

**QUARTERLY MEETING OF THE
ARKANSAS STATE BOARD OF HEALTH
October 24, 2019**

MEMBERS PRESENT

James Zini, D.O., President
Nathaniel Smith, M.D., MPH, Secretary
Phillip Gilmore, Ph.D., President-Elect
Melissa Faulkenberry, D.C.
Terry Yamauchi, M.D.
Marsha Boss, Pharm.D
Donald Ragland
Darren Flamik, M.D.
Balan Nair, M.D.
Thomas Jones, R.S.
Lane Crider, P.E.
Stephanie Nickols
John Clay Waliski
Dwayne Daniels, M.D.
Brad Erney, DMD, PLC

CALL IN

Anthony Hui, M.D.
Mike Riddell, M.D.
Susan Weinstein, D.V.M
Catherine Tapp, M.P.H
Greg Bledsoe, M.D.,
Surgeon General

NOT PRESENT

Vanessa Falwell, A.P.R.N.
Perry Amerine, O.D.
David Kiessling, D.P.M.
Eddie Bryant, M.D.

GUESTS PRESENT

Laura Shue, General Counsel
Reginald A. Rogers, Deputy General Counsel
Misti Chansley, AMCARE Senior Life Partners
Glen Baker, ADH, Public Health Laboratory
Connie Melton, Branch Chief, Health Systems
Brian Nichols, ADH, Administrative Law Judge
Shirley Louie, Center Dir. Public Health Practice
Matt McClure, Home Instead Senior Care
Marisha DiCarlo, Ph.D, Center Dir. Health Pro
Meg Mirivel, ADH, Director of Communications
Danyelle McNeill, ADH, Boards and Commissions
James Bledsoe, M.D., Medical Dir., EMS/Trauma
Greg Brown, ADH, Branch Chief, EMS/Trauma
Appathurai Balamurugan, MD, DrPH, ADH,
Deputy Chief Medical Officer
Becky Bennett, ADH, HFS, Section Chief
Cristy Sellers, ADH, Center Director Health Adv.
Shanna Maguffee, WRAAA
Kim Stead, Kindred
J. Don Adams, ADH, CLPH Field Support Services
Luke Mattingly, Carelink
Brandy Sutphin, ADH, Senior Epidemiologist
Namvar Zohoori, M.D., Chief Science Officer
Stephanie Williams, ADH, Chief of Staff
Christin Gunn, Mullenix & Associates
Pat Purifoy, ADH, CHA-Family Health
Lori Simmons, ADH, CPHP Branch Chief, Epi
Kelli Kersey, ADH, Health Sys Licensing and Reg.
Shane David, ADH, Pharmacy Serv. Section Chief
Jo Thompson, ADH, CFO, Office of Administration
Matt Gilmore, ADH, Boards and Commissions
Brooks White, ADH, Administrative Law Judge
Chuck Thompson, ADH, Managing Attorney
Clint Penzo, State Representative
Haley Ortiz, ADH, Sub Misuse Injury Prevention
Michael St. Clair, ADH, Law Clerk
Tressa Williams, Legal Services

MEETING OF THE ARKANSAS STATE BOARD OF HEALTH

The quarterly meeting of the Arkansas State Board of Health was held Thursday, October 24, 2019, in the Charles Hughes Board Room of the Freeway Medical Building in Little Rock, Arkansas.

CALL TO ORDER

Dr. Zini called the meeting to order at approximately 9:59 a.m. Attending via teleconference was Dr. Anthony Hui, Dr. Mike Riddell, Dr. Susan Weinstein, Ms. Catherine Tapp and Dr. Greg Bledsoe. Dr. Zini asked for a roll call and Dr. Smith asked Laura Shue to conduct one. Ms. Shue began the roll call by first announcing that we have a full Board, welcomed the four new members Dr. Daniels, Dr. Melissa Faulkenberry, Clay Waliski and Stephanie Nickols, who were oriented in September, and proceeded to call the roll.

After the roll call, Dr. Zini also welcomed the new Board members. Dr. Smith asked the new Board members to share a little about themselves.

Dr. Melissa Faulkenberry stated she has been in practice for 22 years as a chiropractor and lives in Little Rock. Dr. Dwayne Daniels stated he is an orthopedic surgeon in El Dorado. Stephanie Nickols stated that she owns Mountain Harbor Resort and Spa and is from Mt. Ida, Arkansas. Clay Waliski stated he lives in Carlisle, Arkansas and represents the hospitality industry, and owns Nick's Barbeque and Catfish.

APPROVAL OF MINUTES

Dr. Zini asked for review and approval of the August 1, 2019, Minutes. There were no corrections. Lane Crider made a motion for approval of the Minutes and Thomas Jones seconded. Motion carried.

OLD BUSINESS

County Health Officer Appointments, Faulkner and Johnson Counties

Dr. Namvar Zohoori presented and asked for approval of two appointments of County Health Officers. Dr. Zohoori stated that there is one County Health Officer in every county in the state. They are nominated by the County Judge and approved by the Board of Health. County Health Officers are not paid and voluntary, but they are very well known within their communities and are a big help and great advocates for the work done by the Health Department. They are involved in a number of different activities to promote the use of local Health Units and services that are available there, advocating with our State and local policy makers for various health related policies and are also involved in education and health promotions. They also assist where there are issues regarding emergency preparedness planning and implementation.

The first of the two County Health Officers for approval, is from Faulkner County, Dr. Robert Rook, who is nominated by Hon. Jim Baker. He works with the Conway Family Practice Clinic. He is a graduate of UAMS College of Medicine and completed his family practice residency there as well. He has served in a number of positions in the County as the Regional Board of Directors for Conway Regional and also as President of the Faulkner County Medical Society.

The second nomination is Dr. Sarah Woodruff, Johnson County. She is nominated by Judge Herman Houston. She is also a family physician, graduating from the University of Arkansas for Medical Sciences. She currently works at the Johnson Regional Medical Center as an attending physician and also the Clarksville Medical Group as a physician partner.

Dr. Smith said to the new members if they have questions about the roles and responsibilities of the County Health Officers, there are two County Health Officers on the Board, Dr. Zini and Dr. Bryant. They have been serving in those roles for many years. Dr. Smith asked Ms. Shue to talk about the background of Dr. Rook. Dr. Zini recommended that the County Health Officers be taken individually and to first discuss Dr. Rook.

Ms. Shue stated that we received the nomination letter from the County Judge, Mr. Baker, in February and the Board held the nomination in our April meeting because Dr. Rook had pending criminal matters. Those have been resolved after a trial set in August on allegations of sexual assault. The trial went forward and the alleged victim was not able to testify so double jeopardy attached. He has no pending criminal matters set before him at this time and there are no pending actions against him with the Medical Board.

Dr. Zini asked if there were any discussion from the Board. He stated this was brought up before. There being no questions or discussion, Dr. Zini asked if the Board was ready to vote. He said that this is recommended to the Board and asked if we needed a recommendation from the Board, a motion. Dr. Smith said we need a motion and a second.

Dr. Riddell moved that the Dr. Rook be accepted as County Health Officer. Dr. Bryant seconded the motion. Abstentions were Dr. Smith, Dr. Bledsoe, Mr. Ragland, Mr. Waliski and Dr. Daniels. Dr. Zini asked for a count of members voting in favor by a show of hands and a verbal vote from those appearing via teleconference. Motion passed with a vote of 13.

The next candidate was Dr. Sarah Woodruff from Johnson County. Mr. Jones moved to approved Dr. Woodruff as County Health Officer for Johnson County and Dr. Nair seconded. Motion carried.

NEW BUSINESS

Arkansas Central Cancer Registry

Brandy Sutphin, presented two requests. The first request was from the North America Association of Central Cancer Registries, which included four sub-requests; the Affordable Care and Cancer Stages at Diagnosis passive request, the Breast Cancer subtypes in U.S. Males passive request, the Trends in Testicular Germ Cell Tumor Incidence in the United States passive request and the Trends in Testicular Germ Cell Tumor Incidence in the United States, Part 2. This is an active request that in addition to previous trends requests single years of age be added.

The second request was from UAMS to use their data to calculate the impact of UAMS Mobile Mammography Van on cancer screening in women and cancer detection and early detection in women. Dr. Porter was available for questions.

Dr. Nair asked about the differences between an active and passive request. Ms. Sutphin stated that it concerns the details in the data that is requested, if data can be used to more easily identify individuals such as single of year age it becomes an active request and must be approved prior to the release. Passive requests are approved at request but can be retracted after release.

Dr. Yamauchi asked if the Board has to approve these like this grant every year, and why not just approve for the length of the grant, unless there is major change. Ms. Sutphin stated by law, anytime anyone requests to use their data, even if it is through NAACCR grant, the Board of Health still has to approve it. Dr. Yamauchi said it seems like we approved use of the data before. Ms. Sutphin stated that was other requests through NAACCR. Researchers request to use data through NAACCR and each time they make a request, NAACCR forwards those requests to them and each time it has to be approved for new requests.

Dr. Smith commented that there is a statutory requirement to review these requests and that has been in statute for some time. In the future, that may be something we look to change to where we have another process for approving those more quickly. As the Department applies for additional funding that would ultimately support the National Cancer Institute we may need a more streamlined approach similar to what some other states are using. We already have a process of scientific review for these. That is something that we will probably have more discussion on but for the time being we have a statutory requirement to review those here.

Dr. Zini asked is there ever a cost other than like in this case in this instance it is provided by a grant, does it ever cost the Health Department otherwise? Ms. Sutphin stated that they require other outside researchers to pay a cost for the work but thinks it is below \$800. Dr. Zini asked if it is always budget neutral for the Health Department. Ms. Sutphin answered yes.

Catherine Tapp moved and Dr. Hui seconded to approve the requests of the Arkansas Central Cancer Registry. The motion carried.

Dr. Zini reminded the Board that all the items on the agenda require a vote and will require a motion.

Vital Records Revised/Updated Disinterment Request and Disinterment Approval Forms

Shirley Louie presented and asked for approval of two forms, both involving disinterment of a human body that is buried in Arkansas. Act 1254 of 1995 states that in order for a body to be disinterred, the process has to be approved by the State Registrar. These forms have been in place for a while. She is updating and revising them. The previous forms were paper, completed by hand and either faxed or hand delivered to their office. The new forms are revised as to the way they look, the way they are processed, as well as the processes. They are using them within Vital Records. The first form is the Request to Disinter. This form is completed by a licensed Funeral Director. It contains all the information about the deceased, where the body is currently buried, where the body will be buried, the purpose for the disinterment, and requires it to take place 30 days after approval. Once the request for permission is submitted, it is reviewed by the State Registrar and a permit is issued. That permit goes back to the licensed Funeral Director and the licensed Funeral Director is responsible for making sure that they follow the policies and procedures and the rules that apply to disinterment.

Dr. Zini asked if this ever involves a court or just when a cemetery is being moved for some reason, and not involving a criminal investigation. Ms. Louie stated that it can. They have approximately 75 requests per year. Most of them are to have a body moved from one cemetery to another. Often times it is from a private cemetery to the State Veteran Cemetery or from one plot to another within the same cemetery for family purposes. Another reason can be because they put the body in the wrong place or if there is not enough space for everybody to fit in that plot. But a third possibility is that law enforcement or the court requests that the body be disinterred for forensic purposes.

Mr. Crider moved and Mr. Waliski seconded that the forms presented by Ms. Louie be approved as presented. Motion carried.

Newborn Screening-Additional Testing

Dr. Glen Baker presented and asked for permission to proceed with the development and addition of four new assays for newborn screenings. These are recommended by the Uniform Screening Panel, a national panel serving under the U.S. Department of Health. They review newborns for congenital diseases and tests that might be useful in making the diagnosis and managing the patient and make those recommendations available to all of the states. The Lab follows those recommendations that are current as are the majority of the states. There are four new tests that have been recommended we will move those forward and implement them in the laboratory.

At the present time, 31 tests are performed on newborns, two of them are performed at the hospital. Hearing and the critical congenital heart disease is performed at the hospital. Twenty-nine of the tests are performed in the laboratory. Those are performed on dried blood spots that are collected from the children soon after 24 hours of birth, submitted to the laboratory and then we perform the 29 tests.

Of the four additional tests, three of them have FDA approved procedures. CLIA standards require the laboratory, when dealing with clinical specimens, that the tests performed have FDA approval. One test does not, that is for Spinal Muscular Atrophy (SMA). There is an option to implement that test, by giving the laboratories the opportunity to develop a laboratory approved methodology and accepting that as validation to do the tests. These four tests can be performed in our local health laboratory utilizing existing blood samples without having to require new blood samples from the hospital. Three of the tests are FDA approved and can be performed in the laboratory using existing instrumentation and trained personnel. We do not require additional staffing or new equipment. The only additional costs would be for the reagents.

The fourth test, for spinal muscular atrophy, does not have an FDA approved methodology. It is different from the other tests in that it tests for the absence of or malfunction of gene SMN1 on chromosome five. That gene is responsible for maintaining the neuron protein that maintains stability of normal motor neuron function. In its absence, degeneration and later complications for the patient can result.

The SMA test can be developed in the laboratory and we are in the process of doing that. We are working with some of the other states that are basically in the same situation we are in developing the assay. We are monitoring their activity and patterning some of ours after that activity. We are working with some of the chemical suppliers to make sure we get the reagents. That test will require a clean room that is free of the contaminating DNA. We have that room established and it is ready to be used. It will require new equipment and we have identified that equipment and have it board. It will require an additional analyst simply because it is a different platform than what we are using for the other tests and must be handled separately. We have that position approved and will be recruiting for that.

There will be an additional charge for the SMA test of \$10.00, which was approved in the presentation to the Legislature. The SMA test, in addition to being recognized by the Screening Panel, is mandated by the Legislature.

The SMA is stated to occur in 1 in 10,000 – 15,000 individuals. That probably will change, as it is not a routinely performed assay. As more states start performing the SMA test, it may return on the frequency of the disease. It is also recessive, which means that both parents must carry the defect and it is estimated that every 1 in 20,000 – 50,000 individuals are a carrier of the affected gene. Possibly, you will find that the population in Arkansas is 15 – 17,000. In checking with the neurologist at Children's Hospital, they are following at least three patients that we know of with this disease.

The assay can be and is being developed in the laboratory and it will be validated by receiving samples from prurient cases as well as screening 3,000 – 5,000 unknown samples to make certain that they are part of the facts of developing the assay of the disease might give you a false positive. Each of these tests, this one plus the three additional ones, plus the 29 that we now perform, are monitored by a follow-up program of the Health Department and they follow those children for 18 years. That follow-up group program staff have developed procedures to address these patients and the Children's Hospital has developed the methodology to follow these patients and neurologists are committed to following these patients.

The Pompe disease occurs in about one in every 40,000 individuals. This is a glycogen storage disease where glycogen is stored in the nerve and interferes with the function of the child.

MPS1, mucopolysaccharidosis, only occurs in about 1 in 100,000 people. Dr. Baker stated that during his clinical laboratory rotation as a resident at the University of Missouri, he was assigned one patient to prove that they had mucopolysaccharidosis. It is a rare disease and probably none of the physicians in Arkansas will see a patient with it, but it is recommended that we follow that. Mucopolysaccharide is a complex glucose that is not metabolized by the body and builds up in the individual and which you see in the pictures of the children with the disease.

Cerebral XLD is the third disease that occurs in about 1 in 17,000 individuals. It is a fatty acid accumulation around neuro fibers and alters their function. We are prepared to proceed with the development of the assay going for a public hearing and before the Legislature for approval. There should not be a problem with Legislative approval since one of the tests is mandated by the Legislature.

Dr. Bryant asked if because a gene is present, will we probably get a better education of what other kinds of genes are present. Dr. Baker replied yes, actually with the SMA there is a spectrum of diseases. These four and two occur primarily in the newborn and we want to identify those because the therapy that is available is effective when given early in the newborn's life. There is a new drug that was approved by the FDA for this drug by the company Novartis. You may have seen it in the paper because that drug is \$2.1 million per patient per treatment. It is one dose intravascular. There was an article in the Wall Street Journal about Novartis stating that they were being paid, the drug had been approved for three months and in that three months they had collected \$160 million in fees. They did indicate in the article that they have offered time payment to the insurance companies, if they wish to make partial payments. No one has accepted that according to the Wall Street Journal.

There is a follow-up program in place for the SMA that is at no cost. The follow-up program has that in place and at present and plans to implement it. It is a matter of identifying the patient, the physician responsible, sending them a package of material, they will collect the blood sample and send it to organization and they will validate the presence of the abnormal gene doing a whole sequencing on that patient and identify other problems that might be there and that is at no cost.

Dr. Bledsoe moved to accept the tests and the rule amendments and Dr. Riddell seconded.

Dr. Nair asked if these are added to what is already being done. Dr. Baker replied yes, it would be a total of 35 tests. Dr. Bryant asked if there is always a 100% penetrance of the gene. Dr. Baker responded yes, but there are four different clinical manifestations of the disease. The one we are concerned about is the impact on the newborn where it is almost immediate and can be treated with this new drug. The others are different, they are displayed by teenagers and adults who have more subtle problems. Dr. Bryant replied that means there are other genes in play. Dr. Baker stated yes, and when these samples are submitted to this company, they will identify them.

Dr. Yamauchi asked if there are three tests that are approved, and a fourth that has not been proven to be an effective screening, it sounds like you are going to be testing to see how effective or true it is by looking at some of these children that have the syndrome. Dr. Baker stated the test is not FDA approved, which means it has not met all of the requirements of the FDA of population screening. They are in the process of doing that, and hopefully, the FDA will approve the assay by mid-20. Prior to that time, the laboratory does have the option of developing the assay that is available and being utilized by at least four states as an approved assay. Dr. Yamauchi asked how the testing is not going to cost additional money, even though you have to have a clean room and the tech that will only run this test. Dr. Baker replied \$10.00 but we will ask the Legislature for an additional fee of \$10.00 to the existing fee of \$121.00, which will cover all of the tests. Dr. Yamauchi asked if that covers the cost of a clean room and a tech only doing this test. Dr. Baker stated that is correct. We need one additional person to manage this workload which is separate than the basic workload that we have.

Dr. Zini asked if Arkansas is the second state to do this. Dr. Baker stated several states now have legislation requiring this test be performed. Indiana started the assay by developing their own at the University of Indiana. The Lab is making sure we understand what they did and the approach to developing it.

Lane Crider asks for clarification on what the Board was voting on. Dr. Zini stated that the motion is these four tests are being added to the menu and these tests, at least the SMA test, was from a legislative new act requirement. Dr. Baker stated that the Lab is asking for permission to proceed with the rule and testing activity. Dr. Smith stated this will add these tests to our rules, one is requiring staffing, the other three we are adding because they are now a part of the recommended testing package nationally.

Dr. Riddell asked if the SMA was 1 in 40,000. Dr. Baker responded 1 in 17 – 20,000 but the carrier rate is one every 20,000 to 50,000. Dr. Riddell stated that it would be good to know for counseling purposes you are probably based on 37,000 – 40,000 births a year, you are probably going to pick up 2 – 3 cases a year. Dr. Baker stated that is correct, unless the frequency is greater than published data which is limited because there are not a lot of states doing the tests.

After a vote, the motion carried.

Licensed Lay Midwifery Rules Revisions

Chuck Thompson presented a rule revision in relation to occupational licensure requirements from the Legislature the past session. We reviewed several of these rules at the last Board meeting. These amendments ensure that we are in compliance of Acts 315, 426, 820, 990, and 1011, which require certain language for reciprocity, military licensure, licensure for those veterans and their spouses, and prohibiting criminal offenses. It is not substantive in the sense of science or public health, it is occupational licensure and that language is agreed upon language between the Department, the Attorney General's Office, and the Department of Labor. The agencies are trying to keep the same language, make it clear, concise, and in compliance with these statutes. One other change is the Act requiring hospitals to report transfers that they know about when a newborn is transferred to the hospital after a birth attended by a licensed lay midwife. We have a form that our staff created in response to that legislation that the hospitals will use to report these transfers to the Department.

Dr. Weinstein moved and Dr. Hui seconded that the changes be accepted. Motion carried.

Private Care Rules Revisions

Becky Bennett presented three different rule sets, starting with private care. In 2017, Health Facility Services began revising rules for the private care agencies. They met with industry leaders and got their comments, concerns and recommendations and created draft rules. In 2019, Act 811 was enacted and required the formation of a rule working group to be made up of representatives from the industry, both home health and private care. The Act stipulated changes in who was capable of supervision of care, define primary offices, sufficient number of regional offices to meet the client needs and to not require registered nurses to make supervisory visits. They also created a hundred-mile radius for a service area. These same requirements would apply to home health agencies who delivered personal care.

Health Facility Services sent the working group a copy of our draft that we had created, working on it since 2017, and asked them to review it and to come to the first meeting prepared to vote on whether they wanted to use that draft or start over from the beginning. The working group voted to start with the draft because they had recognized that several of their recommendations were already put in this draft. The changes the working group suggested including replacing the term "plan of care" with "aide assignment sheet." They wanted to change "practitioner" to "supervisor," replacing survey intervals to no more than once every three years, replacing registered nurse to qualified supervisor and define client as a Medicaid eligible recipient. These requested changes are agreed to by the rule-working group as defined in Act 811 of the 2019 Legislative Session.

Ms. Bennett requested to move forward with the administrative rule working process. Mr. Ragland moved and Mr. Crider seconded to accept the private care rules revisions. Motion carried.

Home Health Rules Revisions

Ms. Bennett recognized several members from the rule-working group who were present and thanked them for their service.

Ms. Bennett presented on Home Health Agencies Revisions. There are two types of home health agencies that are licensed in the State. There are two classes, a Class A and a Class B. A Class A is Medicare certified and provides skilled or professional care and personal care. A Class B is not certified by Medicare and provides personal and/or attended care and may provide skilled care. Because of Act 811 of 2019, we reorganized home health rules to segregate different type of services by different provider types. If there was a rule that only applied only to skilled care, we put it in its own section in the rules. Examples would be skilled professionals, registered nurses, physicians, so we clumped all those together and made it one big category rather than defining a physical therapist and social worker. We defined assessments because assessment is a skilled activity, not a nonskilled, and we looked at discharge planning because that is not performed in personal care.

We also assured Home Health Aide Services was placed in its own section since it is not applicable in Personal Care Services. If there are rules that apply to all service types, we placed those in General Requirements. An example would be quality assurance. All provider types have to conduct quality assurance activities.

Lastly, when possible, we mirrored Federal CMS Regulation or the conditions of participation to avoid conflicting rules and to make it easier for the provider to meet the requirements and for the surveyors to enforce the requirements.

Dr. Yamauchi stated that he was confused that there are so many changes and who can qualify. He noted that huge blocks have been taken out, and he expressed that, perhaps it was due to the expertise of the group, questioned whether those changes are necessary. Ms. Bennett stated they felt they were. The reason they combined all of the skilled professionals is that some agencies may have a specific type and by putting that under the Skilled Professional we go to their Board for their scope of practice so it kind of onus back on the Boards that govern those types of skilled services. For instance, registered nurses, the Arkansas State Board of Nursing. If we were to receive a complaint on a nurse's practice we would refer that to the State Board of Nursing. It gives us an opportunity to not only have our rules but they intermingle with the other scopes of practices in the State of Arkansas. If we have a surveyor that went into a facility and was looking at all the requirements, if their HR records had all these different types of services, we would assure that they are following their scope of practice. Dr. Yamauchi asked whether you could still use physical therapy or podiatry. Ms. Bennett answered yes. But we would refer to their Board for their scope of practice. Dr. Yamauchi responded that is what bothers him. For a podiatrist or physical therapist, they would have to require certain recommendations or requirements? That is not a health board? Ms. Bennett answered no but they have the authority to refer it to that licensing board. If there was a complaint about physical therapy, we would go

and investigate it and go look and see if it met any of regulations but we might also have to refer that to that licensing board for their determination on discipline on that employee or that person. Dr. Yamauchi asked if it would require them to use an occupational therapist. Ms. Bennett replied that it would only if they have to provide occupational therapy services, then they would have to use one.

Dr. Nair moved and Dr. Erney and Dr. Weinstein seconded to approve Home Health Rules Revisions. Motion carried.

Abortion Rules Revisions

Ms. Bennett stated that the draft rules for abortion facilities were presented to the Executive Committee Meeting on July 8 and subsequently to the Board in August. At the August 1, 2019, Board meeting, it was determined that a subcommittee was needed to review the draft rules prior to the October Quarterly Board Meeting. The subcommittee was formulated by volunteers, including Dr. Marsha Boss, Dr. Mike Riddell, and Donald Ragland, as well as staff from Department of Health Legal and Health Facility Services. The subcommittee met and recommended a few changes. The first one was changing the definition of abortion to align with Act 953, which is the most current legislative definition for abortion. We added the use of manufacturer's directions for use for equipment biologicals and medications. That rule will always be current since manufacturers are required to keep their recommendations current. The last thing was adding current copy for all printed materials and DVDs provided to patients. That is an everlasting rule because we will assure that the most current copy of any literature that it is required to be in an abortion facility is the most current provided by the Arkansas Department of Health.

Dr. Boss stated that Ms. Bennett forgot to mention that the 20-week abortion ban had been removed because an 18-week abortion ban had passed, which is enjoined. Since it is enjoined, the 20-week ban was put back in because it is not enjoined and currently that is what it is. Dr. Boss commended Ms. Bennett and her committee on the job they did. Dr. Zini also commended Ms. Bennett on their work and thanked all the volunteers and staff for their assistance.

Dr. Boss moved and Mr. Ragland seconded that the new rules and regulations for abortion facilities be accepted. Motion carried.

EMS Rules Revisions

Greg Brown stated he was seeking approval to start the administrative process for the EMS rule revisions. Some of the changes are substantive, some are requirements about military licensure from recent Acts that were passed, and the rest are grammatical and general updates.

On Page 19, Medical Direction is one of the big changes in our rules. We created a new subsection for Medical Direction allowing the medical director who oversees the providers for

the EMS service to restrict their scope of practice in any way that he or she feels that needs to be done and with that they need to let the Department know that they have restricted their scope of practice. We took out a large section of the Scope of Practice, replacing about four pages of skills with a paragraph. It is very simplified but it follows the National Scope of Practice.

Dr. Smith said the first part of the presentation does not have any page numbers. Mr. Brown stated he added the page numbers to his copy and would relate the page numbers as he presents.

Mr. Brown continued, on Page 20, there is a section on Tiered Response. Any service in the old rules had to send the most highly licensed ambulance to every 911 call. This gives them the ability to use an Emergency Medical Dispatch protocol to send the most necessary ambulance to the call. It also allows EMS Service data to be submitted within 14 days instead of a month. We compromised and went to 15 days so that had an opportunity to do some quality assurance measures on theirs.

On Page 32, some of the FAA requirements were removed for air medical services. One of those happened to be hot refueling which is refueling an aircraft while it is running with a patient on board. Anything that would be FAA restrictive we removed from the Air Medical Section of the rules.

Dr. Weinstein pointed out that in the Tiered Response on Page 19, Section III, Section 6, there is a typo, air ambulance licensure. Licensure is misspelled. Mr. Brown said they will make that change.

Mr. Brown stated there were additional requirements added to flight personnel to include some of the FEMA classes, 100, 200, and 700, as well as pre-hospital trauma life support and the TMCC course. All changes have been reviewed and approved by the Arkansas Ambulance Association, Arkansas EMT Association, the Trauma Advisory Committee, the EMS Subcommittee and all of our educational subcommittees as well.

On Pages 47, 48 and 49, just about all of those pages have been removed. It listed by line item everything that an ambulance provider must do. The problem with that is National Scope Practice changes and every time it changes it would require us to go back and add rules or add a line or take something away. We added a paragraph at the beginning, and most states have done this, allowing our licensed providers to perform those skills that are outlined in the National Scope of Practice model including pharmacology medication and all of the skills that are outlined there as long as they have been credentialed by their medical director. Dr. Bledsoe has been working on that as well, and now we have recommended change by all of our providers and EMS services to make more clarity to what actual skills our provider can do.

Mr. Brown continued, if you want to go to Page 61, one of the Acts that was passed this last Legislative session was Act 958 which was the initiative that requires all EMS providers in the state to make a national certification. It also allows those who have let their national registry

certification lapse to gain it back by submitting a \$10.00 fee completing their application. It also requires that they maintain national certification throughout their license period within the state. Looking at that section, it is about six pages that have been marked through. The reason that is because when these rules went into place, the National Certification Model had changed and so you either renewed under the rules that were under the requirements that were before March 31, 2017 or you could renew on certain requirements after March 31.

Dr. Smith noted that the page numbers mentioned do not correspond to the Board materials.

Mr. Brown explained that entire pages, 94, 95, 96, 97, 98, 99, and to page 103, a large section of that has been taken out. At the top of Page 94, it says the following method licensure renewal will only be accepted until March 31, 2017. The Act took all of that away and it just says that you have to be nationally certified. And those who did not have national certification the registry gave us the way to go back into those who let it lapse.

The next pages clarify those who did not relicense after two years and those who did license after two years. On Page 114, there is an entire new section talking about registration, about those who come into the state through reciprocity making sure that they have a license from the state from which they are coming that they had no actions taken against their license in that state. It is very similar to what other licensing boards do and we just put that language in there to cover those who have come into the state making sure that they did not have any action against their license and leaving us some kind of documentation.

Dr. Zini asked, at the top of that page it says as evidence that the applicant's license from another jurisdiction is substantially similar to Arkansas's, so we do not require it to meet all of our requirements? Mr. Brown responded, if you go back one page before, some of these folks are military individuals and the military does their training differently, and it has the same exact requirements or from time to time will have general folks come from overseas. What we do is we look at all their credentials, education, we have one of our school review it to make sure it meets all of those very similar to what we do and we give license them based on that. Everyone that comes into the state has the exact same national certification. This allows for those folks that would otherwise not come from a registry.

Dr. Zini stated his concern that one could get into a difficult situation regarding the definition of "substantially" in making sure that they meet our requirements. Mr. Brown explained that this was the language that came directly from the Act that was passed this Session.

Chuck Thompson explained that the language is substantially similar. It is not really defined in the statute, but that language is copied directly from the statute in compliance with the General Assembly's intent. Dr. Smith asked if this is what we have been including in all of our rule language across the agencies, and Mr. Thompson answered, across the agencies, including the agencies represented by the Attorney General's Office.

Mr. Brown stated that on Page 120, regarding the language about physicians acting as medical directors from a U.S. Educational Program, we just ensured that there is a physician overseeing the initial training of our paramedics and EMTs. On Page 128, same information, we added ACLS in addition to our advanced CMTs. If they want to use that they can hold that and we allow them to conduct EMT and advanced EMT classes within their service if they have a private career education license from the Department of Education.”

Dr. Boss asked whether the EMS people take a test to get registered, and Mr. Brown replied, yes. Dr. Boss replied that the people in her profession, call it reciprocity, from another state or from government, is that what we are talking about? Mr. Brown replied, yes.

Mr. Brown continued, on Page 150, there is a section there about the Trauma Rules. This section was not updated they are under revision currently and we are not sure what those revisions will look like but once the Trauma Rule revisions are finalized and approved by the Board and eventually approved, we will be back to amend these particular pages to include the Trauma Triage guidelines which is an appendix in the very back of the EMS rules.

On Page 154, a lot of additional information was placed in the violation section of the rules. The reason is that many of the violations that we currently have or have been seeing over the last two years did not fall within anything that was in the violation section of our rules. We looked at other states around us. We worked with legal counsel to update this section to the things we are seeing now as far as violations within the state. It has changed a lot within the last 3 – 4 years of what we are seeing as violations among our providers.

Mr. Brown discussed the appendix of the Equipment List. We removed numbers of a lot of these items. We wanted to know do you have the equipment to take care of all patients that you are going to be dealing with according to your general protocols and scope of practice. Instead of having a name of a drug we put the classification of the drug because medical directors can choose to use different drugs within that classification.

The Trauma Triage guidelines is going to be updated in the next revision.

Mr. Crider asked about the minimum number of items required and why there is no longer a minimum. Mr. Brown stated that is the way it was always done.

Dr. Boss stated her concern that we see more EMS people that are being convicted or could be convicted or having problems or lining up in front of us and I do not understand why. I do not know what the criteria is to be an EMS or pass a test or whatever. The EMS people show up before this Board in trouble. Mr. Brown stated that every EMS provider that comes through undergoes a background check when they are initially licensed. Dr. Boss asked if they are tested for drugs. Mr. Brown replied no, initial drug testing for a provider is not done. That is an employment by the service. We background check both federal and state, depending how long they have lived in Arkansas.

Dr. Smith added that, in terms of individuals that we as an agency directly license, there are a lot of EMTs and a lot of cosmetologists. That is why those are the ones we see the most of. With these others they are licensed by their own Boards and do not see those here. Dr. Boss stated every job she ever had, she drug tested. Dr. Smith explained that is true for the jobs, but you were not tested for your license. We do not employ these folks but the reason that we have the most licensure actions on these, our cosmetologists and emergency medical personnel, is because numerically they are the ones directly licensed by our Board. Mr. Brown stated we license over 7,000. They are often young people and sometimes their lives are bogged in a bad pattern after they get their licensure. Mr. Brown agreed that it is a young person's profession.

Dr. Ridell and Mr. Gilmore motioned and Dr. Bryant seconded that the EMS rules revision be accepted. Motion carried.

The Board meeting took a break at 11:21 and reconvened at 11:29.

Radiologic Technologist Licensing Rules/Lead-Based Paint Activities Rules Revisions

Mr. Chuck Thompson recommended to take the radiologic technologist licensing rules revision and the lead-based paint activities rule revision together. He provided out a one-page update to the Board Packet, as the draft of the rule references Act 990 of 2019.

Dr. Zini paused to check with our phone Board Members to make sure that were back on the line.

Mr. Thompson stated that the lead-based paint activities rules originally had language referencing Act 990. Act 990 does not apply to two things the Department of Health does; it does not apply to EMS and does not apply to our certification to remove lead-based paint because those two occupations are listed in Title 20. Act 990 at the last minute was amended to not apply to Title 20. Mr. Thompson asked that the Board approve the rule with the caveat that the language regarding Act 990 be removed from the lead-based paint licensing rules.

Dr. Zini stated the agenda refers to radiation technologist licensing rules, but the cover page says radiologic technology licensing. Mr. Thompson noted a typo on the agenda. We are talking about rad techs licensure, use of x-rays, that type of things. Dr. Zini, we need to make sure that is corrected. The cover page on the section says Radiologic Technology Licensing. Dr. Smith stated that the agenda is wrong.

Mr. Crider motioned and Dr. Erney seconded to approve the Radiologic Technologist Licensing and Lead-Based Paint Activities rules revisions. Dr. Weinstein are we doing the first, the radiologic technician licensing or whether we are doing both, that plus lead-based paint? Dr. Zini, explained: it is my understanding that we were doing the radiation first and we have not taken up a motion regarding lead-based yet. Mr. Thompson stated he was hoping to do them at

the same time. Dr. Zini asked Mr. Crider if that was his motion, and Mr. Crider replied yes, based on the information given. Dr. Zini stated it is both. Motion carried.

Dr. Boss asked, what are the lead-based activities? Mr. Thompson stated that there is an obscure act that requires us to license and certify contractors and those that remove lead-based paint when they are doing renovations and things of that nature. ADH is primary, but if we were not administering it, the EPA would do it. There are probably only about 16 in the state.

Cosmetology Rules Revisions

Mr. Thompson presented the occupational licensing rule changes and substantive changes which are mostly formatting. He explained that there are some continuing education requirements that were made with the cosmetologist input they felt was more applicable for current practice. The major one when it comes to the Department, is a fee reduction. We generally do not ask for fee reductions. However, the program has been so efficient with the use of technology that has led to cost savings. There are many cosmetologists, as it is a very popular field and it has grown. Those two things together have led to some cost savings. We want to pass those along to the licensees and to the citizens of Arkansas. The Legislature have not approved these rules yet, but we have mentioned it to them and they are very appreciative and very thrilled with that as well.

Dr. Zini stated that one of the things that impressed him was how much of a reduction there was. Dr. Zini asked about the fee schedule and how much it is actually reduced. Mr. Thompson stated that the cost savings will be \$200,000 the first year and then maybe \$125,000 ongoing. For specific fees, I would have to have Kelli Kersey or Ms. Connie Melton come up but that is the cost savings we estimate to the citizens of Arkansas.

Dr. Zini asked if the fees have been reduced from \$150.00 per licensee to around \$50.00. Mr. Thompson replied that it reduced the license fee for schools. Dr. Zini pointed out that it was because of the Department of Health's assistance in helping this program become more efficient.

Ms. Kersey stated the fee reductions could be found on Page 6 of the Board package. In 2013, the fees for the practitioner were reduced because of a substantial cost reduction when it moved to the Department. We are now passing it along to establishment and school owners. It was over \$200,000 for this year. Mr. Thompson stated that was the most recent information that was presented along to the Legislature.

Dr. Boss asked whether people that do nails are cosmetology certified or if that was a different area. Ms. Kersey stated they are practitioners. We have cosmetologists, nail techs, estheticians and electrologists. Dr. Boss stated those are all under Health but the barbers they are different. Ms. Kersey stated, that is correct.

Dr. Bryant moved and Mr. Crider seconded to accept the cosmetology rules revisions. Motion carried.

Massage Therapy Rules Revision

Chuck Thompson presented the occupational licensing model language and substantive changes, the vast majority of which is formatting, and continuing education matters. The Massage Therapy Technical Advisory Committee has worked on this for a number of years just to improve the ease of reading and some things when it comes to education that they thought needed to be improved.

Dr. Weinstein asked a question, about whether “there is a word missing on Page 11, a new section 9, it says applicants for licensure are considered who have completed and graduated with a minimum of five? I think the word hundred is missing.” Dr. Zini, yes, we can take that as an editorial correction and we will correct that editorially.

Mr. Thompson affirmed that it would be corrected.

Mr. Crider asked if there are any specific differences in the rules for infant massage or other requirements. Mr. Thompson stated that unless you specifically exempted out in some manner all individuals practicing the occupation have to be licensed. Dr. Faulkenberry asked if a massage therapists could operate under a practitioner’s license. Mr. Thompson explained some of the massage therapist are exempted out based on being a medical practitioner.

Dr. Nair motioned and Dr. Bryant seconded that the message therapy rules revision be approved. Motion carried.

OTHER BUSINESS

Administrative Updates/Centers/Offices Updates

Chief of Staff Stephanie Williams presented the transformation of state government. Ms. Williams informed the Board that: “The first part was the reorganization of all state agencies into 15 operational units, each led by a Secretary that reports directly to the Governor. Dr. Smith is designated and has been sworn in formally as Secretary of Health. He continues to be Director of the Department, but also absorbed 23 Boards and Commissions. As a part of the Governor’s Cabinet, Dr. Smith meets periodically with other Cabinet-level Secretaries.

There is a Peer Working Group of the Chiefs of Staff, which meets monthly as well. There are leads in each of the 15 departments. Mr. Matt Gilmore is our point of contact for Boards and Commissions. He serves as our Transition Team lead for the Department and meets that group. Ms. Meg Mirivel, our new head of Director of Health Communication meets with the other media communication directors from the Departments. Our CFO, Ms. Jo Thompson, is meeting with all the other CFOs and Ms. Tracy Bradford our HR Director is meeting with all the other HR Directors. She stated it is significant for us in learning to work together and have an

opportunity to get to know each other and to share best practices, as meeting our other Chiefs of Staff has been tremendously helpful.

Ms. Williams provided a handout of the 23 Boards and Commissions that came to the Department. Ms Williams noted that the first meeting with the Directors of these Boards and Commissions was held in August, where Dr. Zohoori presented a scientific update and our strategic planning process. We invited Boards or Commissions to give a presentation. The Minority Health Commission Director, Ms. ShaRonda Love, presented at that meeting. The next meeting with this group will be October 31 in the Public Health Laboratory and Dr. Baker has offered a tour similar to what many of the Board Members received over the summer. During that meeting, Sue Tedford, the Director of the State Board of Nursing, will be giving a presentation. Things are moving along smoothly as we have focused primarily on critical issues. Some of the Boards and Commissions had issues with space, like leases expiring.

Ms. Williams reported that we have been able to move the Spinal Cord Commission into space we had available here at Freeway Medical downstairs on the First Floor. That move was completed last month.

We are learning more on how they do their financial management and HR practices. Our CFO, Jo Thompson, has set up a schedule for onboarding the Boards and Commissions into our financial management structure. She is holding individual meetings with them. Beginning next month, Tracy Bradford, our HR Director, will begin the same process for Human Resource Management. Mr. Gilmore is available if there are particular questions about how things are going. Secretary Smith is also meeting with the Boards and has made himself available.

PUBLIC HEALTH SCIENCE/PROGRAM UPDATES

Vaping Related Pulmonary Tests Investigation

Dr. Bala presented an update on vaping related pulmonary tests investigation. There is a nationwide outbreak on vaping e-cigarette associated lung illness. Nationally the numbers have come close to 1,500, with about 33 deaths. Other than Alaska, almost all the states have this outbreak.

In the state of Arkansas, Dr. Bala leads the investigation along with CDC Epidemiology Intelligence Officer Allison James. The Department of Health is coordinating with the CDC and FDA on this investigation along with our legal counsel. Dr. Bala continued, that to date in Arkansas we have about 20 cases of vapor-related pulmonary illness and three of them are confirmed, about ten are probable and seven under investigation. This classification happens as any individual that has a history within the last 90 days of using e-cigarette or vaping product and develops respiratory illness or GI symptoms. Respiratory seems to be the dominant one followed by nausea, and vomiting as seen by the clinician and had a chest x-ray where they found some pulmonary infiltrate or a CAT scan, which showed some signs of lung illness. Once

they are ruled out influenza, now that we are entering into the flu season and other infectious disease panel, and they did not have any underlying medical conditions causing their pulmonary illness they are considered to be a confirmed case. We have seven cases that are under investigation and a total of about 20.

We are also collecting samples, conducting medical history, and interviews with the patients across the state. Samples are collected and sent to the CDC laboratory for testing. What was found was similar to the national findings, which is about two-thirds of them with THC or CBD. We have weekly calls with the CDC and their people coordinating the monthly investigation. CDC has not pinpointed any specific agent or entity. The way e-cigarette or vapor works is the electronically charged coil is used to burn the fluid and anything oil based can cause severe lung illness. Nationally there are 33 deaths. There are no deaths in Arkansas to date but we are working on the investigation on that. We periodically send two physicians and other health care providers what are the signs and symptoms to look for and what are the clinical course of the patients and how to reach out to the Health Department outbreak response been in seeking help for this investigation.”

Dr. Boss asked why Alaska has no vaping incidents. Dr. Smith stated that it is likely because it is sparsely populated and there are long distances between where people live and health care centers that can do CT scans, et cetera. Some of it may be an ascertainment issue. Part of it is how aggressively you look for it. Someone gets sick with severe respiratory illness and they are put in the hospital and treat them with antibiotics. They either get better or they do not.

Dr. Zini questioned, is the phenomenon with the atomization of vapor or the compounds that are being carried by the vapor. Dr. Bala stated that currently there is no definitive answer. They are still investigating and CDC is still giving weekly updates. It appears that maybe it is just the process rather than the product but it is an ongoing investigation. In the initial part, THC was named, vitamin E was named. Dr. Smith replied there are different patterns of injury, and may not be one single substance. Inhaling super-heated oil into your lungs can create a certain type of injury and have been lipid-laden micro-phases that could be representing the process of clearing that out of the lungs but there could be other substances involved. What is in the fluid is highly variable. These are engineered as open systems to where people can put all sorts of in those. There are a lot of different things that are put in them and once those compounds are heated they can change through chemical reaction into different unexpected substances. It may not be just one thing and there are multiple patterns of injuries. A lot still needs to be done to understand this.

Mr. Waliski stated that being in restaurant business, he does have an understanding that a lot of his younger employees vape. They basically said that it is the replacement cartridges that are not necessarily licensed by whatever company makes whatever vape pod it is. The younger people that he has talked to are convinced that they are basically having black market pods and stuff that is designed to look like the real thing but it is not, it might be something worth looking into or analyzing further.

Dr. Smith stated the decision to make these open systems where you can get these pods from other places, was an intentional design decision. Just like the way these things are packaged and marketed has not been very successful in the adult market. They only make up about 3.2% adults actually vape even though these products are touted as basically cigarette replacements for adults. In contrast, 20.8% of high school students are current vapers. This has been a largely unsuccessful product among adults, which is supposedly the targeted audience and has been a block buster among under aged who are prohibited by law from purchasing these. In a recent survey, 30% of high school students who vape, also vape THC, which is obviously not designed by the manufacturer, but the design decisions are driving that.

Dr. Flamik stated he has read that certain states have banned certain items and asked whether those actions are warranted and are we going to follow the CDC lead on this. Dr. Bala stated that several states have taken different steps. In Arkansas, we have the implementation of Tobacco 21.

Dr. Smith said: “this is a product that is putting people in the hospital and killing them. It should not be something that you have to ban in a perfect world. I do think that whatever we do, education and enforcement of existing laws should take care of most of the problems. There has been one state, Massachusetts, which put a temporary ban on these products. There is a rationale to that. If it was lettuce or Blue Bell ice cream that was making people sick and putting them in the hospital and actually causing deaths, there would have been a federal agency that recalled the product already. It would not be up to individual states. We are in a different regulatory environment with this. That temporary ban in Massachusetts has already been challenged in court. How successful it will end up being is unclear. A number of other states have taken approaches towards banning flavoring and these are the things in large part make them so appealing to children, which is really where the usage occurs. We will directly address this issue of the severe pulmonary lung injury or the e-cigarette vaping associated lung illness or EVALI as it is called.”

Dr. Bala noted there is a separate web page within the Department of Health to update the general public and the providers about this outbreak investigation.

Hepatitis A Outbreak

Mike Cima, PhD. presented a slide presentation on the Hepatitis A outbreak, a review of the clinical features, and transmission of Hepatitis A. Hepatitis A is a viral illness and generally presents with fever, reduced appetite, nausea, vomiting, abdominal pain in the right upper quadrant and jaundice. It is general a self-limiting infection and in very rare instances can result in cholestasis or relapsing hepatitis. In very, very rare instances, death. What makes this disease difficult to investigate is the incubation period is exceptionally long, about 30 days. The incubation period is the time between exposure and when a person starts developing symptoms. On average about 30 days and can be as long as 50 days. Unlike Hepatitis C or Hepatitis B,

Hepatitis A does not have a chronic infection associated with it and once a person is infected or received the vaccination they are found to have immunity for life. Since late 2016, the United States has been experiencing an outbreak of Hepatitis A predominately among high risks groups. These include people who are using and injecting drugs, experiencing homelessness and men who have sex with men predominately. Since that time, 30 states declared an outbreak of Hepatitis A, 28 which are continuing to address that outbreak. Arkansas is one of them.

Dr. Cima stated that “transmission occurs among susceptible individuals through close personal contact, i.e., household and sexual contact or through contaminated food, i.e., infected food handlers. It was thought before this multi-state outbreak that one exposure was relatively rare and this would include your injection drug users.

Here in Arkansas, we identified our outbreak of Hepatitis A predominately among people who are using and injecting drugs, experiencing homelessness and men who have sex with men. In February 2018 prior to that point in the past decade, we have had less than 13 generally cases of Hepatitis A, most of which were attributable to international travel to areas of the world where Hepatitis A is far more common.

In 2018, we experienced a 34 percent increase over the baseline infection rate here in Arkansas. A map of the counties that have been impacted since the beginning of our outbreak was shown. Our outbreak started in Clay County, which is the far northeastern part of our state. The outbreak crossed over from Oklahoma. We had our first few cases crop up in Clay County and gradually moved southward and has now impacted greater than 50 counties here in Arkansas with Greene and Craighead Counties experiencing the heaviest impact with more than 200 cases between them. The demographic breakdown of cases so far there are far more men than women have become infected with Hepatitis A and more white individuals have been reported to have Hepatitis A infection compared to all other races. The total case count as of this morning is 433.”

A chart of the risk factor breakdown for Arkansas was presented. People who are using and injecting drugs count for the majority of cases. Two hundred fifty-five (255) or 59% of individuals have either self-reported or tested positive for a variety of illegal substances. Of those 255, 144 have self-reported that they prefer to inject their drugs. That is 57% of people who are using drugs.

Dr. Cima continued: “We have had 21 food handlers that we have addressed over the course of the outbreak. Among the cases of Hepatitis A, the number that are co-infected with Hepatitis C is 108, which is a quarter of cases so far. Based on a study, we would expect 2% of our general population to be infected with Hepatitis C. This speaks to the impact of the people who are using and injecting drugs. The number of people hospitalized for Hepatitis C stands at 52%. This is consistent with other states. Greater than 50% of their cases have been hospitalized as a result of this outbreak.

The epi curve shows that our outbreak started in the early part of 2018 and really took hold in the summer of 2018 with a peak occurring in October. Since then, we have continuously received cases of Hepatitis A, generally between 3 – 5 cases per week.

Dr. Cima explained that he participates in CDC phone calls biweekly to obtain information about what occurring in other states. They are providing education in the form of messaging to providers, hospital partners in the field to be on the lookout for Hepatitis A. He has presented to a number of different venues including county health officers and recently to the Public Health Committee at the state Legislature.

Additional grant money has been received for the response; however, that money has stopped specifically for Hepatitis A outbreaks. We do provide the vaccine for free while targeting high risk groups as this outbreak is affecting people who are predominately considered to be high risk. When addressing the outbreaks in jails where the risk population tends to aggregate a lot of other states have seen a number of their cases occurring in their jails and prisons. We also respond to food handler exposures, 21 cases have occurred in food handlers.

Dr. Cima continued with a summary of vaccination efforts: “To date 33 mass clinics have been conducted, predominately in the northeast part of our state. Additional 27 clinics have been done in jails with greater than 1,500 people vaccinated in those venues. In total, more than 35,000 vaccines have been delivered by ADH staff, almost half of which have been delivered as a result of the food handler exposure. More than 500 food handlers have been vaccinated since the beginning of the outbreak.”

Dr. Cima explained: “The presentation provides an estimation on what the cost of the outbreak is projected to be using a previous outbreak that was associated with a contaminated food exposure. Based on the parameters set forth by this study we would estimate that using our outbreak numbers this outbreak has so far cost \$4.8 million. This is extraordinarily conservative. This is an entirely different population than what this study was looking at. We are dealing with a high risk population of people who are infected with Hepatitis C, Hepatitis B, and people who are using drugs. It is quite possible that because of this outbreak is actually substantially more than \$4.8 million.”

Contributing factors to this outbreak is the worsening drug epidemic, which certainly plays a role and it is not just opioids. Here in Arkansas, methamphetamine is far and wide the most commonly abused drug and nationally methamphetamine has been identified as the fourth wave of abuse epidemic which started with prescription drug use, then went to heroine, then synthetic opioids like fentanyl and now methamphetamine. As we are seeing within our outbreak the number of co-infections with Hepatitis C is indicative of injection drug use or potentially indicative of injection drug use increasing throughout our state and nationally.

Hepatitis A in Arkansas and throughout the country is likely to continue for months especially as the outbreak shifts to more densely populated areas. Of late, we have identified cases of

Hepatitis A cropping up in Jefferson County and central Arkansas. While it has not taken hold we are likely to see more cases in these areas before the outbreak is over.

We continue to investigate cases timely and provide vaccinations for our targeted risk groups as well as communicate what is happening with our outbreak in the state for our state quotas.”

Dr. Flamik asked whether the Department was offering vaccines to the general public or just targeting the food workers. Dr. Smith replied that we are mostly trying to reach those with defined risk factors. We have been giving a lot of Hep A vaccinations to people who are potentially exposed through a food handler. About 14,000 of the 30-plus thousand immunizations that we have given have been to people who otherwise are low risk, they just happen to eat at a restaurant where a food handler was diagnosed with Hep A.

In Greene County, because it a relatively low population rural county and we had such a high concentration of cases and because we were having trouble because of stigma really identifying those who were at risk. We offered it to the general public and we got about half of our target population. Dr. Smith said he did not know how many of those were high risk but as this goes on we are learning how to better target our higher risk populations, trading experience with other states. He thinks we are getting better at that and hopefully in the future we will have some more specific data. This is the population at risk and this is the proportion of that population that was immunized. Overall we have had success. Four hundred thirty-three is far too many people for a vaccine preventable disease but compared to Kentucky, West Virginia, even Tennessee where they have thousands of cases throughout the state, we seem to be making some progress. This has been a learning experience for all the states.

Dr. Flamik asked is there any requirements for food handlers to be vaccinated. Dr. Smith stated there are no requirements for food handlers to be immunized for Hepatitis A. Just as a reminder, we have been immunizing children for Hepatitis A along with Hepatitis B as part of their routine childhood immunizations so in another 20 years this will not be such an issue. That is a long time to wait to solve a problem like this. Dr. Smith noted that there was legislation proposed in the last Legislative Session that would have made it a requirement for restaurants to have their food handlers immunized and we had offered to provide that free of cost for those who do not have insurance. That did not get out of committee but a lot of the restaurants, especially in the infected areas, have voluntarily required that because it just takes one case to really impact a business adversely.

Mr. Waliski stated that obviously a law or something like that would have to be passed before it is required. Restaurant owners highly encourage it just like perhaps getting a flu shot every year. No one in this business takes any joy or pleasure in seeing someone's operation being affected like that. One of costs that you did not have broken down is the cost of, imagine the stigma and if that is your livelihood, having to deal with that. What I might suggest would be because restaurants are subject to either bi-annual or an annual inspection with the local health inspector. Something that might could potentially work would be that anytime they have an inspection

perhaps if they have a flyer or something they could hand out or something that we could post that would make it where we could encourage our staff but at the same time they could see it and they do not want to let it be known, they do not want to advertise it, they could just see it. Go to the local health agency. A lot of the staff who work at restaurants it is a market thing or maybe prohibitively expensive or if you are a smaller operator that could be a good chunk of change if it is \$85.00 a pop or whatever it is on the market.

Dr. Smith added that for those who do not have insurance coverage there are free Hep A immunizations for food handlers but people have to know about it and have the information.

Mr. Waliski stated that he has been in his industry for decades and had no clue that it existed otherwise I would push it a lot harder. If there is something that can be deliverable from the people on the ground conducting those inspections, it could potentially stem some of this that we are seeing.

Dr. Falmik stated that it does seem like the Department is making a concerted effort in those areas. It is rare that you see an infectious disease of a 30-fold increase in one year. That is quite concerning. Dr. Smith stated our efforts have been concentrated where we have seen a lot of cases just because we had such a rapid uptick but realize more needs to be done in other parts of the state because it may become a statewide epidemic. We do not want to just be following the epidemic we would like to get ahead of it. Dr. Cima added that we are working on innovative strategies aimed at our target high-risk groups trying to get ahead of this outbreak before it really takes hold and in these high-risk areas of the state.

Dr. Boss asked how long have kids been receiving immunization for A & B. Dr. Cima stated that the vaccine for Hep A was licensed in 1995 and became a regular part of the immunization schedule in perhaps in 2000. Dr. Boss asked if that was for little ones. Dr. Smith replied he thinks it was made a school requirement in 2013, but it was already being recommended by pediatricians before that. Dr. Boss asked if there are a lot of 20 and 30 year olds unimmunized. Dr. Cima responded this is the population that it is predominately impacting. The medium age we have seen so far in this outbreak is in the late 30s.

Prescription Drug Take-Back, October 26, 2019

Ms. Shue reminded the Board of the Prescription Drug Take-Back Day on Saturday, October 26, 2019 from 10:00 – 2:00. The last drug take-back day resulted in over 14 tons of medication collected in Arkansas. Arkansas ranks third nationally in pounds collected per capita. There are 310 collection sites in Arkansas. She mentioned that flyers were available and encouraged members to take them to help promote the event. A flyer regarding the Arkansas Vape Take-Back Day taking place at the same time was also made available. Educators are encouraged to bring confiscated electronic nicotine devices with the battery removed. That is something new to add to the Prescription Drug Take-Back Day.

Ms. Shue will ensure that Board Members participating via telephone receive a copy of the handouts and any additional paperwork that was handed out in addition to our rules and also general reminder that the cancer registry data request, the Board of Health Subcommittee needs to have a quick meeting after the meeting.

Public Health Science Update

Dr. Zohoori presented updates in terms of some of the activities. Dr. Zohoori explained: Earlier the Board approved two County Health Officer appointments. One of the things provided for the County Health Officers in an annual symposium. Every year there is a weekend symposium where they bring as many of them that will come and provide a scientific program for them with continuing medical education on various topics that may be of importance to them both as public health practitioners and also in their clinical practice. Doctors Zini and Bryant are regular attendees of that. Each time we have about 60% of our County Health Officers that show up. This year the symposium was the last week in September and dealt with a number of important issues. Our entire Saturday morning session was dedicated to immunizations and heard from various aspects of immunizations including some of the risks in Arkansas, vaccine hesitancy and some of the policy challenges. One of the speakers was Dr. Jose Romero from UAMS who serves on the National Advisory Committee on Immunization Practices. He also provided a presentation.

There were a number of other topics that were dealt with including mass shootings in schools and gun violence, hometown health improvement and making our schools and communities healthier, HIV elimination, emergency preparedness, our social media platform and how we use those at the Department of Health, water quality, Hepatitis A, acute flatus myelitis, and also vaping related pulmonary injuries, just to give you an idea of the scope of topics that are provided on an annual basis. Topics are chosen each year based on what is topical and what is important.

Dr. Zohoori reported that they are moving into the strategic planning sessions for the Department. There is a four-year strategic priorities plan that is implemented each year. The next four years will be 2020 – 2023. The first day of planning was in early October with a group of our staff at the Health Department and a few of our partners including Dr. Zini.

Dr. Zohoori continued: “Thank you for your participation and representing the Board. As well as a few members from the College of Public Health including Dr. Mark Williams, Dean of the College of Public Health. Eight areas are being tagged as being important strategic priorities over the next four years. Those are addition mental health and suicide prevention, social determinants of health, obesity, access to care, public health work force development, vaccines and infectious disease prevention, health education and infant mortality. The second phase of this planning will occur on November 22. About 100 subject matter experts from across the state, not only the Health Department, will be brought in to help us go through the eight areas to

determine what strategies to use, and what measures to use to both implement and track the progress of these over the next four years.”

PRESIDENT’S REPORT

Dr. Zini stated he spends a lot of time with Dr. Zohoori and the staff does such an outstanding job. He is always impressed with everyone. Our Health Department does such an outstanding job in our state. Dr. Zini relayed that when he was being considered to be appointed to the Board, and he has served on other Boards and some are now going to be under our Secretary, but he was told that this Board plays such an important role in our state to the health of our population. It is the most powerful single Board because of all that it regulates. Looking at our agenda last time and this time and the directives from the Legislature to update all of what we do, it is a herculean effort. He stated he is so honored to be on this Board and to have chaired this Board and really appreciates all the hard work. Dr. Zini commended Dr. Boss on her work on abortion and the other committee members. He added that everyone seems to be willing to help and hopes the new Board members see the dedication from other Board members. Thank you very much for all that you do as well.

SECRETARY OF HEALTH’S REPORT

Dr. Smith highlighted some of the areas we, in Arkansas, especially the Arkansas Department of Health, are interacting with other states and our federal partners for some national initiatives. One is ending the HIV epidemic. Later today, we have our HIV Elimination Task Force Meeting. Dr. Smith stated that Dr. Zohoori mentioned Dr. Jose Romero and his role with the CDC’s Advisory Committee on Immunization Practices (ACIP), and that they met yesterday and this morning. He had the opportunity to participate yesterday as a liaison member for the Association of State and Territorial Health Officials. During that meeting, they approved the adult and childhood immunization schedule for next year, which is very important. He stated they also reviewed data on the progress towards a licensed Ebola vaccine. This has been used in central Africa. Over 200,000 individuals have been immunized. That is in process for FDA licensure here.

This morning, they are reviewing the measles outbreaks that we have had and talking about CDC national strategy for immunizing with competence. He is hoping to hear more about that next month in a meeting with the CDC Director, Dr. Redfield.

Dr. Smith stated that last month he also participated in a national meeting with the Association of State and Territorial Health Officials, basically, all the state health department directors. Chief of Staff Stephanie Williams gave a presentation on our Hometown Health initiative and she also received the Swearingen Award, which is the highest award that an organization gives to someone who is not a director of a health department. He believes she is only the second Arkansas recipient in the Swearingen Award.

Dr. Zini relayed that January 23, 2020, would be the next Board Meeting. Dr. Zohoori also stated that the Educational Session after the meeting. Dr. Zini thanked the staff for lunch.

Ms. Shue introduced Tressa Williams as the new Board of Health liaison who started Monday. She stated that they worked together at the Attorney General's Office and Tressa comes from the Friday Firm.

Dr. Zini reminded the Board that there are lists of Board Committees that he would like the Board Members to have an opportunity to review. There are five committees, which include the Executive Committee, Nominating Committee, Administrative Hearings Committee, Local Grant Trust Fund Committee, and the Arkansas Central Cancer Committee.

Dr. Zini asked Dr. Riddell, Catherine Tapp, Dr. Nair and Dr. Hui to remain on the line for the Arkansas Central Cancer Committee to meet after the meeting is adjourned.

Motion made and seconded to adjourn.

Meeting adjourned at approximately 12:40 p.m.



Nathaniel Smith, M.D., MPH
Secretary of Health
October 24, 2019