORY moves the permit holder from a Low Risk Establishment to a Medium or High Risk Establishment, the permit holder must complete the required Food Protection Manager Training within 30 days (pursuant to BOH Ordinance: Certified Food Protection Manager Training Verification, adopted 11-14-17).

4. The RISK CATEGORY WORKSHEET will be kept on file with the Environmental Health Division until the establishment's permit becomes inactive, or a more recent RISK CATEGORY WORKSHEET is completed.

Permit Holders Found Operating Outside Their Risk Category During an Inspection (Food Service Establishments & Mobile Food Service Establishments)

1. Whenever a Public Health Sanitarian finds a food service permit holder conducting a food service operation outside their RISK CATEGORY, the Public Health Sanitarian shall cite the operator of the FOOD SERVICE ESTABLISHMENT or MOBILE FOOD SERVICE ESTABLISHMENT for failing to adhere to their permit conditions.

2. The Public Health Sanitarian shall review the operation's practices and complete a new RISK CATEGORY WORKSHEET based on his/her observations. The completed worksheet will be reviewed with the permit holder at the conclusion of the inspection.

3. IF the permit holder agrees with the Public Health Sanitarian's findings, he/she shall sign and date the worksheet. The Public Health Sanitarian will note the change on the establishment's inspection report and submit a copy of the inspection report and the new RISK CATEGORY WORKSHEET to the Senior Public Health Sanitarian for review.

    a. The Public Health Sanitarian shall notify the Senior Public Health Sanitarian and the appropriate clerical staff of the change. A new permit indicating the appropriate RISK CATEGORY will be issued for the remainder of the permit cycle. If the change in RISK CATEGORY moves the permit holder from a Low Risk Establishment to a Medium or High Risk Establishment, the permit holder must complete the required Food Protection Manager Training within 30 days (pursuant to BOH Ordinance: Certified Food Protection Manager Training Verification, adopted 11-14-17).

    b. The RISK CATEGORY WORKSHEET will be kept on file with the Environmental Health Division until the establishment's permit becomes inactive, or a more recent RISK CATEGORY WORKSHEET is completed.

OR

IF the permit holder disagrees with the Public Health Sanitarian's findings, an ADMINISTRATIVE HEARING will be scheduled to ensure that the permit holder has a chance to be heard in a formal setting and that due process is observed. The Senior Public Health Sanitarian shall notify the Public Health Sanitarian and the appropriate clerical staff of the outcome of the hearing and make any permit changes/implement any penalties deemed appropriate by the Board of Health.

Temporary Food Service Establishments

1. The permit applicant shall complete the RISK CATEGORY WORKSHEET and submit a signed copy to the Health Department along with their TEMPORARY FOOD SERVICE ESTABLISHMENT permit application.

2. The assigned Public Health Sanitarian shall review the proposed menu and the RISK CATEGORY WORKSHEET for completeness and accuracy. The Public Health Sanitarian will contact the permit applicant with any questions regarding the permit application or the RISK CATEGORY WORKSHEET.

3. Once the Public Health Sanitarian has determined that the worksheet is acceptable, he/she will sign the establishment's RISK CATEGORY WORKSHEET and submit it, along with the permit application for processing.

4. The assigned Environmental Health Division clerical staff preparing the establishment's permit shall include the appropriate standard language from the tables above on the TEMPORARY FOOD SERVICE ESTABLISHMENT's Permit to Operate.

Permit Holders Found Operating Outside Their Risk Category During An Inspection (Temporary Food Service Establishments)

1. Whenever a Public Health Sanitarian finds a TEMPORARY FOOD SERVICE ESTABLISHMENT permit holder conducting a food service operation outside their RISK CATEGORY, the Public Health Sanitarian shall cite the operator for failing to adhere to their permit conditions.

2. The Public Health Sanitarian shall review the operation's practices and complete a new RISK CATEGORY WORKSHEET based on his/her observations. The completed worksheet will be reviewed with the permit holder at the conclusion of the inspection.

3. IF the permit holder agrees with the Public Health Sanitarian's findings, he/she shall sign and date the worksheet. If the change in RISK CATEGORY moves the permit holder from Low Risk Establishment to Medium or High Risk Establishment, the permit holder must discontinue service of all medium risk and high risk foods for the remainder of the event (pursuant to BOH Ordinance: Certified Food Protection Manager Training Verification, adopted 11-14-17).

   OR

   IF the permit holder disagrees with the Public Health Sanitarian's findings, an ADMINISTRATIVE HEARING will be scheduled to ensure that the permit holder has a chance to be heard in a formal setting and that due process is observed. The Senior Public Health Sanitarian shall notify the Public Health Sanitarian and the appropriate clerical staff of the outcome of the hearing and make any permit changes/implement any penalties deemed appropriate by the Board of Health.

Definitions:

ADMINISTRATIVE HEARING – a formal hearing initiated the Health Department and presided over by a hearing officer appointed by the Cattaraugus County Board of Health, the results of which are reported to the Board of Health during a public session for action.

FOOD SERVICE ESTABLISHMENT – A place where food is prepared and intended for individual portion service, and includes the site at which the individual portions are provided, whether consumption occurs on or off the premises. The term excludes food processing establishments, retail food stores, private homes where food is prepared or served for family consumption, and food service operations where a distinct group mutually provided, prepares, serves and consumes the food such as a "covered-dish supper" limited to a congregation, club or fraternal organization. (definition obtained from 10NYCRR Subpart 14-1.20(a)).

MOBILE FOOD SERVICE ESTABLISHMENT - A mobile food service establishment is a self-contained food service operation, located in a vehicle or a movable stand, self or otherwise propelled, used to store, prepare, display or serve food intended for individual portion service, or a pushcart which is a cart or barrow, manually propelled, used to vend food intended for individual portion service. (definition obtained from 10NYCRR Subpart 14-4.30(a)(b)).

PERMISSION TO OPERATE – Formal permission granted to a religious, fraternal, or charitable organization by the Health Department to conduct limited food service at their premises, in accordance with the provisions of 10NYCRR Subpart 14-1.184.

RISK CATEGORY/CATEGORIES – A food service establishment permit designation describing the type of foods that may be served by the establishment, which is used when determining permit fees and food manager training requirements.

RISK CATEGORY WORKSHEET – A standardized worksheet used by the Environmental Health Division to assign risk categories to food service establishments.

TEMPORARY FOOD SERVICE ESTABLISHMENT - A "temporary food service establishment" means a place where food is prepared or handled and served to the public, with or without charge, and which operates at a fixed location in conjunction with a single event or celebration of not more than 14 consecutive days duration. (definition obtained from 10NYCRR Subpart 14-2.1(a)).

Applicable Forms:

FS-1: Risk Category Worksheet

References:

10NYCRR Subpart 14-1: Food Service Establishments

10NYCRR Subpart 14-2: Mobile Food Service Establishments

10NYCRR Subpart 14-4: Temporary Food Service Establishments

Board Of Health Ordinance: Certified Food Protection Manager Training Verification, adopted 11-14-17

Local Law Number 1-2017: A Local Law Establishing Fees for Cattaraugus County Health Department Services and Repealing Local Law Number 3-2011 (Intro Number 3-2011), as Amended

Review Schedule:

This policy must be reviewed/revised every three years, beginning with the year of adoption.

Revision History:

Revision Date	Pages/Section Revised	Revised By (initials)	Description of Revision
4/5/18	*Initial Adoption*	*RKD*	*Initial Adoption*

	Cattaraugus County Health Department			
	Policy Title:	Use of Previously Abandoned OWTS		
	Policy #:	OWTS-P-1	**Effective Date:**	4/5/18
	Date Reviewed:		**Next Review Date:**	1/1/21

Purpose:

This policy is intended to establish standardized criteria under which the use of previously abandoned ONSITE WASTEWATER TREATMENT SYSTEMS (OWTS) may be allowed by the Environmental Health Division.

Applicability:

This policy shall apply to all requests from the public to use previously abandoned ONSITE WASTEWATER TREATMENT SYSTEMS for new residential construction in Cattaraugus County.

Policy:

1. Any ONSITE WASTEWATER TREATMENT SYSTEM, which has been disconnected from a dwelling and unmaintained for a period greater than one year, shall be considered "abandoned".

2. The use of previously abandoned ONSITE WASTEWATER TREATMENT SYSTEMS for newly constructed dwellings will be allowed, provided the following conditions are met:

    - An OWTS PERMIT TO OPERATE the ONSITE WASTEWATER TREATMENT SYSTEM was previously issued by the Environmental Health Division.
    - The design flow of the ONSITE WASTEWATER TREATMENT SYSTEM is adequate for the projected flow of the new structure.
    - The lot in question meets the minimum lot size requirements established in the Sanitary Code of the Cattaraugus County Health District (SCCCHD 16.4.3).
    - There are no outstanding Sanitary Code violations (or other documented issues) pertaining to the operation of the ONSITE WASTEWATER TREATMENT SYSTEM.
    - The owner uncovers the septic tank(s), pump stations, and distribution box to allow CCHD staff to conduct a visual inspection of these system components. Any deficiencies discovered during the inspection must be corrected prior to approval to use the system.

3. The use of previously abandoned ONSITE WASTEWATER TREATMENT SYSTEMS will NOT be allowed unless the above criteria is met.

Procedures:

Granting/Denying Permission to Utilize a Previously Abandoned OWTS

1. Parcel owner must submit a written request to the Health Department asking for permission to utilize the previously abandoned ONSITE WASTEWATER TREATMENT SYSTEM in question. This request must include:

    - Identification of the lot in question (Address and/or Tax Map Number)
    - The number of bedrooms in the proposed dwelling
    - Any ONSITE WASTEWATER TREATMENT SYSTEM records available to the owner documenting its construction and maintenance

2. The assigned Public Health Sanitarian will review the request to utilize ONSITE WASTEWATER TREATMENT SYSTEM to determine if the criteria for approval are met. If so, the Public Health Sanitarian will schedule an appointment to inspect the uncovered system components and identify any deficiencies.

3. The assigned Public Health Sanitarian will respond to the request in writing indicating whether the request will be approved or denied. If the request is denied, the reasons for denial will be detailed in the letter.

Definitions:

ONSITE WASTEWATER TREATMENT SYSTEMS (OWTS) – Any excavations, piping, tanks, equipment or other appurtenances, designed to treat flows of wastewater, commercial pet waste, or fecal matter less than one thousand gallons per day. System components may include, but are not limited to, absorption beds, leach fields, sand filters, septic/holding tanks, and pumping stations utilized in the process of conveying, retaining, treating or disposing of such waste. These systems are regulated by 10 NYCRR 75. *(Definition obtained from SCCCHD 2.32)*

OWTS PERMIT TO OPERATE – A permit issued by the Environmental Health Division certifying the construction of an ONSITE WASTEWATER TREATMENT SYSTEMS (OWTS) and allowing it to be placed into service in accordance with the provisions of SCCCHD, Chapter 2, Part 16.5

Applicable Forms:

None

References:

Sanitary Code of the Cattaraugus County Health District, Chapter 2, Part 16.4.3

Review Schedule:

This policy must be reviewed/revised every three years, beginning with the year of adoption.

Revision History:

Revision Date	Pages/Section Revised	Revised By (initials)	Description of Revision
4/5/18	*Initial Adoption*	*RKD*	*Initial Adoption*

	Cattaraugus County Health Department			
	Policy Title:	Minimum Lot Size Requirements for OWTS Permits		
	Policy #:	OWTS-02	**Effective Date:**	4/5/18
	Date Reviewed:		**Next Review Date:**	1/1/21

Purpose:

Minimum lot size restrictions for the construction of ONSITE WASTEWATER TREATMENT SYSTEMS (OWTS) were incorporated into the "Sanitary Code of the Cattaraugus County Health District" during its August 6, 2015 revision by the "Cattaraugus County Board of Health". *(See SCCCHD 16.4.3)* The purpose of this Sanitary Code change was to create a regulatory mechanism to prevent future encroachment on drinking water supplies, and other environmental resources by OWTSs.

This policy is intended to establish a framework for implementation of these minimum lot size restrictions into the Environmental Health Division's onsite wastewater treatment system permitting process.

Applicability:

This policy shall apply to the permitting of all ONSITE WASTEWATER TREATMENT SYSTEMS by the Environmental Health Division, except those OWTSs that have engineering site plans approved by the Cattaraugus County Health Department in accordance with NYS Realty Subdivision Laws (*Article 11, Title II of the NYS Public Health Law & Article 17, Title 15 of the NYS Environmental Conservation Law*).

Policy:

1. Construction of **NEW** ONSITE WASTEWATER TREATMENT SYSTEMS is prohibited on the following:

    - Lots less than 40,000 sq. ft. where public water utilities ARE NOT available.
    - Lots less than 15,000 sq. ft. where public water utilities ARE available.

Table 1 - Minimum Lot Size Determination

	Public Sewerage Utilities	***Onsite Wastewater Treatment***
Public Water Utilities	*N/A*	*15,000 sq. ft.*
On-Site Water Supply	*N/A*	*40,000 sq. ft.*

2. Construction of **REPLACEMENT** ONSITE WASTEWATER TREATMENT SYSTEMS will be permitted on lots not meeting the minimum lot size requirements, provided that the system will serve an already existing residential structure.

    In such a case, a waiver from the minimum lot size requirements will be granted automatically, with the following standard conditions:

    - The replacement ONSITE WASTEWATER TREATMENT SYSTEM must be located on the same parcel as the residence, or located on adjacent land with a permanent legal easement for its use and maintenance.
    - In the event that this residence is destroyed/demolished/removed from the parcel, the replacement ONSITE WASTEWATER TREATMENT SYSTEM permit to operate and the waiver from the minimum lot size will automatically expire after one year.

The permit applicant must sign the Cattaraugus County Health Department MINIMUM LOT SIZE WAIVER FORM. This form documents acknowledgment that if the structure is destroyed or removed, the OWTS permit to operate will be revoked and the system must be abandoned.

Procedures:

Issuance of Waiver from Minimum Lot Size Requirements for Replacement Systems

1. Permit applicant must complete both an application for an OWTS PERMIT TO CONSTRUCT and the standardized MINIMUM LOT SIZE WAIVER FORM. If the OWTS cannot be located entirely within the same parcel as the residence, the permit applicant must also provide documentation to the Health Department that they have obtained a permanent legal easement allowing the system's construction and maintenance on an adjacent parcel before an OWTS PERMIT TO CONSTRUCT can be issued. This documentation will be kept on file with the Environmental Health Division.

2. The assigned Public Health Sanitarian will review the permit application and any site constraints, and issue an OWTS PERMIT TO CONSTRUCT as normal.

3. Once the system is constructed and has passed a final construction inspection, the Public Health Sanitarian will issue an OWTS PERMIT TO OPERATE with a copy of the approved MINIMUM LOT SIZE WAIVER FORM. In addition, the following condition clearly printed on the front of the permit:

   "In the event that this residence is destroyed/demolished/removed from the parcel, the replacement ONSITE WASTEWATER TREATMENT SYSTEM permit to operate and the waiver from the minimum lot size will automatically expire after one year."

Definitions:

MINIMUM LOT SIZE WAIVER FORM – A standardized form used by the Environmental Health Division to document the issuance of a waiver from the minimum lot size requirements established in the Sanitary Code of the Cattaraugus County Health District.

ONSITE WASTEWATER TREATMENT SYSTEMS (OWTS) – Any excavations, piping, tanks, equipment or other appurtenances, designed to treat flows of wastewater, commercial pet waste, or fecal matter less than one thousand gallons per day. System components may include, but are not limited to, absorption beds, leach fields, sand filters, septic/holding tanks, and pumping stations utilized in the process of conveying, retaining, treating or disposing of such waste. These systems are regulated by 10 NYCRR 75. *(Definition obtained from SCCCHD 2.32)*

OWTS PERMIT TO CONSTRUCT – A permit issued by the Environmental Health Division allowing the construction of an ONSITE WASTEWATER TREATMENT SYSTEM (OWTS), in accordance with the provisions of SCCCHD, Chapter 2, Part 16.3

OWTS PERMIT TO OPERATE – A permit issued by the Environmental Health Division certifying the construction of an ONSITE WASTEWATER TREATMENT SYSTEM (OWTS) and allowing it to be placed into service in accordance with the provisions of SCCCHD, Chapter 2, Part 16.5

	Cattaraugus County Health Department			
	Policy Title:	Minimum Lot Size Requirements for OWTS Permits		
	Policy #:	OWTS-02	**Effective Date:**	4/5/18
	Date Reviewed:		**Next Review Date:**	1/1/21

Applicable Forms:

OWTS-2: Minimum Lot Size Waiver Form (Existing Structure)

References:

Sanitary Code of the Cattaraugus County Health District, Chapter 2, Part 16.4.3

Review Schedule:

This policy must be reviewed/revised every three years, beginning with the year of adoption.

Revision History:

Revision Date	Pages/Section Revised	Revised By (initials)	Description of Revision
4/5/18	*Initial Adoption*	*RKD*	*Initial Adoption*

U.S. DEPARTMENT OF ENERGY | OFFICE OF ENVIRONMENTAL MANAGEMENT

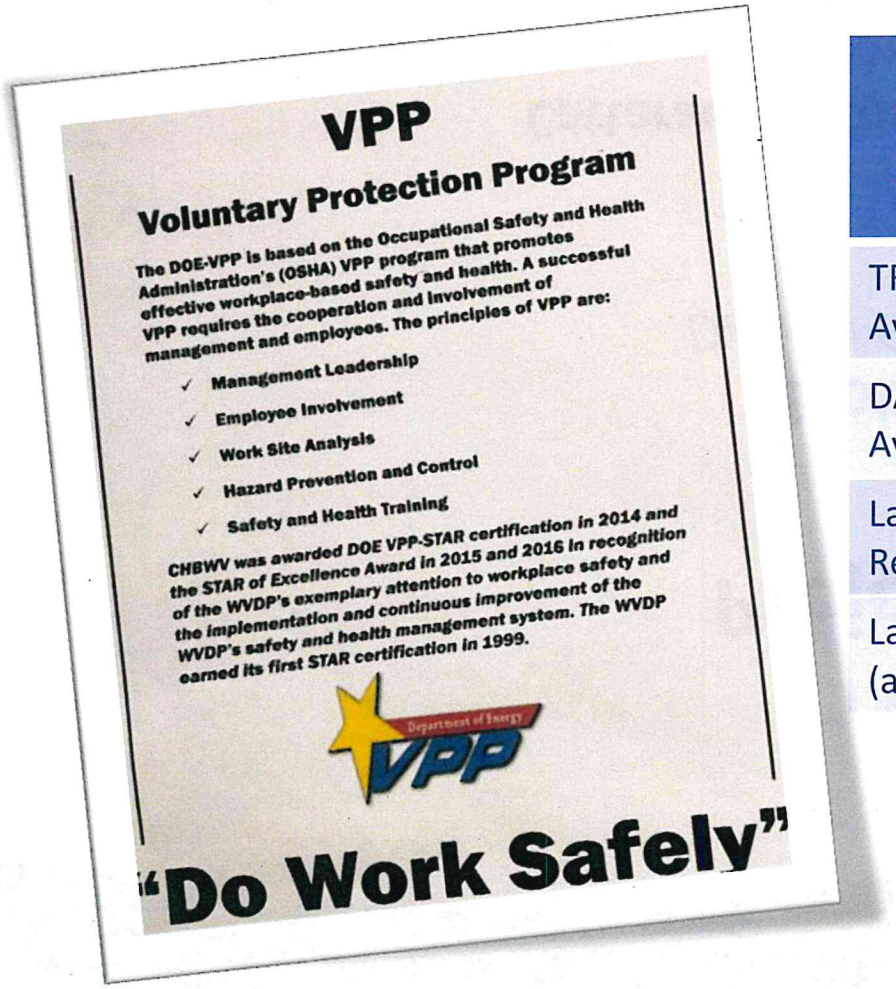
WVDP
Project Update

Scott Anderson
Deputy General Manager

Cattaraugus County Health Department
Board Meeting

March 7, 2018

Safety



Metric	March 2018 12-Month Rolling Average
TRC (12-Month Rolling Average)	1.33
DART (12-Month Rolling Average)	.33
Last Lost-Time Case Recordable	April 24, 2017
Last Recordable Injury (arm strain)	November 28, 2017

Department of Energy VPP

2017 Accomplishments

- ✓ Began Vitrification Demolition (September 11, 2017)
- ✓ Recertified as a DOE-Voluntary Protection Program STAR site
- ✓ Accelerated offsite legacy waste shipments
- ✓ Achieved significant progress toward preparing the Main Plant Process Building for demolition
- ✓ Completed major site infrastructure upgrades
- ✓ Successfully partnered with DOE toward reconfiguring site's electric supply delivery system
- ✓ Conducted support initiatives to benefit local communities

Contract Scope

Milestone 1

✓ Complete Relocation of 275 HLW Canisters and 3 Non-conforming HLW Canisters to Long-term Interim Storage ***(Completed)***

Milestone 2

- Process, Ship, Dispose of all Legacy Waste, not including Transuranic Waste (TRU)

Milestone 3

- Demolish and Remove the Main Plant Process Building and the Vitrification Facility

Milestone 4

- Complete All Work in Performance Work Statement, including Balance of Site Facilities, Surveillance and Maintenance, and Site Operations

Legacy Waste Processing

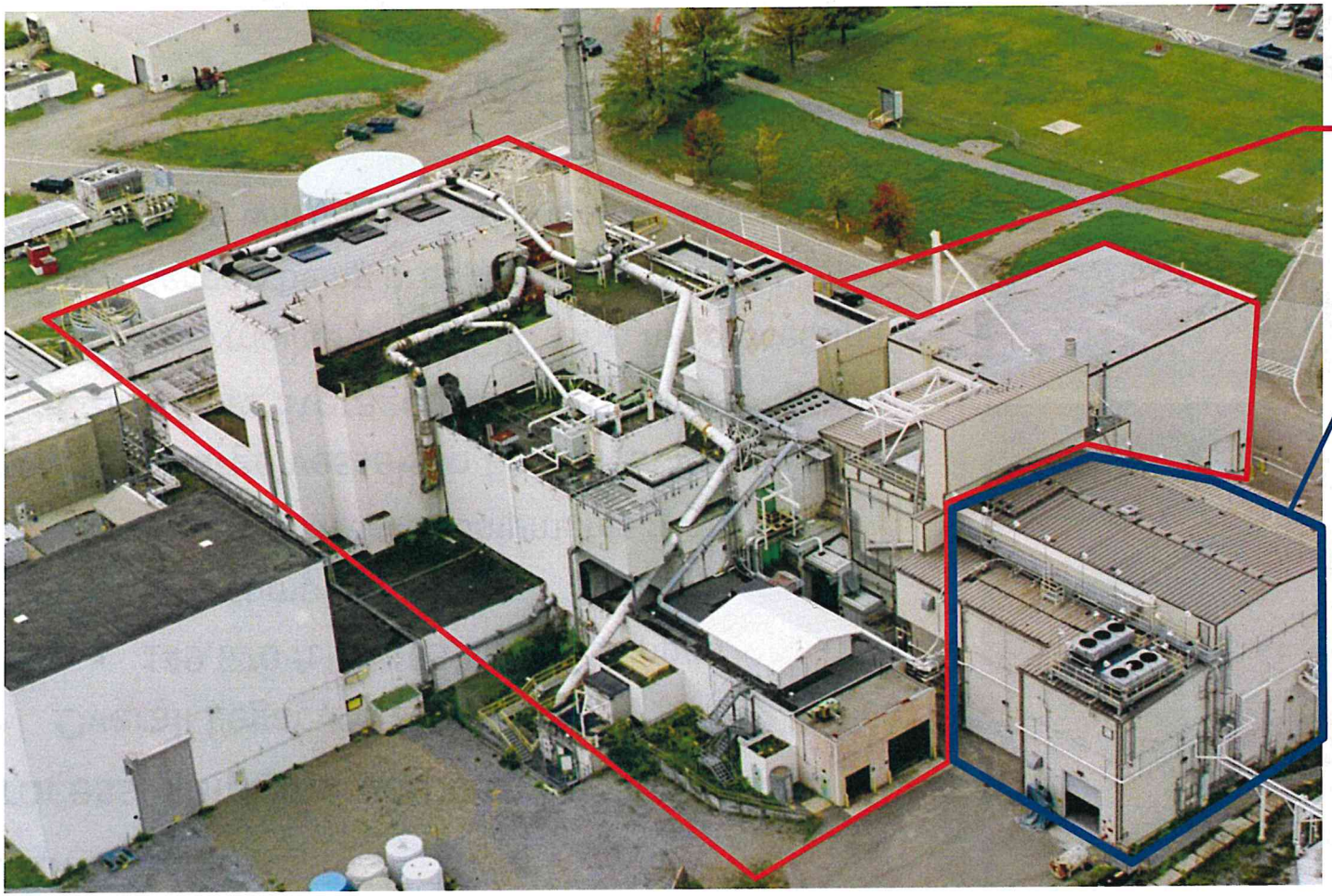
Milestone 2

- Process, ship and dispose Legacy Waste
  - Overall Legacy Waste status
    - 149,670 ft^3 of 165,515 ft^3 shipped
    - 90% complete
    - Approximately 24 shipments remain
  - Three large vessels in Chemical Process Cell-Waste Storage Area (CPC-WSA)
    - First moved out of CPC-WSA for processing
    - Second being prepped for processing
    - Third will be shipped intact for processing offsite
- Planned completion September 2018

Filled waste boxes moved to onsite shipment-ready area

One of the large components sits in the doorway of the CPC-WSA

Deactivation Progress

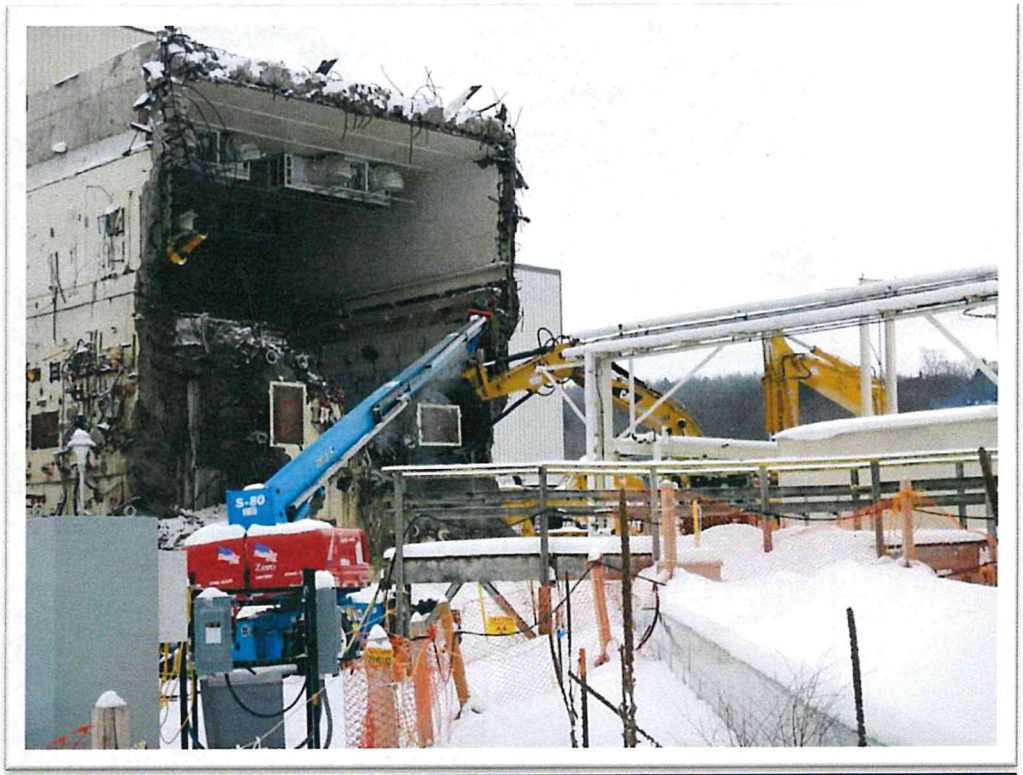


- Milestone 3 - Vitrification Facility (VF) Demolition – 50% Completed
- Milestone 3 - Main Plant Process Building (MPPB) Deactivation – 82% Completed
- Milestone 4 - Balance of Site Facilities Demolition – 19 of 47 Facilities Completed

Milestone 3 – Vitrification Facility

Milestone 3 – Vitrification Facility

- Demolition began on September 11, 2017
  - Phase 1 **Completed** (November 2, 2017)
    - Outer access aisles
  - Phase 2 is ongoing
    - Process Cell
    - Shield Doors
    - South Wall
  - Phase 3
    - Crane Maintenance Room
    - Tunnel
    - Secondary Filter Room
- Planned completion Spring/Summer



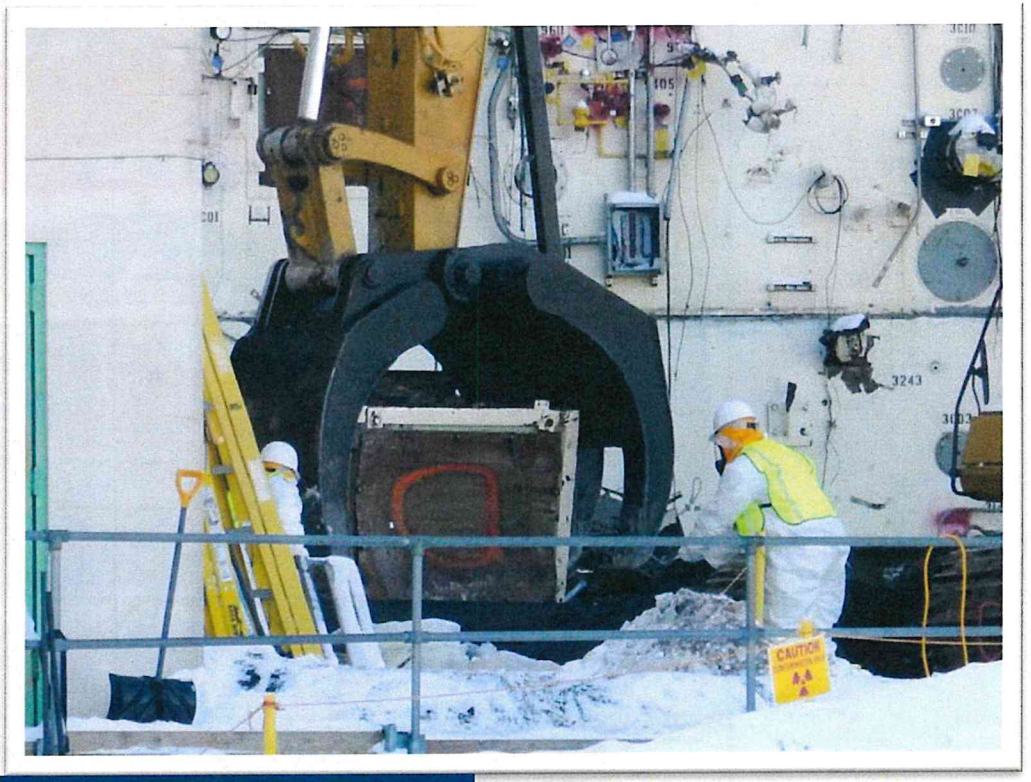
Removal of first shield window from the Vitrification Facility

January 18, 2018

Vitrification Demo Equipment

(Left Photo) hydraulic hammer attachment and (Right Photo) turbo mister

Vitrification Facility Phase 2 Demolition

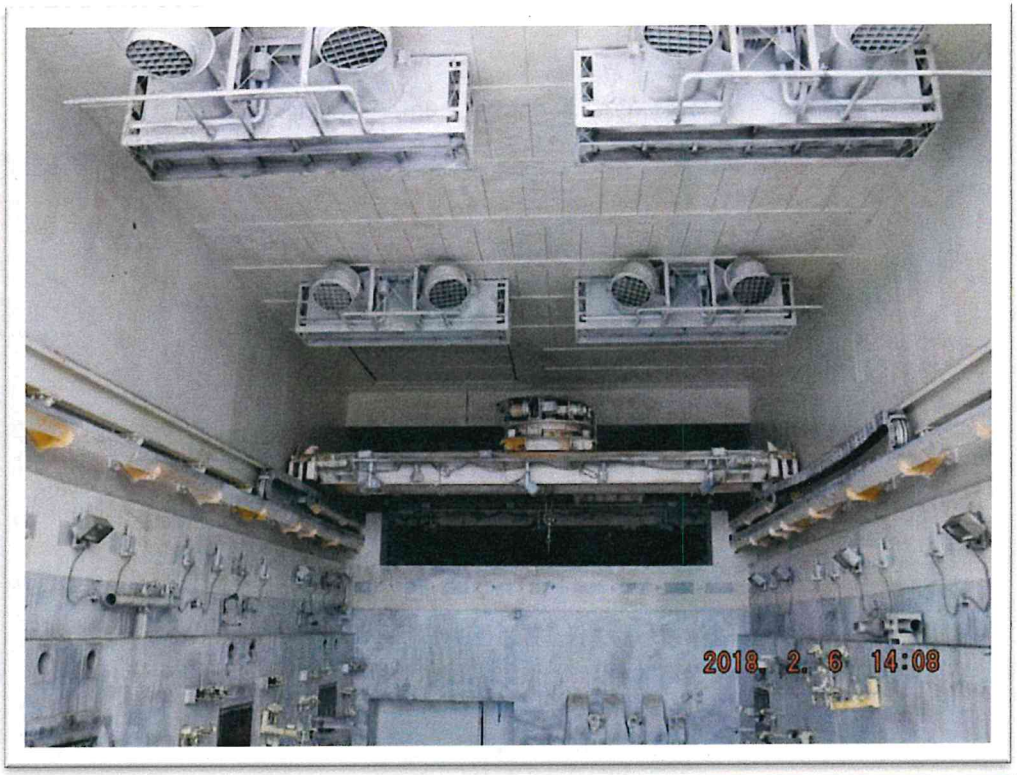


Removal of second shield window from the Vitrification Facility
January 19, 2018

Vitrification Facility Phase 2 Demolition

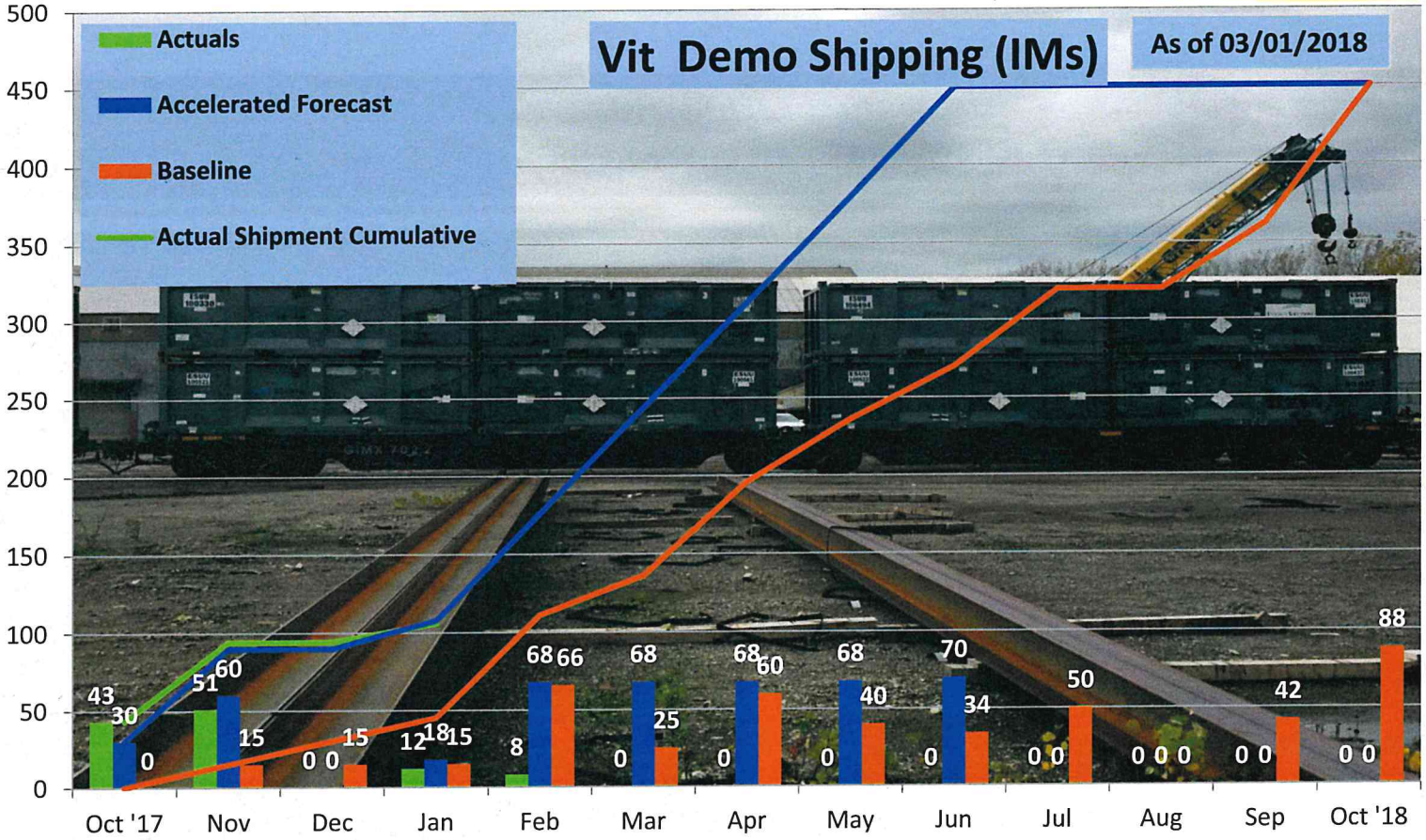
Shearing vitrification cell liner
January 31, 2018

Vitrification Facility Phase 2 Demolition



Inside view of VIT cell and coolers
February 6, 2018

Vitrification Facility Waste Disposal



Expected Debris Quantity: ~450 Intermodals (IMs)

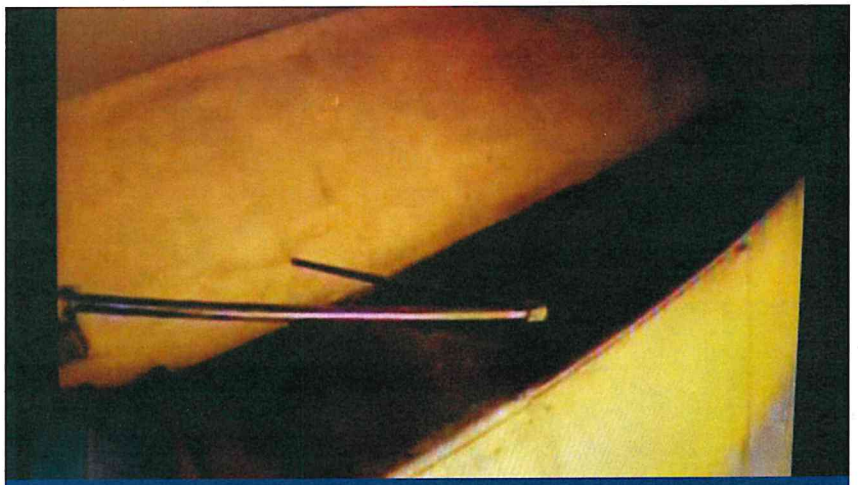
Status: 129 Intermodals Loaded; 114 Intermodals Shipped

MPPB Deactivation

Milestone 3 – Main Plant Process Building

- Six groups are performing deactivation and decontamination in MPPB
  - Asbestos-containing material (ACM) removal
  - Deactivation in radiological areas
- Several new areas now demolition-ready
  - Uranium Process Cell and Uranium Loadout
  - Acid Recovery Pump Room
  - Off Gas Cell Blower Room
  - Head End Ventilation
- Overall Status: 82% Deactivated
- Planned completion mid-to-late Summer

Chemical Process Cell Crane Room



South Ledge Before Decontamination

South Ledge After Decontamination

Balance of Site and Infrastructure

Milestone 4

- Performing deactivation to support removal of 47 Balance of Site Facilities
  - 19 facilities demolished and areas restored to date
- Reconfiguring Infrastructure for facility demolition and future site needs
  - All data and phone equipment are now located in the new data center
  - Received approval from County Health Department to connect new potable water distribution system
  - New electrical substation
    - Completed installation of cross braces on power poles
    - Scheduled power line installation on March 2
    - Expect operational in April 2018
  - Rail Spur upgrades scheduled for Spring/Summer

Roof being removed from VIT Hill restrooms

2018 Goals

- Perform All Work Safely and Compliantly
- Complete Disposition of Legacy Waste
- Complete Vitrification Facility Demolition
- Complete Main Plant Process Building Deactivation and Begin Demolition
- Initiate Off-site Rail Shipments
- Complete Gas and Electric Reconfiguration to Support Facility Demolition
- ✓ Complete Communications and Computer System Migration to New Data Center ***(Completed)***