



Concerning Our Health

Sexually Transmitted Diseases Rise in Putnam

Rates of the sexually-transmitted disease *Chlamydia trachomatis* (CT) have been rising dramatically in Putnam County, in comparison to both the national average and New York State (without New York City).

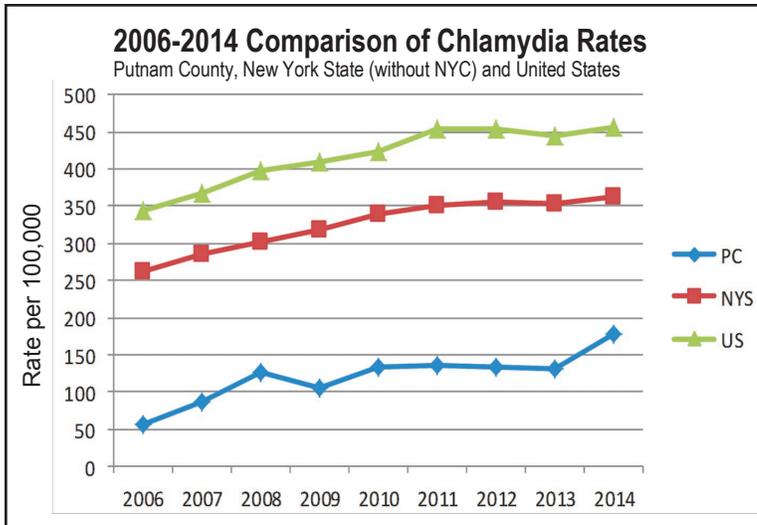
Over eight years from 2006 to 2014, Putnam's rate increased more than 200 percent, compared to 32 percent in the country and 38 percent in NYS.

Sexually transmitted diseases reported to the health department also include gonorrhea and syphilis, and syphilis numbers have also

surged in recent years, particularly among men in NYS. So far in 2016, there are twelve confirmed cases in Putnam, compared to seven for all of 2015.

The rise in CT-infection prompted Expedited Partner Therapy (EPT) to be signed into New York State Public Health Law in 2009, permitting health care providers to provide patients with CT antibiotics or a written prescription for antibiotics to deliver to his or her sexual partner(s) without clinical assessment of those partners. EPT has been shown to reduce CT re-infection rates. If a partner is unable, unlikely or unwilling to seek direct care, this strategy serves as an alternative for managing the care of partners of CT patients, with chlamydia alone. More information for healthcare providers:

<http://www.health.ny.gov/diseases/communicable/std/ept/>



Putnam's chlamydia rate increases have outpaced both New York State's (without New York City) and the national rate.

Common Ground on Bed-sharing: Risk Reduction

Sudden infant death syndrome (SIDS) remains a mystery. While rates have declined by more than 50 percent since the Back-To-Sleep campaign was launched in 1994, in recent years this reduction has plateaued. At the same time, deaths from other sudden and unexpected infant deaths (SUIDs), such as accidental suffocation and strangulation (ASSB), have increased, due in part to better investigation and data collection. Over the decade from 2004 to 2013, approximately 3,500 babies died suddenly and unexpectedly each year in the U.S.

Medical experts and public health advocates continue to recommend both breastfeeding and safe sleep environments, along with back sleeping, to reduce these numbers. Co-sleeping in the form of room-sharing—but not bed-sharing—along with a firm sleep surface, free from soft objects and loose bedding, comprise the most safe sleep

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Opioid Epidemic Action Plan Ramps Up

Medical schools and professional associations nationwide, along with federal agencies, have stepped up efforts to combat opioid overdoses. The 2016 National Rx Drug Abuse & Heroin Summit in March offered a forum where proposals and plans were presented by the private sector and government to improve treatment access and further enhance education on opioid prescribing for healthcare providers.

One proposal, backed by the **American Society of Addiction Medicine**, was to increase the current patient limit for qualified physicians prescribing buprenorphine from 100 to 200 patients. (Health and Human Services (HHS) has since officially raised the limit to 275.) Other initiatives include funding 271 community health centers across the country and expanding medication-assisted treatment (MAT) in 11 states, while integrating it with non-pharmacologic therapies. These plans are made possible with the release of more than \$100 million by HHS and by the Substance Abuse and Mental Health Services Administration (SAMHSA).

More than 60 medical schools nationwide, including highly ranked institutions such as NYU School of Medicine, Baylor College of Medicine, and the University of Rochester School of Medicine and Dentistry, announced that beginning this year, their students will be required to take some form of prescriber education before graduating, in line with the newly released Centers for Disease Control and Prevention Guidelines for Prescribing Opioids for Chronic Pain.

Medical training also received a boost last October, when the **American Board of**

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Public Health Summit VI Convenes Record Number of Community Partners

More than 78 public health partners from 47 different community agencies convened at Putnam Hospital Center (PHC) on June 6 for the Sixth Annual Public Health Summit, organized by the Putnam County Department of Health with support from the hospital. The event serves as an opportunity

Edward Murphy, president of the Putnam Chapter of the National Association of Mental Illness, casts his vote for promoting mental health and preventing substance abuse as the top health priority.



for community health partners to discuss progress on the Community Health Improvement Plan (CHIP), and to learn of new developments concerning the county's various health priorities.

With a streamlined format, the half-day event began with an initial data presentation by Erin Pascaretti, the health department's epidemiologist, followed by panel presentations and discussions by community partners on current interventions, many of which were evidenced-based programs. Dozens of community interventions were discussed by panel presenters convened to tackle the two CHIP priorities—promoting mental health and reducing substance abuse, and preventing chronic diseases. (See listing of community activities and interventions at right.)

Everyone who works or lives in Putnam County is encouraged to participate in the CHIP process, by making your opinions count. **Take the online community asset survey, accessible through**

the homepage of the Putnam County website at www.putnamcountyny.com until July 31.

The direct link is www.tinyurl.com/Community-Asset-Survey

Select Activities and Interventions

- ▶ Mental health first aid training
- ▶ safeTALK, suicide prevention training
- ▶ CIT (crisis intervention team) training for law enforcement
- ▶ ASIST (Applied Suicide Intervention Skills Training)
- ▶ Anti-stigma media campaigns
- ▶ Text4Teens initiative
- ▶ Lifelines curriculum in most school districts
- ▶ "B4Stage4" media campaign
- ▶ Peer-to-peer mental health programs
- ▶ "Means Matter" forum and campaign
- ▶ Communities That Care (CTC) Coalitions
- ▶ Two Partnership for Success (PFS) grant surveys
- ▶ CTC Prevention Needs Assessment survey
- ▶ Second Annual Substance Abuse Prevention Conference at PHC
- ▶ Medication Take-Back Days
- ▶ MedReturn boxes
- ▶ Family Meals campaign
- ▶ Narcan trainings
- ▶ Simulated Impaired Driving Programs
- ▶ Pre-Prom Programs
- ▶ Work-site wellness programs
- ▶ Daycare and school gardens
- ▶ Chronic Disease Self-Management Programs (CDSMP)
- ▶ Policy work to include "eCigs" in Indoor Clean Air Act
- ▶ Electronic Medical Record (EMR) with tobacco use questions
- ▶ Electronic referrals from EMR to Quitline
- ▶ Freedom From Smoking training
- ▶ "5As" for smoking cessation counseling
- ▶ POW'R Against Tobacco surveys
- ▶ Tobacco-Free Parks
- ▶ Tobacco-Free Housing
- ▶ Tobacco-Free Grounds
- ▶ Smoke-Free media campaigns

Common Ground for Breastfeeding and SIDS Prevention Advocates: Risk Reduction, continued from front page

environment. However, some caregivers continue to resist this advice, and tired breastfeeding moms understandably use bed-sharing as a way to ease and increase the practice of breastfeeding. Ultimately the goal for healthcare providers and public health advocates is to empower parents to make the best choices for their own baby, with the most current and comprehensive information about risk reduction.

Putnam County's Child Fatality Review Team, coordinated by the county's Child Advocacy Center, has firsthand experience with how tragic the practice of bed-sharing can be, having studied two cases since 2014 in which bed-sharing led to unfortunate results. Breastfeeding moms who take the baby to bed may need to set an alarm clock, or enlist their partner to remain awake to ensure the mom returns the infant to a safe sleeping spot before falling asleep herself. At the very least, parents should be counseled to ask themselves the ultimate question before they decide to sleep with their infant: if the worse were to happen—and it can happen in a risk-free sleeping environment—how responsible would they feel and might they think that bed-sharing and/or accidental suffocation had contributed to the tragedy? This question, as unpleasant and difficult as it may be to consider ahead of time, is

worth thinking about before parents make their choice, according to the biological anthropologist James McKenna at the University of Notre Dame, known for exploring mother-infant co-sleeping in relationship to breastfeeding and SIDS.

Generally accepted risk factors for SIDS and other SUIDs include sleeping with a baby on a sofa, or in a bed if the mother smokes (even prenatally) and/or has taken alcohol. It is less well known that even bed sharing alone—in the absence of parents who smoke or a mother using drugs or alcohol—remains a risk.

Additional clarity comes from a 2013 study, the largest ever analysis at publication time. Review of individual records from five major case-control studies (1472 SIDS cases, 4679 controls) found that even without the added factors of smoking or alcohol/drugs, there was an increased risk associated with bed sharing. Smoking and alcohol/drug use do increase the risk, but eliminating them did not remove the risk completely. The researchers summarized that a **considerable reduction in SIDS rates could be attained with the elimination of bed sharing.**

Source: Carpenter R, McGarvey C, Mitchell EA, *et al.* Bed sharing when parents do not smoke: is there a risk of SIDS? An individual level analysis of five major case-control studies. *BMJ Open* 2013;3:e002299. doi: 10.1136/bmjopen-2012-002299

CDC Issues Guidelines for Prescribing Opioids for Pain

Approximately 50 percent of prescription opioids are dispensed by primary care providers. To support informed clinical decision making and appropriate prescribing, as well as improved communication between patients and providers, the Centers for Disease Control and Prevention (CDC) has developed the agency's first-ever recommendations for primary care clinicians on prescribing opioids.

Among the 12 recommendations, of primary importance is the recognition that **opioids are not first-line or routine therapy for chronic pain** (*Recommendation 1*). When started, the best-practice mantra is “**start low and go slow**” (*Recommendation 5*). Studies show that high dosages (≥ 100 morphine milligram equivalent (MME)/day) are associated with 2 to 9 times the risk of overdose compared to < 20 MME/day.

Other key recommendations include: offering evidence-based treatment (e.g. medication-assisted treatment (MAT) and behavioral therapies) for opioid use disorder (*Recommendation 12*) and avoiding concurrent prescribing of opioids and benzodiazepines whenever possible (*Recommendation 11*). One study found patients prescribed **high dosages of opioids long term (>90 days) had 122 times the risk of opioid use disorder** compared to patients not prescribed opioids. Another study found concurrent prescribing was associated with nearly quadrupling risk for overdose death compared with opioid prescription alone.

From the comprehensive guidelines, a checklist for primary care providers considering opioids for treating chronic pain in their adult patients was developed as well (See column at right.) More information and the complete guidelines, visit:

<http://www.cdc.gov/drugoverdose/prescribing/guideline.html>

Opioid Action Plan, *continued from front page*

Medical Specialties (ABMS) officially recognized addiction medicine as a subspecialty at their annual meeting. The **American Board of Preventive Medicine** sponsored the subspecialty application, and now physicians certified by any of the 24 ABMS member boards, can become board-certified in this new area. It also promotes fellowship programs in addiction medicine with accreditation by the **Accreditation Council on Graduate Medical Education**.

For further information about the opioid epidemic action plan in Putnam: Doreen Lockwood, CASAC, Project Coordinator, Partnership for Success (PFS) grant, National Council on Alcohol and Other Drug Dependencies—Putnam

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Primary Care Providers' CHECKLIST

for prescribing opioids for chronic pain

For treating adults (18 and older) with chronic pain ≥ 3 months, excluding cancer, palliative, and end-of-life care

Considering long-term opioid therapy

- ▶ Set realistic goals for pain and function based on diagnosis (e.g., walk around the block).
- ▶ Check that non-opioid therapies tried and optimized.
- ▶ Discuss benefits and risks (e.g., addiction, overdose) with patient.
- ▶ Evaluate risk of harm or misuse:
 - Discuss risk factors with patient.
 - Check prescription drug monitoring program (PDMP) data. (Required in NYS.)
 - Check urine drug screen.
- ▶ Set criteria for stopping or continuing opioids.
- ▶ Assess baseline pain and function (e.g., PEG scale).
- ▶ Schedule initial reassessment within 1 to 4 weeks.
- ▶ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

Renewing without patient visit

Check that return visit is scheduled ≤ 3 months from last visit.

Reassessing at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ▶ Assess pain and function (e.g., PEG); compare results to baseline.
- ▶ Evaluate risk of harm or misuse:
 - Observe patient for signs of over-sedation or overdose risk. If yes, taper dose.
 - Check PDMP. (Required in NYS.)
 - Check for opioid use disorder if indicated (e.g., difficulty controlling use). If yes, refer for treatment.
- ▶ Check that non-opioid therapies optimized.
- ▶ Determine to continue, adjust, taper or stop opioids.
- ▶ Calculate opioid dosage morphine milligram equivalent (MME):
 - If ≥ 50 MME /day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone training and medication.
 - Avoid ≥ 90 MME /day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- ▶ Schedule reassessment at regular intervals (≤ 3 months).

For this and other clinical tools:

www.cdc.gov/drugoverdose/prescribing/resources.html



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Kristin McConnell Joins Board of Health

Kristin E. McConnell, M.S., CPP-G, has joined the Putnam County Board of Health (BOH). Ms. McConnell filled the position left vacant by Arthur McCormick, DVM, when he retired in March.

Ms. McConnell, who has a Master's degree in justice administration from Western Connecticut State University, is the executive director of the Putnam County chapter of the National Council on Alcoholism & Other Drug Dependencies in Carmel, where she has worked since 2007. She previously worked as a prevention specialist and community coalition coordinator at Student Assistance Services Corp in Tarrytown.

The BOH serves in an advisory capacity to the Health Commissioner. Currently, Michael Nesheiwat, MD, is serving in the position as Interim Health Commissioner. The by-laws dictate that at least one legislator and three physicians

are members of the board. The remaining four are laypersons; all must be Putnam County residents. Other BOH members



Putnam County Clerk Michael C. Bartolotti swears in Kristin E. McConnell to her position on the BOH.

include President Daniel C. Doyle, DMD; Vice President Joseph Avanzato, MD; Barbara Scuccimarra, Putnam County Legislature; Carl Albano, Alternate Putnam County Legislature; Theresa A. Burdick, RN, FNP, APRN, Secretary; and Raymond E. Phillips, MD, FACP.

Zika on the Web



www.health.ny.gov/diseases/zika_virus/

The New York State Department of Health Zika page has a link to specialized information for health care providers, including 5 health advisories and 5 provider webinars. A report on Statewide Mosquito-borne Disease Activity, dated June 29, indicates 310 human cases of Zika in NYS year to date (1 in Putnam), all travel-associated. Twenty-two* pregnant women (0 in Putnam) have been reported to the CDC's Pregnancy Registry by NYSDOH.

*NYC reports separately.

www.cdc.gov/mmwr

Since January 2016, 30 *Morbidity and Mortality Weekly Reports* (MMWR) have been issued by the Centers for Disease Control and Prevention (CDC) on the Zika virus. Topics have ranged from blood supply screening (June 24 report) to establishment of two surveillance systems to monitor pregnancies and congenital outcomes among women with laboratory evidence of Zika virus infection in the U.S. and territories (May 27 report).