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MASSACHUSETTS ASSOCIATION OF HEALTH BOARDS, INC.

Supreme Judicial Court To Hear Arguments Challenging Board of Health Authority to Regulate

On December 2, 2004, three private clubs in Athol, the American Lithuanian Naturalization Club, the Franco-American Naturalization Club and American Legion Post #102 sued the Board of Health and the Town of Athol, alleging that a board of health regulation that prohibited smoking in private clubs was unlawful and unenforceable. The regulation was passed by the Athol Board of Health pursuant to G.L. Ch.111, s. 31, which gives boards the authority to make reasonable health regulations. The intent of the regulation was to reduce exposure to second-hand smoke, a known carcinogen, and a substance known to cause cardiovascular and respiratory illnesses.

The private clubs argued that the board of health exceeded its authority to promulgate reasonable health regulations. They also argued that the recently enacted Smokefree Workplace Law (G.L. Ch.270, s.22) pre-empted cities and towns from further regulating smoking. An additional argument asserted was that the regulation violated private club members constitutionally protected rights to privacy and to associate.

The clubs filed a Motion for a Preliminary Injunction in the Worcester Superior Court. Town counsel for Athol argued that G.L. Ch.270, s.22 specifically states that nothing in the law ". . . shall preempt further limitation of smoking by the commonwealth or any department, agency or political subdivision of the commonwealth." (A municipality is a political subdivision of the commonwealth.) The law also says that nothing in the law ". . . shall permit smoking in an area in which smoking is or may hereafter be prohibited by law including, without limitation: any other law or ordinance or by-law or any fire, health or safety regulations." Town counsel also argued that G.L. Ch.111, s.31 gives boards of health the authority to make reasonable health regulations, regardless of the state law.

On December 27, 2004, Judge John McCann, Justice of the Worcester Superior Court ruled in favor of the clubs, holding that the new state law prohibiting smoking preempts (prevents) cities and towns from further regulating smoking. Judge McCann suggested in his Memorandum of Deci-

CONTINUED ON PAGE 34

MAHB Learning Center

MAHB has launched a web based Learning Center which will offer a broad curriculum of web-based courses relating to Emergency Preparedness, Environmental Health, Community Health, Management and Governance. This is the first major expansion of the MAHB's role in providing education and training since the ground breaking Certification Program began in 1996. This comprehensive training system for local boards of health utilizes the same web communication system employed

CONTINUED ON PAGE 2

Inside This Issue

Mini-Grant Applications to Fund Tobacco Compliance Checks Will Be on MAHB's Website in September

Once again, in collaboration with the Massachusetts Department of Public Health, MAHB will be offering cities and towns that do not receive funding from the Massachusetts Tobacco Control Program, mini-grants to conduct compliance checks. Boards will receive a flat rate of $40.00 per compliance check conducted. In consideration for this flat rate per retailer, boards of health will be responsible for all tasks involved in conducting the compliance checks, including, but not limited to hiring and supervising inspectors, and following up on enforcement issues.

Applications will be available in September for checks from October to December. A second round of applications will be accepted in January so that boards of health can conduct more than one compliance check. If you have any questions, or need any additional information, feel free to e-mail Jenna Roberts at jennaroberts@yahoo.com.

MAHB Representative Appointed to Drinking Water Assessment Advisory Committee

Dr. Wendy Heiger-Bernays has been appointed to the Safe Drinking Water Act Assessment Advisory Committee, representing MAHB in the "non community public water system" position on that committee. Dr. Heiger-Bernays is Chair of the Lexington Board of Health and is a member of the Boston University School of Public Health faculty.

The Committee is responsible for assisting the department of Environmental Protection in operating its Federal Safe Drinking Water Act Assessment Program. The Assessment contributes substantial support to DEP's Drinking Water Program. It also reports to the Legislature annually on the operation of the Assessment and on the accomplishments of the Drinking Water Program through the Assessment, and on any rate changes.

Learning Center Continued from page 1

by Harvard University, MIT and the US Army. MAHB will soon have the potential to offer multimedia presentations on-demand as well as real time meetings, and large on-line seminars.

MAHB members will be able to take a variety of Internet based courses by registering from the MAHB web site. The Learning Center will not replace the three on-site MAHB Fall Certification Programs, but is intended to expand Certification and other training opportunities to those who are unable attend these popular sessions. The first pilot courses will be available this fall.

For more information, visit www.mahb.org/learningcenter.htm.

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The primary purpose of the Massachusetts Association of Health Boards is to assist and support Boards of Health [and related governmental and community organizations/agencies] throughout the Commonwealth in meeting their statutory and service responsibilities, through programs of education, technical assistance, representation, and resource development.

The editor's desk

By the time you read this, the MAHB Learning Center should be up and running with a limited (to start) number of courses available. It will not replace our on-site Certification Program, which currently reaches over 200 people every year. It is intended to serve the roughly 800 board members who do not attend our programs. This ambitious project utilizes the same software that runs many university distance learning programs. Please check it out and give us suggestions for additional course topics. Future courses will have a full audio component.

The Emergency Preparedness Coalitions have completed a second year of funding and in the Plymouth and Bristol Sub-Coalitions, where MAHB serves as host agent, we are gearing up to hire additional consultants to assist in planning, implementation and training.

Our two coalitions, each representing 24 communities, have come far since the first organizational meeting. We meet monthly, with each health board sending one or more representatives, and operate democratically, with every community in attendance receiving one vote. Decision making is generally by consensus. Nearly all of the local health representatives are either public health nurses, agents or directors. I'm very proud of "my" people. They are striving to do their jobs and take on these new post 9/11 responsibilities, and I relish my small supporting role. In the event of an emergency, most of these public health pros will do their utmost to protect their communities.

The great majority of boards of health work effectively with their professional staff, but I have observed a disconnect between the work of the Sub-Coalitions and a small minority of the local boards. Despite my pleas that the Coalition representatives keep their board members informed, some fail to do so. Board members have an integral role in evaluating the effectiveness of their staff, advocating for resources and providing local leadership. In some towns, the health agents operate on their own, with little input from their elected or appointed boards of health.

If you, the elected and appointed board of health members who have statutory authority to set health policies and hire and supervise staff, do not stay up to date with emergency preparedness planning activities, then you are failing in your fiduciary responsibilities. Do you know or care that some health agents are resisting efforts to include your names on the 24/7 call down lists (see the next article) because they say you don't know enough to be useful? In some situations, competent health agents develop an arrogant attitude toward their board members because throughout their careers they see little or no leadership from board members. In other cases, poorly qualified agents in politically dysfunctional towns have been allowed to operate with little or no managerial oversight, and they too, have disdain for their board members.

These are harsh words from your Executive Director, intended as a wake up call. I see excellent board members struggle against outrageous political obstacles to support their professional staff. Other towns have energetic and idealistic new board members trying to shake off decades of laissez fair mismanagement. Some very dedicated health agents are treated with utter contempt by their board members who seem more interested in ensuring a smooth road for developers than working to build community support for public health. It is this tiny minority who must be challenged to transform themselves into public health leaders, or find another public office to fill.

Board members are the key to an effective local public health program. Good board members encourage and support professional development and use the bully pulpit of public office to educate the community about the role of public health in keeping their families safe. Voters who are educated on public health issues are more likely to elect or demand the appointment of dedicated board members, and more likely to support adequate funding for local boards of health.

I strongly urge every board of health member to become involved in their regional preparedness coalition. If you cannot attend the meetings, then read the minutes and ask your representative to keep you up to date on the issues. By now you should all have identified your Emergency Dispensing Sites, had meetings with the Fire Chief and other

CONTINUED ON PAGE 33

24/7 Response and Massachusetts Boards of Health

by Beverly Anderson
Acting Deputy Director
Center for Emergency Preparedness
Massachusetts Department of Public Health

In 2003, the Massachusetts Department of Public Health (MDPH) worked in collaboration with local health officials across the Commonwealth to establish 15 regional local health emergency preparedness coalitions. Since the formation of the emergency preparedness coalitions, cities and towns across the state have been developing plans to better prepare for and respond to public health emergencies. Increasingly, public health agents at the state, regional and local levels have been expected to play the role of "first responder", particularly when emergencies impact health. Influenza pandemics, "dirty bombs", terrorist attacks involving chemical or biologic agents, and natural disasters will require the leadership of local health officials to address community health needs. While major disasters occur rarely, local health departments provide response more frequently to local emergency events, e.g., outbreaks of food borne illness, or a case of meningitis. These types of events require rapid response to reduce or eliminate exposures leading to disease/health impacts so that a higher level emergency does not occur.

Both large and small-scale events require rapid action from local Boards of Health and their staff on a 24/7/365 basis to contain and prevent the spread of disease in the community. Under M.G.L. Chapter 111, Boards of Health are responsible for the control of diseases dangerous to the public health within their community. To fulfill this responsibility, members of the local health Emergency Preparedness coalitions continue to work on the development of plans for 24/7 coverage for their respective health departments or commissions. By supporting this effort,

Both large and small-scale events require rapid action from local Boards of Health and their staff on a 24/7/365 basis to contain and prevent the spread of disease in the community.

Boards of Health can ensure that the response to an act of terror or other events in their community can be rapid and effective.

However, many Boards of Health do not have adequate staff to provide 24/7 coverage of the community with regard to emergency response. While smaller towns may not have full time staff, larger communities may also be restricted with regard to 24/7 capacity by contracts or other issues. While MDPH provides back-up where feasible, state resources are also limited, particularly in the case of widespread emergencies, or if major state events such as the Boston Marathon are concurrent with a local emergency. For this reason, alternative models for 24/7 coverage must be considered.

A reliable 24/7 contact and response plan should include the following elements:

1) 24-hour availability of a key primary contact, in many cases 911 dispatch services.

2) Redundant back up with potential responders (e.g., health staff or contract services such as a Visiting Nurse Association)

3) Contact capacity including radios and/or cell phones in addition to home contact information.

4) Contact information for emergency preparedness Regional Coordinators provided by MDPH.

5) Contact information for regional partners—other towns and cities within a coalition where Boards of Health and their agents may be willing to participate or serve as back up responders if municipal public health staff are unavailable. For this type of response, a formal mutual aid agreement may be necessary, or documentation that allows a neighboring town's health agent equal authority to enforce health regulations in another town.

6) A description of key expertise/resources in the call-down list so that the best responder can be identified.

7) At least one or more persons on the contact list registered with the Health and Homeland Alert Network (HHAN) to receive alerts from MDPH.

8) In some cases, an Emergency Preparedness Coalition may choose to have their host community/agent or a contractor serve as either an intermediary for calls, or to serve as 24/7 responders for emergency follow up for individual towns. Emergency Preparedness Coalitions have been encouraged to evaluate the use of funding provided by MDPH for this purpose.

Plans incorporating these elements will support local Boards of Health in meeting emergency response requirements, consistent with the overall mission of disease prevention.

In terms of actual response, communities and their Boards of Health within the 15 regional coalitions should begin negotiations for mutual aid agreements that facilitate the sharing of personnel and other resources during emergencies. Such agreements allow for the transfer of authority to a health agent in a neighboring community, and provide measures for compensation for those who share their resources with other communities. A model mutual aid agreement has been developed by the Center for Emergency Preparedness at MDPH, in collaboration with the Advanced Practice Center at the Cambridge Health Alliance. Included with the model is information on legal issues involved in the development and execution of these agreements.

For further information on 24/7/365 planning, contact your emergency preparedness Regional Coordinator.

Names and contact information for DPH Regional Coordinators can be found at the following URL:
http://www.mass.gov/dph/bioterrorism/advisorygrps/pdfs/regional_roles_3_04.pdf

Coalition for Local Public Health Survey

The Coalition for Local Public Health represents MAHB, MPHA, MEHA, MHOA and MAPHN. Seeking tools to advocate for local public health, the Coalition decided to pool resources and ask our members to participate in a survey which will measure the funding and staffing resources town by town.

MAHB is working to set up a data polling account by the end of 2006 so that every board of health will be issued a password allowing access to update your community profile. Unlike other surveys, the results will be intended specifically for use by your constituent organizations so that we can more effectively advocate for a strong local public health infrastructure.

Look for an announcement on the MAHB Listserv and our website for information about how you can log on and update your local public health information.

Legislative Update

MAHB Supports the following bills:

HB-2685 By Rachel Kaprielian: Reestablishes and regulates the operation of the health protection fund and the tobacco settlement fund; allocates the articulated fees related to the cigarette excise tax to the health protection fund; mandates the use of said monies for smoking cessation and prevention programs; allocates the articulated fees, including, but not limited to monies resulting from the settlement of the tobacco litigation case, so-called, to the tobacco settlement fund; mandates the use of said monies for tobacco control and reduction programs, including, but not limited to youth smoking prevention programs; regulates the allocation of funds from the health care security trust fund to said tobacco settlement trust fund.

SB-1368 By Richard T. Moore, Edward G. Connolly. Submits the Massachusetts emergency health powers act; articulates provisions relative to development of a comprehensive plan to provide a coordinated response to public health emergencies and facilitate the early detection of same; establishes mandatory reporting requirements, including, but not limited to reporting all cases of injury, illness or condition which may indicate or cause public health emergencies; classifies diseases caused by the articulated biological agents as included within said conditions; articulates mandatory reporting requirements for pharmacists, pharmacies, laboratories and veterinarians; regulates the investigation of instances of said injuries, illnesses and conditions; authorizes the governor to declare a state of public health emergency; regulates said declaration; articulates the powers of the governor during said emergencies, including, but not limited to suspension of regulatory statutes; articulates the duties of the public health authority, including, but not limited to planning and execution of public health emergency assessment, mitigation, preparedness response, and recovery for the commonwealth; articulates the powers of said authority, including, but not limited to closing infected facilities and creation of protocols to limit the entry of persons or materials that may pose a threat to the public health; authorizes said authority to purchase and distribute antitoxins, serums, vaccines, immunizing agents, antibiotics, and other pharmaceutical agents or medical supplies; regulates the conducting of physical examinations during said emergencies; regulates vaccination and treatment of persons during said emergencies; regulates isolation and quarantine of individuals or groups during said emergencies; regulates collection of specimens during said emergencies; articulates regulations pertaining to possession of biological agents and banned biological agents, so-called.

SB-1758 By Richard T. Moore. Exempts municipal boards of health from compliance with the uniform procurement act.

MAHB Opposes the following bill:

SB-492 By Stephen M. Brewer. Effectuates and applies the standards for the on-site disposal of sewage adopted by the department of environmental protection in all municipalities; authorizes local boards of health to petition for adoption of more stringent requirements should local environmental conditions require same.

Sections 16-20 of House Bill 4324 - see the next page for details.

Legislature Blocking Needed Environmental Health and Safety Rules!

Massachusetts has some of the nation's strongest environmental health and safety protections. Many groups are working to make them even stronger and more effective. But these protections are at risk, thanks to the economic stimulus bill filed in the House.

The regulatory impact statement requirements of House Bill 4324, sections 16 through 20 of the House's economic stimulus bill, would discourage state agencies from issuing needed health, safety, and environmental rules by requiring that state agencies prepare a detailed "regulatory impact statement" every time they propose a new regulation. To make matters worse, agencies must file the regulatory impact statement with the Secretary of Economic Development who would have veto power over the statement's method and could hold up regulations indefinitely.

The Senate is still developing its own economic stimulus bill, but if the Senate version also includes cost-benefit language, agencies may fail to act to protect our health and environment, or they may be delayed in acting because of the provision's onerous requirements.

The organizations listed below have joined together to oppose similar legislation filed in past sessions. Please join us in stopping this misguided proposal.

ALS Association
Clean Water Action Alliance of Massachusetts
Conservation Law Foundation
Environmental League of Massachusetts
HealthLink
Massachusetts Association of Health Boards
Massachusetts Association of Conservation Commissions
Massachusetts Audubon Society
Massachusetts Coalition for Occupational Safety & Health
MassPIRG
People for the Environment
Toxics Action Center
Women's Community Cancer Project

This Cost-Benefit requirement will weaken protection of the environment and public health. The new requirements under this proposal will increase the degree of effort required to implement important laws passed by the legislature. The real impact of this will be that important laws passed by the legislature will take longer to implement, and changes updating existing regulations will be less likely – in both cases halting regulation that protects the public from unnecessary health risks and environmental harm. By providing the Secretary of Economic Development indirect veto power over regulations – the Secretary could essentially return regulations to the agency indefinitely under the guise of improper methodology – important health and environmental regulations could be permanently held up for political reasons.

This Cost-Benefit provision is anti-democratic. The bill is intended to rein in agencies that their critics say are too responsive to public opinion. Elected legislators should be very skeptical of arguments that government is too responsive to public will. The regulatory process is already open to any cost-benefit analyses or risk assessment any stakeholder wishes to offer beyond the agencies' own charge to look at all factors in developing new regulation. This provision provides the administration power over which laws passed by the legislature are enacted and enforced by providing the Secretary of Economic Development the power to halt regulations.

This Cost-Benefit provision will increase bureaucracy. In this time of "downsizing" government, how will the new requirements under this amendment be carried out? Economists and lawyers must be hired to carry out additional cost-benefit analyses. The regulatory review process will be protracted as advocates on both sides argue over the methods and assumptions of analyses carried out under the amendment's requirements. And every five years a new analysis will have to be undertaken. By requiring that the regulatory impact statement be approved first by the Secretary of Economic Development, the legislature is creating a tremendous bottleneck for regulatory approval and putting considerable strain on the resources and staff of the Executive Office of Economic Development.

This Cost-Benefit provision takes aim at a problem that does not exist. There is no evidence that current agency regulatory practices are wasteful or are making irrational choices about what to regulate or issuing rules in less than a careful, open manner. Our state officials have real problems they should be addressing rather than imposing more red tape requirements for needed environmental, health and safety rules.

Is it a good idea to drink sewage?

By Ravi Nadkarni
MAHB President

In a recent OpEd article in the Boston Globe, Prof. Jeffrey K. Griffiths, Associate Professor of Public Health and Family Medicine at Tufts University School of Medicine, said: "It doesn't take a medical degree to know that drinking poop is bad for us." Prof. Griffiths was criticizing a recent EPA proposal to allow the discharge of sewage to waterways without biological treatment, where raw sewage and treated sewage would be "blended". But the same problem has existed in Massachusetts since 2000, when DEP started allowing treated sewage, called "Reclaimed Water", to discharge into the ground in the recharge area of drinking water supplies.

Sewage is normally treated through settling to remove solids (primary treatment) and then treated biologically to remove organic compounds (secondary treatment). The second step requires air (oxygen) and by supplying oxygen, the treatment breaks down complex organic compounds to simpler forms. During this step, the pathogens are killed through oxidation and predation. The same two steps occur in septic systems; the first in the septic tank and the second in the "biomat" in the leach field. More recently, another layer of treatment, tertiary treatment, has been required to reduce the nitrogen content of wastewater. Nitrogen reduction relies on other bacteria that reduce nitrates to gaseous nitrogen in an oxygen-neutral environment in the presence of a source of carbon. Carbon sources include raw sewage, methanol, sugar and many other compounds.

EPA's Drinking Water Standards limit nitrogen in potable water to 10 mg/l. This is because high levels of nitrogen will inhibit the absorption of oxygen in blood. This is a problem for infants under 6 months of age or for certain elderly persons, both of whom have a low level of acid in their stomachs. Also, nitrogen is the limiting nutrient in salt and brackish water and excess nitrogen will promote plant growth in such waters.

The DEP "Interim guidelines" of 2000 allow non-potable uses, such as toilet flushing, landscaping, irrigation, etc. as well as discharge into a drinking water source. Although people could be exposed to this water when it is used on a golf course, the major concern is the use of such water to replenish drinking water supplies. Prior to 1999, DEP did not allow treatment plants to discharge into the ground in Zone 2 of a public water supply aquifer. The DEP "Interim Guidelines" have changed that restriction so any sewage plant with tertiary treatment to reduce nitrogen to below 10 mg/l can discharge to such a drinking water source. This water also has to meet other standards for pollutants in drinking water as defined in the Safe Drinking Water Act. The proponents of this approach would argue that this approach protects public health since it is complying with the Federal Drinking Water Standards. But, these standards were developed for natural waters, not for reclaimed water. Reclaimed water contains numerous chemical compounds never found in natural waters, compounds which are not removed during biological treatment. Such compounds include nitrosoamines, endocrine disrupters and their breakdown products, prescription and nonprescription drugs, veterinary and human antibiotics, home care products, industrial and household wastewater products, sex and steroidal hormones and so on. Already, many of these constituents have been measured in a variety of effluents at concentrations that are known to cause environmental impacts and have been implicated as mutagens and carcinogens. None of these compounds are even tested for on a routine basis. Unlike a failure of biological treatment, which is likely to result in acute effects such as diarrhea soon after ingestion, these compounds cause long term, chronic effects. These constituents are not considered in the design of plants for biological treatment of wastewater and the technology that might remove these compounds is not affordable.

In view of these uncertainties, the DEP "Interim Guidelines" on reclaimed water for potable use are extremely short sighted and dangerous. A better way to protect drinking water, a method that has stood the test of time, is through land use controls and limits on density.

DEMYSTIFYING EXECUTIVE SESSION

By Melinda Calianos J.D.
Attorney Consultant, MAHB

The Massachusetts Open Meeting Law, MGL. Ch. 39 s. 23B, provides that all meetings of local boards be open to public attendance. The public must be sufficiently notified of any meeting so that anyone who wishes may be present to hear the Board members discussions about public policy within the Board's jurisdiction. Discussions amongst Board members are thus aired before the public they affect. But the statute also recognizes that certain situations warrant a more private discussion among Board members. In certain, limited situations a Board may convene an Executive Session where the public is not invited and minutes of the session are not available until a date in the future.

While the public is not invited to the Executive Session, this does not mean that the public is not made aware of the closed meeting, nor does it necessarily mean that only board members are present. MGL ch. 39 s. 23B carefully outlines when an Executive Session may be held, what a board must publicly accomplish before an Executive Session may occur, and what must happen after.

The Nine Purposes for Executive Session

The statute outlines nine reasons that a local board may recess to an Executive Session. MGL ch. 39 s. 23B states that executive sessions may be held only for the following purposes:
(1) To discuss the reputation, character, physical condition or mental health rather than the professional competence of an individual…,

(2) To consider the discipline or dismissal of, or to hear complaints or charges brought against, a public officer, employee, staff member, or individual...

(3) To discuss strategy with respect to collective bargaining or litigation if an open meeting may have a detrimental effect on the bargaining or litigating position of the governmental body, to conduct strategy sessions in preparation for negotiations with nonunion personnel, to conduct collective bargaining sessions or contract negotiations with nonunion personnel.
(4) To discuss the deployment of security personnel or devices.
(5) To investigate charges of criminal misconduct or to discuss the filing of criminal complaints.
(6) To consider the purchase, exchange, lease or value of real property, if such discussions may have a detrimental effect on the negotiating position of the governmental body and a person, firm or corporation.
(7) To comply with the provisions of any general or special law or federal grant-in-aid requirements.
(8) To consider and interview applicants for employment by a preliminary screening committee or a subcommittee appointed by a governmental body if an open meeting will have a detrimental effect in obtaining qualified applicants; provided, however, that this clause shall not apply to any meeting, including meetings of a preliminary screening committee or a subcommittee appointed by a governmental body, to consider and interview applicants who have passed a prior preliminary screening.
(9) To meet or confer with a mediator, as defined in section twenty-three C of chapter two hundred and thirty-three, with respect to any litigation or decision on any public business within its jurisdiction involving another party, group or body, provided that: (a) any decision to participate in mediation shall be made in open meeting session and the parties, issues involved and purpose of the mediation shall be disclosed; and (b) no action shall be taken by any governmental body with respect to those issues which are the subject of the mediation without deliberation and approval for such action at an open meeting after such notice as may be required in this section." MGL ch. 39 s. 23B

Who May Be Present at Executive Session

Counsel or advisors to the Board may be present at Executive Session provided all are identified in the minutes. In addition, if Executive Session is held to "discuss the reputation, character, physical condition or

mental health rather than the professional competence" of a particular individual, or, "to consider the discipline or dismissal of, or to hear complaints or charges brought against, a public officer, employee, staff member, or individual," the statute allows those individuals to be present for the discussion and provides him or her with certain rights and options.

In these instances the statute mandates that, "the individual involved in such executive session [must be] notified in writing by the governmental body, at least forty-eight hours prior to the proposed executive session. Notification may be waived upon agreement of the parties. A governmental body shall hold an open meeting if the individual involved requests that the meeting be open. If an executive session is held, such individual shall have the following rights:
(a) to be present at such executive session during discussions or considerations which involve that individual.
(b) to have counsel or a representative of his own choosing present and attending for the purpose of advising said individual and not for the purpose of active participation in said executive session.
(c) to speak in his own behalf." MGL ch. 39 s. 23B

Procedures for Executive Session

A Board must follow certain procedures in order to properly enter into Executive Session.

First, no executive session can be held unless an open meeting of the board, for which proper notice was given has first convened. When executive session is being held in order to discuss a particular individual, written notice of the proposed executive session that will involve discussion of that individual must be given to the person at issue at least 48 hours before the meeting is to be held.

Once an open meeting has convened, a majority of the members of the Board must vote to go into executive session. The vote of each member must be recorded on a roll call vote and entered into the minutes of the meeting. The presiding officer must also cite the purpose of the executive session for the record and whether or not the open meeting will reconvene after the executive session.

Minutes: Minutes of every executive session must be kept. Similar to the requirements for open meeting minutes, the minutes must state the date, time, place members present or absent and the action taken. Minutes must include a record of every vote taken and all votes must be recorded roll call votes. Written minutes, preferably typed, must be created. Unlike an open session, an executive session may not be recorded by audio or videotape. Records of any executive session may remain secret as long as publication may defeat the lawful purposes of the executive session, but no longer. Thus, ultimately, all records of executive session will become open to the public. Records of any executive session are made public when they have been approved by members of the Board for release to the public and notice of such approval has been entered in the records of the governmental body.

Helpful Publications

Open Meeting Law Guidelines, Commonwealth of Massachusetts Office of the Attorney General, Tom Reilly, Attorney General (published 2002) (this publication provides a detailed and clear discussion of Executive Session)

Massaschusetts General Laws MGL. Ch. 39 s. 23B

Major Signs of a Stroke

- **Sudden numbness or weakness of the face, arms or legs**
- **Sudden confusion or trouble speaking or understanding others**
- **Sudden trouble seeing in one or both eyes**
- **Sudden trouble walking, dizziness, or loss of balance or coordination**
- **Sudden severe headache with no known cause**

If you think someone is having a stroke, you should call 911 immediately. - The National Institute of Neurological Disorders and Stroke

Arsenic: From Fifty to Ten

by Ann Backus, MS
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Department of Environmental Health
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and
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Source: Ayotte et al, 2003

By January 23, 2006, government-regulated public water systems must comply with the new arsenic rule and meet the 10 parts per billion (ppb) standard for arsenic in drinking water. The rule, passed in 2001 by EPA as part of the Safe Drinking Water Act, lowered the standard from 50 ppb to 10 ppb in an effort to lower human exposure to arsenic in drinking water.

Government-regulated public water systems affected include those serving entire communities as well as those designated as Community Water Supplies (CWSs) that serve at least 25 people over six months or have more than 15 service connections. (CWSs may include sections of towns, condominium developments, apartment complexes, schools, day care centers, and nursing homes.) Approximately 30% of all drinking water in New England is from public supply systems.[i] While private wells are not "government-regulated," private well owners are strongly advised to test their wells and to install an arsenic treatment system if the arsenic concentration exceeds 10 ppb. Approximately 20% of all drinking water in New England is supplied by private wells.[1]

[1] Ayotte JD, Montgomery DL, Flanagan SM, and Robinson KW. Arsenic in Groundwater in Eastern New England: Occurrence, Controls, and Human Health Implications.
Environ. Sci. Technol. 37:2075-2083, 2003.

The New England Arsenic Belt

Arsenic is an element that is naturally present in the earth crust and can also be found in underground water that often supplies well water used for drinking. The United States Geological Survey (USGS) National Water-Quality Assessment (NAWQA) Program recently analyzed 28,000 water samples across the country. These samples identified a New England "belt" of wells that tested high for arsenic. As shown in the USGS map, this belt runs from northern Maine along the coast, through southeastern New Hampshire and into Massachusetts between Boston and Worcester.[i] While many of these wells were in compliance with the old standard of 50 ppb, they will not comply with the new standard of 10 ppb. The research estimates that 87,000 people in eastern New England receive water from public well supplies with arsenic concentrations greater than 10 ppb. In addition, these affected individuals are concentrated in eastern Massachusetts. NAWQA research also indicates that 103,000 people in eastern New England receive water with arsenic concentrations greater than 10 ppb from private wells.[i] Additional research by USGS and the Massachusetts Department of Health is underway_to test private wells within the belt.

Health Effects of Low Level Arsenic Exposure

Exposures in the range of 10 to 50 ppb are considered low-level exposures. According to the Agency for Toxic Substances and Disease Registry (ATSDR), low-level exposure has been associated with skin keratosis, liver damage, neurological impairment and serious cardiovascular problems such as arrythmias.[2] Long-term exposure to arsenic has both acute and chronic health effects. According to EPA, studies have linked long-term arsenic exposure through drinking water to "cancer of the bladder, lungs, skin, kidney, nasal passages, liver, and prostate."[3] Continuing research raises additional concerns about the danger of arsenic exposure. For example, a 2003 article on arsenic methylation, by researchers in the Harvard Superfund Basic Research Program, demonstrated that low, chronic exposure to arsenic increases the risk of skin cancer.[4]

Also demonstrating the negative effects is an article by researchers in the Dartmouth Superfund Basic Research Program that

demonstrated that low levels of arsenic can promote vascularization, angiogenesis and tumorigenesis.[5]

Treatment and Compliance

MAHB members have an important role in relation to the new arsenic rule. After testing at every entry point, if any measurements exceed the 10 ppb, action is required. The options include changing the water source, partnering with another water system, or installing treatment technology. As the need to consider arsenic as a drinking water hazard is new to most health boards, compliance may take time and energy. Education for boards of selectmen as well as of those served by public and private wells will be critical for a successful transition to compliance.

Treatment can be done in bulk for all users or at the tap for each user. According to EPA, activated alumina, reverse osmosis Point of Use technology, or modified lime softening are the treatments of choice. Thought must be given to the disposal of the waste generated by these treatment options and to the maintenance and monitoring of the system.

Planning worksheets, treatment options, and financial considerations are discussed at www.epa.gov/safewater/ars/pdfs/regguide/ars_final_app_f.pdf.

Contact:
Chris Ryan, EPA Region I arsenic in drinking water expert at 617/918-1567.
Ann Backus, MS, to reach Harvard or Dartmouth researchers at 617/432-3327.
Ann Backus is Director of Outreach in the Department of Environmental Health. Julie Bradley is a Research Project Coordinator in the Occupational Health Program at the Harvard School of Public Health.

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Promoting Safer Nail Salons

By Healthy Cosmetology Members: Eileen Gunn, Toxics Use Reduction Institute; Rick Rabin, M.S.P.H., Division of Occupational Safety; Dr. Cora Roelofs, UMASS Lowell Work Environment Department; Lynn Rose, Health and Safety Specialist

Nail salons have cropped up on every main street across Massachusetts in the last few years. Many of the chemicals used in nail products are potentially hazardous to the health and safety of workers and customers, yet safety practices and regulations have not caught up with the potential public health and safety risks. Salons often inhabit spaces that were not designed to handle the air quality and safety issues and salon owners and workers are not trained in health and safety hazards of toxic chemicals, thus are unaware of potential problems. Adding to the problem, is the large populations of immigrant workers, especially in nail salons, that do not have English as their first language and do not have regulatory or basic health and safety information in their native language. In addition, there are regulatory roles at multiple municipal departments and state agencies that aren't clear or coordinated. The combination of hazardous chemicals, inadequate ventilation, unclear multi-jurisdictional regulatory roles, language and cultural barriers, and lack of training on health and safety make promoting safe salons both necessary and particularly challenging.

In the face of all this, there is a need and an opportunity to create a new type of approach to preventing health and environmental impacts that trumps the legal and jurisdictional barriers and creates a collaborative, proactive climate to solve this complex issue and make salons safer workplaces.

What are the Issues in Nail Salons?

Odors and Air Quality

Professional nail care salons use many products from nail hardeners, artificial nails, polishes, drying agents, polish removers, and disinfectants that contain hazardous chemicals. Many of these chemicals evaporate into the air at room temperature during product use or become airborne through nail filings. Workers and customers can then breathe dust and vapors or come into skin contact with the products.

Often the ventilation in a salon is inadequate to protect occupants from being exposed to chemical vapors. State building codes require that salons have plentiful fresh air, but do not specify that contaminants are removed. And even with the best ventilation system overhead, workers are working at close range within their breathing zone with these chemicals. Additionally, adjacent spaces with shared ventilation systems or shared wall construction receive and circulate chemicals from the salon. Furthermore, it is not clear that most salons are satisfying even the basic requirements of adequate general ventilation year-round.

Multiple Chemical Exposures

A primary concern for public health is the sheer number of chemicals used in salons on a daily basis. In addition to breathing vapors, nail technicians can be exposed through contact with the skin and ingestion. Of particular concern are the number of solvents and chemicals classified as reproductive toxins because many of the workers are young women of reproductive age. Some nail products contain formaldehyde, a known human carcinogen. Also, the disinfectants used in salons are registered pesticides which are toxic, and some such as quaternary compounds, can trigger asthma.

Overexposure to the chemicals in nail products are associated with reproductive harm, respiratory ailments, occupational asthma, eye and skin irritation, neurological effects such as headache, dizziness, sleep disorders and nausea.

The Occupational Safety and Health Administration (OSHA) standards established in the 1960s for chemical exposure cannot be relied upon to protect these workers because they only apply to one chemical at a time, were designed for high exposures in industrial environments, don't cover many of the new chemicals used in nail products, and don't consider skin adsorption. They are also designed to address acute symptoms, not the chronic exposures which can result in asthma, cancer and reproductive harm. Plus, because of the few numbers of workers in salons and the perception that salons are not hazardous work environments, OSHA is unlikely to investigate hazards in salons.

After reports of contact dermatitis and fingernail damage and deformity in the 1970s, Food and Drug Administration (FDA) concluded that methyl methacrylate (MMA) artificial nail liquid was a poisonous and deleterious substance that should not be used in fingernail preparations. Products with 100% MMA Liquid monomer were removed from the market. This wasn't a specific federal regulation and it was left to individual states including Massachusetts to ban.

The Massachusetts Board of Cosmetology has issued a product warning to prohibit the use of MMA, but it is not specifically banned in their regulations, nor is it inspected for. Despite these restrictions, MMA is being found in Massachusetts salons because of its significantly lower cost.

Lack of Product Safety Testing

The Food and Drug Administration (FDA) regulates products in the cosmetic industry, including nail products. The FDA does not approve or inspect nail or any cosmetic products before they are introduced into the market. FDA relies on the product manufacturers and the voluntary Cosmetic Ingredients Review Board to establish the safety of products.

Jurisdiction

A recent small informal phone survey of local building departments in Massachusetts revealed a wide variation in knowledge and implementation of the state building code for ventilation in salons. Building departments were asked how they inspected ventilation in nail salons for compliance with the state code and whether there were different requirements for new salons versus change of use or owner. Answers ranged from a full knowledge of the standard that applied to total lack of knowledge of any enforceable standard to the belief that the State Board of Licensure (Cosmetology) had jurisdiction for the ventilation. It seems not all municipal building departments are inspecting salons, some just inspect building assembly uses (churches, night clubs).

When Building Inspectors do conduct an inspection, they review the floor plans and conduct a site inspection to verify what was on the plan is actually in place. They do not conduct ongoing or annual inspections to verify that the ventilation system is actually on and performing according to code. The few towns surveyed also stated that they directed complaints to the health departments.

In our *(see Healthy Cosmetology Committee section)* work with health agents over the last several years on this issue we have found that many believe the Board Cosmetology has jurisdiction over air quality complaints. However, while the Board's regulations state there must be "adequate" ventilation, they do not set ventilation standards and do not inspect ventilation systems in the salon. The Board relies on local building departments to enforce the state building code. As a result, there is minimal and inconsistent regulation of air quality in the salons and adjacent spaces.

Some health agents have taken enforcement action on odors through use of the nuisance provision in the public health code.

Some Boards of Health, such as Holyoke and Sharon, have established their own regulations that specify ventilation standards *(see resources below).* The problem with regulations developed town by town is that the salons migrate to areas where there is less regulation.

What would it take to have safer salons in our communities?

Of course, many of the existing barriers are in the legal and jurisdictional framework and would need regulatory solutions to address them. Perhaps a quicker approach, and the one that the Healthy Cosmetology Committee has been advocating, lies in a proactive non-regulatory education strategy that is heavier on carrots than sticks. Concurrent with an educational approach, there would have to be clarifying of jurisdictional roles and a team approach through collaboration of municipal and state sectors to address the problem.

What could the Board of Health's role be?

Non-Regulatory Measures

- Education and promotion of health and safety

- Provide information on hazardous chemicals, exposure routes, and health effects to salons and the public.

- Provide best practices and toxics use reduction techniques *(see resources below)* to salons.

- Provide information on Division of Occupational Safety's non-regulatory compliance assistance inspections to salons.

- Coordination with the building and fire departments on salon education and inspections.

- Provide information to salons on what adequate ventilation standards are and how to achieve them through providing a list of local ventilation contractors.

- The local building department should be inspecting salons to ensure that the ventilation system meets the state building code, is turned on and is operating properly.

• Upgrade the detailed Certificate of Occupancy to describe the salon compliance requirements with the BOCA Code. A Certificate of Occupancy that specified what type of ventilation system was inspected on-site (was it just a window or a full ventilation system?) that constituted adequate ventilation would help to inform the owners, workers, Board of Cosmetology and Board of Health.

• Provide information on flammable product use, dispensing and storage requirements and fire safety in conjunction with the local Fire Department. This is particularly important since the majority of nail products in the salon are class three flammables, but are not managed as such.

The Healthy Cosmetology Committee would like to hear more from the Boards of Health on how to best address this issue in our communities. The Massachusetts Association of Health Boards will also be holding future trainings on this issue.

Health agents played a key role in setting the agenda for the Committee. For several years, the Committee focused on the development and provision of a series of trainings for health agents on nail salon issues. We completed a Toxics Use Reduction Nail Salon Inspection training of 95 Health Agents in September 2004.

The Committee has been instrumental in identifying statewide issues and resources, focusing research and training efforts, and coordinating both public and private resources to address the issues. Ongoing work includes:

- Sharing of research and progress on community outreach projects
- Encouraging green chemistry research on alternative salon products at UMASS Lowell
- Training Board of Cosmetology inspectors
- Supporting the development of a model vocational salon in West Springfield
- Further development of vocational curriculum to include toxics use reduction
- Development of educational materials for distribution
- Development of a healthy cosmetology website.

For further information or to join the Committee, contact Eileen Gunn at 978-934-4343.

Healthy Cosmetology Resources

Massachusetts Department of Public Health Indoor Air Quality in Nail Salons Fact Sheet http://www.mass.gov/dph/beha/iaq/nails/nails.htm

Massachusetts Department of Labor, Division of Occupational Safety Nail Salon Fact Sheet http://www.mass.gov/dos/iaqdocs/iaq-400.htm

The Massachusetts Division of Occupational Safety can provide non-regulatory inspections and advice on ventilation and chemical management issues. Contact Rick Rabin or Nancy Comeau at 1-617-969-7177.

Artificial Fingernail Products A HESIS Guide to Chemical Exposures in the Nail Salon, State of California Department of Health Services http://www.dhs.ca.gov/ohb/HESIS/artnails.htm

Lab Safety Factsheet – Safety in Nail Salons http://www.labsafety.com/refinfo/ezfacts/ezf281.htm

EPA Nail Salon Brochure (English and Vietnamese) (under revision) http://www.epa.gov/opptintr/dfe/pubs/

Toxics Use Reduction Trainings and Resources for Health Agents and Boards of Health http://download.turi.org/HealthAgentToolkit/ The Toxics Use Reduction Institute can assist you in identifying chemical information and resources for safer salons. Call 978934-3275. Their community website contains detailed presentations on hair and nail salon chemical safety, see http://www.turi.org/community/schools/HealthyCosmetology.shtml.

Town of Sharon Artificial Nail Salon Regulations http://mhoa.home.comcast.net/sharon.htm

RESTAURANT INSPECTIONS BY BOARD OF HEALTH MEMBERS

by Laura Richards J.D.
Attorney Consultant, MAHB

This article addresses the various issues that may arise when Board of Health (BOH) members, acting as agents for the BOH, perform restaurant inspections.

Issue One

Does a BOH member have the authority to act as special agent to inspect restaurants if no health inspector is available?

M.G.L. c.111 s.30 states that "Boards of Health may appoint agents or directors of public health to act for them in cases of emergency...and any such agent or director shall have all the authority which the board appointing him had..." The State Sanitary Code states that if an emergency exists which requires that "...ordinary procedures be dispensed with, the board of health or its authorized agent, acting in accordance with the provisions of M.G.L. c.111 s.30, may...issue an order... requiring that such action be taken as the board of health deems necessary to meet the emergency." 105 CMR 400.200 (B)(1). Thus BOH members can be agents of the BOH when the health agent is unavailable in an emergency situation.

Issue Two

What training and qualifications are required for a BOH member to perform restaurant inspections?

The State Sanitary Code gives the BOH the authority to enforce 105 CMR 590: Minimum Sanitation Standards for Food Establishments: Chapter X. Included in the BOH's power is the responsibility to license, inspect and monitor sanitation practices in food service establishments. (105 CMR 590.052 , 590.053). Under the State Sanitary Code, food sanitarians must be qualified and trained in conducting food inspections and investigations. 105 CMR 590.010(G)(1) states that "any person conducting food inspections for the BOH shall be knowledgeable in foodborne disease prevention, application of the hazard analysis critical control point principles, and the requirements of 105 CMR 590.00 as they relate to food establishments in their city or town." This knowledge may be demonstrated one of two ways:

(a) passing a certified food protection manager or certified food safety professional test that is part of an accredited program recognized by the Department and completing food safety inspection training recognized by the department, or;

(b) being a registered sanitarian or certified health officer who has completed food safety inspection training recognized by the Department." 105 CMR 590.010(G)(2).

Any BOH member who has met one of the above requirements may be appointed as a special agent for purposes of making restaurant inspections.

Issue Three

Compliance with M.G.L. c.268A

BOH members must abide by the conflict of interest law embodied in M.G.L. c.268A entitled "Conduct of Public Officers and Employees". This law sets the minimum standards of ethical conduct for public officers and employees. The law was enacted to ensure that the private financial interests and relationships of municipal officials and employees do not conflict with their municipal responsibilities.

M.G.L. c.268A s.19(a) states that "...a municipal employee who participates as such an employee in a particular matter in which to his knowledge he ... has a financial interest, shall be punished by a fine of not more than three thousand dollars or by imprisonment for not more than three years or both." Thus a BOH member cannot act on a matter that affects his own or his immediate family's financial interests or the financial interests of a business or organization in which he serves as an officer, director, partner or trustee.

Furthermore, a BOH member is precluded from acting on matters that may affect his business competitors.

The two exceptions to this rule are contained in M.G.L. c.268A s.19(b) which states that an appointed board member may act on matters involving his financial interest if prior written permission is obtained from his appointing authority. The second exception allows a BOH member to act on any matter of general policy in which "...the interest of the municipal employee or members of his immediate family is shared with a substantial segment of the population of the municipality." M.G.L. c.268A s.19(b). If a BOH member acting as a special agent to perform restaurant inspections has a conflict of interest as described above than he is "entitled to the opinion of... town counsel upon any question arising under this chapter relating to the duties, responsibilities and interests of such employee...The town counsel shall file such opinion in writing with the ...town clerk and such opinion shall be a matter of public record..." M.G.L. c.268A s.22.

Update on the Hepatitis A Outbreak in Massachusetts

by Erica Berl
MDPH

Since November 2003, there has been a substantial increase in hepatitis A reported to the Massachusetts Department of Public Health (MDPH). In 2004, 999 cases were reported, which is about five times the number of reports usually received in a year. Over the six-year period from 1998 through 2003, MDPH received an average 209 reports of hepatitis A each year.

Initially, most cases were in Hampden and Suffolk counties, but cases have occurred, and are continuing to occur, in all parts of the state. Many of the cases have similar characteristics including unemployment, homelessness, injection drug use, other drug use, or recent or current incarceration. The numbers of reported cases peaked in August at 120 cases and have been declining since then. In February 2005, 31 cases were reported. While it is encouraging that the numbers have been decreasing, they are still well above what is typical.

Hepatitis A is a viral disease spread mainly though the fecal-oral route (person-to-person or foodborne). The incubation period ranges from 15 to 50 days with an average of 25-30 days. People are most infectious from the two weeks prior to symptom onset through one week after symptom onset. Symptoms may include fever, malaise, jaundice, anorexia and nausea. Diarrhea may or may not be present.

The best way to prevent the spread of hepatitis A virus is through good personal hygiene (hand washing). In addition, close contacts of a confirmed case should receive immune globulin (IG) within 2 weeks of exposure. If given within 2 weeks, IG is more than 85% effective in preventing illness. Close contacts include all household contacts, sexual contacts, persons sharing food, beverages or eating utensils with the case, or persons sharing drugs and/or drug paraphernalia with the case. Since November 2003, local public health nurses have spent a significant amount and time and effort on identifying close contacts and providing them with information about hepatitis A prevention and in some cases administering IG.

In response to the widespread outbreak in our state, there has been an ongoing campaign to vaccinate at-risk individuals with hepatitis A vaccine. However, reaching the at-risk population has been a challenge. In March 2004, a letter describing the hepatitis A outbreak was sent to all substance abuse treatment programs, correctional facilities, HIV counseling and testing programs, HIV prevention and education programs, homeless shelters and local health departments. In addition, two statewide meetings were held in March and July of 2004 with representatives from these groups. The purpose of these meetings was to strategize about ways to educate and vaccinate the at-risk population. More recently, nine regional meetings were held in all parts of the state. The goal of these meetings was to increase vaccine coverage of the at-risk population by bringing together those who work directly with them with those in their communities who can administer vaccinations.

Continued to page 34

Advocating for Public Health

by Geoffrey Wilkinson and Eric Weltman

The social and economic benefits of public health are well-documented. Public health programs and policies save lives, reduce illness and injury, prevent costly medical expenses, and keep children in school and adults at work.

Unfortunately, public health often operates under the radar screen. Preventing problems just doesn't grab the headlines the way disasters do.

Clearly, it isn't the stuff of television dramas like "ER" or "CSI." There's little glamour in providing flu shots, inspecting septic systems, and conducting AIDS education. Yet, raising the profile of public health could be instrumental in boosting state funding for the DPH and its programs.

One institution that epitomizes this challenge is the State Laboratory Institute. Tucked away in a quiet corner of Jamaica Plain, Boston, the State Lab provides essential services to all of our communities. The lab provides basic testing services against rabies and mosquito-borne viruses, including West Nile and eastern equine encephalitis. It is our common defense against emerging, antibiotic-resistant diseases. It provides testing and treatment for Tuberculosis. It also provides testing and treatment for sexually transmitted diseases.

The State Lab plays an essential role in our combined efforts to protect against public health emergencies, including bioterrorism. With recent evidence of person-to-person transmission of avian flu in Vietnam and the growing threat of world-wide pandemic influenza, it is critical to have the State Lab fully capable of rapid response for our common defense.

Yet, for many years, the State Lab's budget has suffered from state and federal cuts, rising costs, and inflation. State funding has been reduced 7 percent since FY02, while federal funds are no longer available for basic supplies and equipment necessary to operate the lab. Thankfully, this year, the legislature has proposed an additional $400,000 for this essential public health institution, but funding is still woefully inadequate.

Health boards and their allies can and should take up the cause: educating the public, civic leaders, and elected officials about the importance of the lab to their own communities. There are numerous ideas and opportunities for promoting the State Lab - most of which can be applied to other public health programs.

- A briefing by lab staff on their services. Invitations could be extended to board members, municipal officials, state legislators, and members of the public.

- Publishing an article in your local newspaper. Town weekly and daily newspapers usually welcome letters, op-eds, or columns from local officials.

- Appearing on cable access television. Most cable access stations have civic affairs shows, where board members could be guests, discussing the lab and other programs.

- Conducting outreach to potential allies. Letters, fact sheets, and invitations to education events should be sent to potential allies, such as the fire department, school committee, and council on aging.

- A local resolution supporting the lab. The town board, or city council could be asked to pass a resolution, urging more support for the lab. The resolution could be publicized in the newspaper and forwarded to state legislators.

A little public relations could go a long way in boosting awareness and support for the State Lab and other public health programs.

Geoffrey Wilkinson is the Executive Director of the Massachusetts Public Health Association. Eric Weltman is the Deputy Director of Advocacy & Policy for MPHA. They welcome your comments, suggestions, and requests for information: Eweltman@MPHAweb.org; (617) 524-6696, ext. 111.

Intern Support for Local Public Health Activities

Exposing students to the range of responsibilities of local and state health departments is crucial to the recruitment and preparation of qualified public health professionals. Massachusetts has created a novel internship program for graduate public health students that offers training in both state and local health responsibilities. This article describes the student intern activities during the summer of 2004.

Surveys were sent to 351 local health departments (LBOHs) to ascertain interest in the internship program. MDPH staff contacted two graduate public health schools to determine requirements for student community placements. Based on the responses, a job posting was distributed through schools' practicum offices. Matches were based on geographic preference and similarity of needs and interests between students and LBOHs.

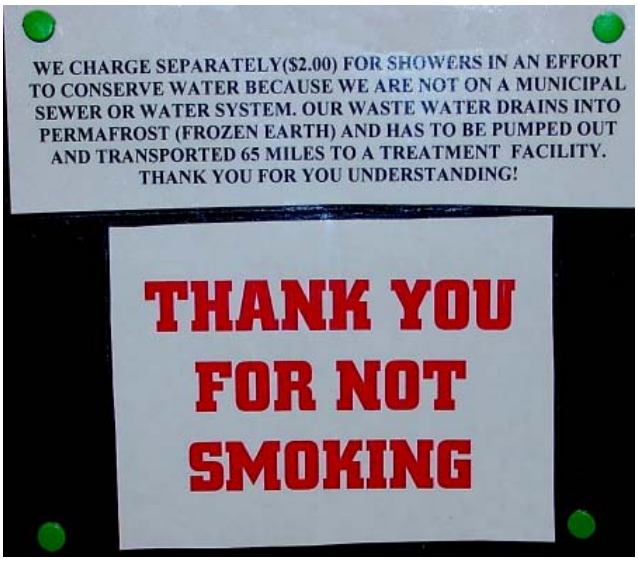
Students developed projects based on their academic interests and town needs. Two students assisted in the development of local bioterrorism preparedness plans. One student took his project a step further and coordinated a tabletop exercise that involved school and emergency response personnel as well as local health department staff. Several students were located in coastal communities and were involved in beach inspections. Other tasks included shadowing staff to perform septic system, soil, food service, and landfill inspections. Students participated in the development of community education programs for West Nile virus (WNV), lyme disease, and sun safety/skin cancer prevention. One student created a poster with a geocoded map of WNV cases for the town. The sun safety program distributed approximately 150 sets of educational materials during two "beach bashes"/community activities. A student assigned with the Region 1 office assisted with the design and distribution of a regional newsletter. Another student assigned to Region 5 trained local health department staff from several towns in the use of the Health and Homeland Alert Network (HHAN).

Eight students and seven LBOH completed project evaluations. Students evaluated the overall project positively (7.8, range 4-10). All students felt they had a better understanding of LBOH responsibilities and would recommend the internship to other students. Seven of eight students felt the internship was a good supplement to their education. Three students expressed a desire to "work with a data set" or stated that the tasks assigned to them were not "epidemiology" related. Students reported that the MDPH mentor was under-utilized.

LBOHs gave the internship program an average overall rating of 9.5, range 8-10. All LBOHs felt their intern was qualified for the assigned tasks and produced a useful product. Suggestions for improvement included offering a choice of students and a longer period to interview the student. LBOHs also requested that MDPH provide more guidance for student projects.

MDPH plans to expand the internship to include veterinary and nursing students. Interns are currently placed with seven local health departments for Spring 2005 and MDPH is in the process of recruiting students for the Summer 2005 program. This program provides efficient and effective public health training and introduces graduate students to the roles and purposes of local and state health departments. It is also a means for MDPH to further support LBOH activities, including emergency preparedness. Any questions about the project can be addressed to Dan Church at (617) 983-6800.

Sign at Alaskan Campground



Health boards struggling with Title 5 issues can be grateful they don't have to deal with permafrost, which must complicate septic system design and installation. Alaskans are among the earliest and hardest hit by global warming. Melting permafrost is sinking entire villages and coastal communities are vulnerable to massive erosion during winter storms since the sea is no longer locked in ice.

Norwood BOH - Providing Oral Health Care for Seniors

The Norwood Board of Health has been active in addressing a crisis emerging in Massachusetts: the lack of accessible oral health care for older adults. With our partners in the Neponset Valley Community Health Coalition's dental subcommittee, we are planning a senior dental care program that will provide reduced-fee dental services to low-income seniors in the South Norfolk County.

The Coalition's dental subcommittee was formed a few years ago, and since then has held seven free diagnostic oral health screenings for senior citizens. We found that many seniors who participated in our screenings could not afford to go to a dentist to fix the problems we found. More than 75% of our seniors have no dental insurance; private dental insurance is expensive, and MassHealth for adults only covers extractions. These elders, who are often in pain, have nowhere to turn.

The Oral Health Foundation gave us a planning grant last year to develop a plan to address the need for accessible oral health treatment services for elderly residents of southern Norfolk County. The grant enabled us to research other oral health access programs, make connections in the community, and establish a well-founded strategy. Our plan is complete and we are preparing to put it into action.

Our solution to the emerging need of seniors for low-cost oral health services is a community-based volunteer dental program: a network of dentists in South Norfolk County who volunteer to treat low-income elders at a significantly reduced fee. Services will take place in dentists' own offices and will include cleanings and routine treatments such as fillings.

The system is appealing to dentists because it is simple and does not involve a lot of paperwork or obligation. Our program manager will pre-screen the seniors for financial eligibility, set up the first appointment, and call with a reminder before the appointment. The program manager will also keep in contact with dentists and their office managers to make sure everything is running smoothly.

Participating dentists agree to accept as full payment the sliding-scale fee paid by the patient; no insurance or additional reimbursement will be involved. This simplifies billing and eliminates the need for burdensome paperwork. In addition, dentists can specify the number of patients they wish us to refer to them, allowing them to accept patients in accordance with their schedules.

We have been meeting with the local dental society and have their support. Even though we have not yet begun our recruiting effort, we already have 20 area dentists who have expressed interest in participating, including several specialists.

We have also enjoyed partnering with students in the allied dental professions. The dental hygiene program at Mount Ida College has worked with us on our dental screening clinics, and Massasoit Community College's dental assisting

program has been very active in the screening clinics and has begun to work with us on some educational outreach.

Other boards of health have recognized the crisis and are working with us to build a solution. Health boards in Canton, Dedham, Walpole, and Westwood have all contributed funds to the project. We look forward to moving forward with this project and welcome any thoughts or comments that will help us best serve the oral health needs of our elderly population.

For more information, contact Gwen Stewart at (787) 784-4944 or gstewart@hessco.org.

Norwood Coalition Promotes Healthy Living

The prevalence of overweight and obesity among Americans has been steadily increasing over the past several decades. It affects people of all age, gender and race with approximately 300,000 obesity associated deaths each year. In Massachusetts, 54% of adults and 25% of teenagers are overweight. The rising overweight and obesity trends are concerning and must be addressed at the local level. The Coalition for a Healthy, Active Norwood was formed in response to data that indicate rapidly rising rates of obesity are leading to an increase in chronic disease and premature death. The coalition's goal is to reduce chronic diseases through community actions that promote healthy eating, active living and maintaining a healthy weight among all Norwood residents.

The Coalition for a Healthy, Active Norwood is comprised of members from the Norwood Health Department, Norwood Public Schools, Recreation Department, Massachusetts Department of Public Health (MDPH) and Caritas Norwood Hospital. The coalition has the vision of *a community motivated to making healthier nutritional choices and increasing physical activity.* Its mission, to foster a community where exercise and healthy nutrition become a part of everyday lives, will be accomplished through....

Creating new partnerships
Addressing the needs for policy changes
Raising awareness of existing community resources
Providing nutritional and fitness programs
Eliminating barriers to participation
Developing community goals
Including activities which meet the needs of our diverse population
Encouraging lifelong changes and
Motivating for success

Carpe **D**iem: "Seize the day" and make a difference in your life!

The first priority of the coalition was to perform a community assessment of the town's 28,000 residents. A community wide survey was developed to assess the barriers to healthy eating and adequate physical activity. It was inserted in resident electric bills and mailed to every household. Over fourteen-hundred surveys were completed and returned. The MDPH is currently analyzing the survey data and will present the findings. The coalition will use the information from the results to make recommendations and implement nutrition and physical activity programs.

The coalition partnered with various groups/ institutions such as local health clubs, local restaurants, the Town Planner, Blue Hills Community Health Alliance (CHNA20), Blue Cross and Blue Cross and Blue Shield (BC/BS), Norwood Cooperative Bank a*nd* schools of higher education to promote healthy eating and increased physical activity. CHNA20 awarded a mini-grant to the coalition to implement *Get- up and Move Norwood a* walking initiative. It is a community walking program which will provide customized program booklets, a twelve-week "getting started" program, pedometers, tracking logs and route maps. The public schools have partnered with BC/BS to implement Jump *up and Go!:* a school based nutrition and physical activity program in the middle school It utilizes a team approach involving the school nurse, food service director, principal, physical education leader and teachers. The coalition partnered with the Town Planner to ensure the development of a walkable community. The coalition worked with the planning board to ensure safe pedestrian access throughout town and walking paths with good lighting and signage. Schools of higher education have aligned with the coalition and its efforts in reducing childhood obesity. Nursing baccalaureate candidates have been placed in elementary schools to implement a nutrition curriculum in grades two and three. Even local businesses have joined the effort to make Norwood healthier. A local restaurant owner and coalition members worked together to identify healthier meal choices on their menu and identified them with the Health, Active Norwood logo.

The Coalition for a Healthy, Active Norwood strives to create partnerships which will support and promote healthy eating and active lifestyles. Combating the obesity epidemic will require a coordinated effort of public health, schools, businesses, policymakers, health providers and commu-

nity leaders. The combined efforts of public and private agencies including local government are needed to mobilize resources and implement sustainable programs which may help decrease chronic health conditions with the potential for long-term consequences. By pooling expertise and coordinating strategies, we can help more of our residents achieve a healthy weight.

Guilford Rail Case Upholds Federal Preemption for Railroads

by Laura Richards J.D.
Attorney Consultant, MAHB

Guilford Transportation Industries, Inc. (Guilford), which runs the Boston & Maine Railroad, owns a railroad yard in Ayer, Massachusetts., which is located in the "Heavy Industry District" as defined under Ayer's zoning by-law. Guilford operates an automobile unloading facility which is bordered by a rail line and is also accessible to other traffic by a road. This facility, situated on 40 acres, has 5 unloading tracks that can handle 35 rail cars as well as 2,000 automobile parking spaces and an 8,800 square foot building. Automobiles arrive by train and are stored until transferred to trucks for distribution throughout New England. Trains arrive twice daily and trucks arrive approximately 75 times a day.

In 1997, Guilford purchased a 126-acre parcel of land across the street from its railroad yard in order to expand its storage capacity. This parcel, which is bounded by two railroad tracks, is also located in the Heavy Industry District. Guilford planned to build and operate a car loading facility on 57.7 acres of this land that would contain an access road, 6 unloading and 2 support tracks, a parking area for approximately 3,000 cars and a maintenance building. Like Guilford's existing facility, this new facility would be used for the unloading from rail cars, storing and transferring automobiles to trucks for distribution. This new site is located in an aquifer protection area categorized as a Zone II wellhead protection area which is an area where precipitation enters the ground and migrates towards a drinking water well. In light of this, the town of Ayer sought protection for the Spectacle Pond aquifer which provides a significant amount of drinking water not only to Ayer but the town of Littleton as well.

In May, 1998 Guilford filed an application requesting site plan approval with the Ayer Planning Board. The town of Ayer hired a consulting engineering firm to study the plan and give recommendations about the construction and operation of the new facility. A report was issued by the engineering firm in June, 1999. Guilford made almost all the changes recommended in the report. In August, 1999 the Planning Board approved the site plan but required Guilford to satisfy 36 additional conditions. In addition, the Ayer Board of Health declared Guilford's proposed plan to be a noisome trade which could be prohibited within the town. Concerned that the town was effectively prohibiting or unduly burdening its proposed operation, Guilford went to federal court to seek a declaration that Ayer's actions were preempted by federal statute. This matter was referred to the Surface Transportation Board (STB) by the Court to evaluate whether Ayer had the right to regulate Guilford's proposed development. The issue before the STB was to what extent regulation by the town of Ayer over Guilford's proposed construction and operation of an automobile unloading facility is preempted by 49 U.S.C. s.10501(b).

The STB found that Ayer's Planning Board permit process and the ordinance determining that automobile unloading facilities are a noisome trade were preempted under 49 U.S.C. s.10501(b) which states that "the jurisdiction of the Board over (1) transportation by rail carriers, and the remedies provided in this part with respect to rates, classifications, rules...practices, routes, services, and facilities of such carriers; and (2) the construction, acquisition, operation, abandonment, or discontinuance of spur, industrial, team, switching, or side tracks, or facilities, even if the tracks are located, or intended to be located, entirely in one state, is exclusive. Except as otherwise provided in this part, the remedies provided under this part with respect to regulation of rail transportation are exclusive and preempt the remedies under Federal or State law."

The STB discussed the general parameters of preemption under section 10501(b) in their decision released May 1, 2001. Noting that state and local railroad regulation has long been preempted to a significant extent, the decision states that "state and local regulation cannot be used to veto or unreasonably interfere with railroad operations. Thus, state and local permitting or preclearance requirements (including environmental requirements) are preempted because by their nature they unduly interfere with interstate commerce by giving the local body the ability to deny the carrier the right to construct facilities or conduct operations." Boston & Me. Corp., 2001 Fed. Carr. Cas. (CCH) p.38,352 (May 1, 2001).

While holding that pre-construction approval requirements gave local authorities impermissible veto power over rail transportation issues, the STB did not hold that all state and local regulation of railroad activities was preempted. Such regulation is permissible if "it does not interfere with interstate rail operations and localities retain certain police powers to protect public health and safety." The test to be applied to local regulations is whether such regulations "unduly restrict the railroad from conducting its operations, or unreasonably burden interstate commerce." The STB listed three guidelines for permissible state and local regulation:

1. Nondiscriminatory enforcement of requirements such as building and electrical codes generally are not preempted;

2. A town may seek enforcement of voluntary agreements between a railroad and town; and

3. The implementation of federal environmental statutes by state and local agencies.

The town of Ayer had argued that it could regulate the new facility under two federal environmental statutes, the Safe Drinking Water Act (SDWA) and the Clean Water Act (CWA), which are not preempted. The STB held, however, that these statutes "may not be used simply to permit local communities to hold up or defeat the railroad's right to construct facilities used in railroad operations through the guise of saying they are enforcing the CWA or the SDWA, as Ayer appears to be doing here."

While not expressly addressing the 36 conditions attached to the permit issued by the town, the STB did state that certain conditions might be reasonable and thus allowable in individual circumstances if they do not unreasonably interfere with interstate commerce. These included "conditions requiring railroads to (1) share their plans with the community, when they are undertaking an activity for which another would require a permit; (2) use state or local best management practices when they construct railroad facilities; (3) implement appropriate precautionary measures at the railroad facility, so long as the measures are fairly applied; (4) provide representatives to meet periodically with citizen groups or local government entities to seek mutually acceptable ways to address local concerns; and (5) submit environmental monitoring or testing information to local government entities for an appropriate period of time after operations begin."

In May, 2003, Guilford and the town of Ayer reached a settlement in the case. They agreed on a permissible list of conditions the town may impose on the new facility and that these conditions would comprise the sole regulatory ability of the town. On July 28, 2003 a Consent Decree was issued by the United States District Court decreeing that Guilford could proceed with the development, construction and operation of an automobile facility in Ayer subject to the following conditions:

1. In constructing the facility, Guilford will install catch basins designed for a minimum infiltration rate of .5 inches per hour, with oil/gas separator hooks;

2. Guilford will conduct test pits in the vicinity of the retention basins to confirm that the soils are consistent with test borings previously submitted, such results to be submitted within one week of receipt by Guilford;

3. Guilford will install a monitoring well network around the facility and will measure quality of groundwater twice yearly

as long as the facility is in operation and groundwater quantity twice a year for four years after completion of the facility, such test results to be submitted within one week of receipt by Guilford;

4. Guilford will comply with all applicable requirements of the Massachusetts Contingency Plan with regard to any releases of hazardous materials at the site;

5. Guilford will develop a Stormwater Pollution Plan consistent with EPA Stormwater Regulations;

6. Guilford will continue to plow that portion of the emergency access road provided to Wagon Road residents that is on Guilford property;

7. Guilford will continue to honor its agreement with Wagon Road residents regarding use of that private crossing and emergency access issues;

8. Guilford will comply with applicable building, electrical, fire and plumbing codes unless such codes are applied in a discriminatory manner, unreasonably restrict the railroad from conducting its operations or unreasonably burdens interstate commerce;

9. Guilford will comply with applicable federal noise control requirements;

10. During construction of the facility, Guilford will comply with applicable state best management practices;

11. Guilford will provide Ayer with informational copies of construction plans and precautions being taken for the construction of the facility not less than 60 days before construction begins;

12. Guilford will provide Ayer with informational copies of as-built plans for the facility not more than 60 days after completion of construction;

13. Should Guilford develop the site for alternative uses, Guilford will provide Ayer with informational copies of construction plans and precautions being taken for any additions, improvements or changes to the site no less than 60 days prior to beginning construction and will comply with those conditions set forth in the Consent Decree that are material to the alternative uses. Ayer may object but Guilford does not agree that Ayer has the right to do so.

14. Should Guilford develop the site for alternative uses, Guilford will supply Ayer with informational copies of as-built plans and precautions being taken for any additions, improvements or changes to the site no more than 60 days after completion of construction.

15. Guilford will install a septic system complying with Title 5 regulations at an appropriate location at the site and may connect to the town sewer in the future.

16. Guilford will install a geomembrane liner under the locomotive area. Testing of the integrity of the liner will be performed at Guilford's discretion such test results to be provided to Ayer within one week of Guilford's receipt of the results.

17. Guilford will not remove snow from the site except for emergency situations.

Board of Health perspective on Guilford

In 1999 MAHB received a letter from a member of the Ayer Board of Health describing this project as a 50 acre asphalt parking lot for 3,000 cars, with 3 rail spurs and 88 trailer trucks per day directly on top of a Zone II aquifer that supplies water to Ayer and Littleton.

The board of health was dealing with complaints in 1998 from idling trains left unattended on tracks for three hours. In 1999 the BOH voted to consider an auto unloading facility a noisome trade" subject to site assignment.

This unfortunate case should serve as a warning and an inspiration to oppose preemption clauses in principle whenever such language is included in legislation.

New Requirements Regarding Meningococcal Disease and Vaccination in Certain Residential Schools and Colleges

Effective August 2005, recently enacted Massachusetts General Laws, Chapter 76, s.15D and related regulations of the Massachusetts Department of Public Health (105 CMR 220.700) will require meningococcal immunization for: 1) all new students at public and private residential schools (e.g., boarding schools) that provide education to students in grades 9-12; and 2) all new, full- and part-time, undergraduate and graduate students in degree-granting programs at post secondary institutions (e.g., colleges) that provide or license housing.

The law states that all new students at affected institutions must:

★ receive information about meningococcal disease and vaccine; and

★ provide documentation of receipt of 1 dose of meningococcal vaccine within the last 5 years or qualify for one of the exemptions to immunization established by the statute.

The two components of the law, described above, apply to **all new** students at these institutions (**whether or not** they reside in school- or campus-provided housing). In addition, at affected residential schools with grades 9-12, the requirements also apply to new students in lower grades (pre-k through 8) if the school combines these grades in the same school or a part of the school with students in grades 9-12.

The law states that affected institutions are **not** required to provide the vaccine or incur expense for the vaccine. However, it is the institution's responsibility to provide information about meningococcal disease and vaccine to all new students.

In contrast to other immunization requirements, this law allows an exemption for students who sign the MDPH-developed waiver form entitled *Information about Meningococcal Disease and Vaccination and Waiver for Students at Residential Schools and Colleges.* The form contains information about the dangers of meningococcal disease, the benefits and risks of meningococcal vaccine, as well as a waiver section for the student to sign that states the student has read the information provided and chosen to waive receipt of meningococcal vaccine.

Meningococcal Vaccine Requirements for Students[1] at Residential Schools with Grades 9-12 and Post secondary Institutions

Residential Schools with Grades 9-12
Post secondary Institutions **that Provide Housing**

Meningococcal Vaccine[2] 1 dose[3] for all new students, regardless of grade (including grades pre-K-8, if these grades are combined in the same school or part of a school with grades 9-12)[4] 1 dose[3] for all new, full- and part-time, undergraduate and graduate students in a degree-granting program[4]

[1] These requirements apply to all new students at affected institutions, whether or not they reside in school or campus-related housing.[2] Meningococcal polysaccharide vaccine is approved for use in those $\geq$ 2 years of age. Meningococcal conjugate vaccine is approved for use in those 11 - 55 years of age. Both vaccine formulations are acceptable for use in students $\geq$ 11 years of age. For those < 11 years, meningococcal polysaccharide vaccine is the only licensed formulation.[3] Administered within the last 5 years.[4] Unless the student qualifies for an exemption.

Students may begin classes *without* a certificate of immunization against meningococcal disease if:

1) the student has a letter from a physician stating that there is a medical reason why he/she can not receive the vaccine **(medical exemption)**;

2) the student (or the student's parent or legal guardian, if the student is a minor) presents a statement in writing that such vaccination is against his/her sincere religious belief **(religious exemption)**;

or 3) the student (or the student's parent or legal guardian, if the student is a minor) signs the MDPH-developed waiver stating that the student has received information about the dangers of meningococcal disease, reviewed the information provided and elected to decline the vaccine **(waiver exemption).** (A signed copy of this information and waiver form must be kept on file at the institution.)

Consideration is being given to amending the law regarding the scope of the requirements. When and if the law is amended, regulations regarding meningococcal vaccination may change. As currently proposed, the amendment would limit the application of the law to new students living in dormitories or comparable congregate environments provided or licensed by secondary schools or post secondary institutions. However, the current law requires that the existing requirements in the law and these regulations be met by August 2005.

For more information and to obtain a copy of the *Meningococcal Disease and Vaccination and Waiver for Students at Residential Schools and Colleges*, please visit the MDPH Immunization Program web site at www.mass.gov/dph or contact the MDPH Immunization Program at 617-983-6800 or toll-free at 888-658-2850.

Rabies Vaccine: An Oldie but Goodie

By Erica Berl, DVM, MPH
Massachusetts Department of Public Health

Ever since terrestrial rabies entered Massachusetts in 1992, rabies control measures have taken on added importance. Our domestic animals, and in particular cats, are at significant risk for contracting rabies and subsequently putting their owners at risk.

Since 1992, 120 cats have tested positive for rabies at the Massachusetts Department of Public Health's (MDPH) State Laboratory Institute (SLI). Strain typing has shown these cats to be infected with the raccoon strain. In fact, all of the terrestrial animals tested in Massachusetts have been infected with the raccoon strain except for a dog that was recently imported from Puerto Rico, where mongoose and canine strains predominate.

In 2004, 8 cats and 2 dogs tested positive for rabies at SLI. All but one of the positive cats and kittens were recently adopted strays. None of these animals were up-to-date on their rabies vaccinations. While there have been rare cases of rabies in vaccinated animals, the vaccine is very effective and remains a critical part of rabies control to keep animals and their owners healthy.

The following true stories describe situations investigated by MDPH staff between June and December 2004. They highlight the importance of timely rabies vaccination and the need for proper quarantine of potentially exposed animals. In addition, they illustrate that veterinarians and veterinary staff are at significant risk for being exposed to rabid animals and should receive proper pre-exposure rabies prophylaxis.

Even Young Kittens Can Have Rabies

In June, a 3 month-old kitten from Berkshire County tested positive for rabies. This kitten was one of six kittens that were displayed for adoption on the side of the road by a family in New York State. The kitten was adopted by a family who was passing by, but soon after, it became ill. The adoptive family took it to a veterinarian in New York State who treated it and sent it home. However, the kitten continued to decline, and it was taken to a veterinarian in Massachusetts who euthanized it and submitted the head to SLI for testing.

After the kitten tested positive for rabies, an attempt was made to find the other kittens so that they could either be quarantined for six months or euthanized and tested. One of the kittens was still with the family in New York. Two of the kittens had been adopted by a woman from Vermont, and she was quickly located. There was no good contact information for the people who adopted the remaining two kittens. The Rensselaer County Health Department (NYS) issued a press release to try to locate the last two people. Fortunately, they came forward and contacted

the health department. All of the adopters elected to euthanize and test their kittens rather than place them under a six-month quarantine. None of the other kittens tested positive, and it is not known how the first kitten was exposed.

Due to exposure to the positive kitten, the family that adopted the kitten had to receive post-exposure rabies prophylaxis (PEP). The veterinarian and staff at the Berkshire County animal hospital had all received pre-exposure prophylaxis, but the veterinarian elected to get boosted because she had done an oral exam on the kitten without wearing gloves. The staff at the New York animal hospital had to be notified as well.

More Kittens….

In November, a resident of Hampden County brought home a litter of four kittens that had been found near his shop at an industrial park. He kept the kittens in a cage the entire time. When the kittens were approximately 7 to 8 weeks old, one of them developed neurologic symptoms and was euthanized. This kitten tested positive for rabies. The three littermates were then euthanized and submitted for testing, and one tested positive.

At least six people who helped care for the kittens received PEP. In addition, it was rumored that several people were feeding feral cats in a colony at the industrial park. Signs were posted requesting that people come forward if they had any contact with the cats. No one responded. Attempts were made to trap the mother cat, but she was never found.

Don't Forget to Vaccinate Those "Indoor Cats"

In October, an adult cat in Plymouth County tested positive for rabies. The cat had been a stray that was adopted in February 2004. The new owners did not have the cat vaccinated for rabies. The cat was being kept indoors, but in August it escaped. When it returned, it had a wound of unknown origin on its paw which appeared to heal completely. Because it was not up to date on its rabies vaccination, the cat was placed under a 6-month quarantine in the home. Unfortunately, in the middle of October, the cat began to favor that same paw. Within a few days it was partially paralyzed in the hind end. The cat was taken to a veterinarian, euthanized and tested positive. There was no history of the cat biting or scratching anyone, but four people in the owner's family received PEP.

Quarantine Animals With Any Suspicious Wounds

In November, an owner brought his cat to a veterinarian's office because it had some wounds of unknown origin. This owner had been caring for this adult cat since 2002, and its age was unknown. The cat was semi-feral and spent most of its time outdoors coming inside mainly to eat. The cat was not up-to-date on its rabies vaccination because every time it had been brought to a veterinarian in the past few years, it was thought to be too ill to vaccinate. At the November visit, the veterinarian did not think the wounds were caused by an animal so it was not reported to an Animal Control Officer, and the cat was not placed under quarantine.

In December, the owner noticed that the cat was dragging its hindquarters, crying a lot and lying in the litter box. The cat was brought to the veterinarian who euthanized it and submitted it for testing. It was positive for rabies. Fortunately, it was not a very sociable cat, and it had very little contact with the owner and the owner's other two vaccinated cats.

At least one veterinary technician, who may have had exposure to the cat's saliva during the December visit, received PEP. Fortunately, the tech had received pre-exposure prophylaxis and only needed two additional doses of vaccine. The staff at the animal hospital who treated the cat in early November were concerned that they could have been exposed to rabies. However, because their exposure to the cat was more than ten days prior to the onset of symptoms, the cat would not have been shedding rabies virus at that time, and that staff was not at risk.

Again… The Importance of Proper Quarantine!

Later on in December, another cat tested positive for rabies. This cat had recently been adopted by a family after it appeared on their doorstep. The cat had visible wounds when it

first appeared. The cat was taken to a veterinarian who recommended that the cat be put under a six-month quarantine as he felt it had most likely been attacked by a fox. The family confined the cat to a bedroom. Within a few weeks, the cat started acting strange and attacked the husband's feet, bit and scratched the son and bit the wife as well. At that point, it was brought to a veterinarian who euthanized it and submitted it for testing. All of the family members received PEP. Fortunately, because the cat was under quarantine, the cat was carefully watched and promptly diagnosed, and human exposures were kept to a minimum.

Don't Miss That First Booster!!!

In December, a dog from Norfolk County tested positive for rabies. This was a young dog who had received its first rabies vaccine in May 2003 but had never received a booster. The family had recently moved and had not yet found a new veterinarian for the dog. In October 2004, the dog scuffled with a skunk and was either bitten or scratched. Since the skunk was not available for testing, and the dog was not up to date on its rabies vaccination, the dog was placed under a 6-month quarantine. The dog was kept in the family's basement during the six months. However, in December, the dog developed neurologic symptoms and was euthanized and submitted for testing. Fortunately, because of the quarantine, only three adults in the house had contact with the dog in the ten days prior to onset of symptoms and needed to receive PEP.

Because of comprehensive rabies control efforts, human rabies is thankfully rare in the United States. Widespread use of effective rabies vaccines for domestic animals and effective pre- and post-exposure prophylaxis for humans have been enormously successful in preventing human cases. However, as the above scenarios illustrate, continued vigilance is needed to keep rabies a rare disease.

For more information on quarantine, isolation and rabies vaccination requirements for domestic animals, please contact the Division of Animal Health, Biosecurity and Dairy Services in the Department of Agricultural Resources at 617-626-1795. In addition, please see the "2003 Rabies Control Plan for Cities and Towns" at http://www.mass.gov/dph/cdc/epii/rabies/controlplan/rabiescp.htm for comprehensive information about the control of rabies in Massachusetts, or visit MDPH's rabies web site at http://www.mass.gov/dph/cdc/epii/rabies/rabies.htm.

For questions about human exposures to rabid or potentially rabid animals or questions about the human rabies vaccines, please call MDPH's Division of Epidemiology and Immunization at 617-983-6800.

Ceramics Studios Source of Child Lead Poisoning

MA Division of Occupational Safety was recently informed of an infant who was lead-poisoned at a Massachusetts paint-your-own ceramics studio. The child, whose parent works at the studio, reportedly had spent much time there. A similar incident, in which the owner was also poisoned, was reported in California. While typically the ceramic paint used by the public (often young children) does not contain lead, the glaze that is subsequently applied by studio employees may be lead-based. When the lead-containing glaze dries and falls on work surfaces and floor, it can spread throughout the studio.

Lead-free, non-toxic glazes and paints are readily available and should be used. For more information, contact: Rick Rabin Lead Registry Coordinator MA Division of Occupational Safety 1001 Watertown St. Newton, MA 02465 617-969-7177, ext. 309

New Public Health Regulation Clarifies Smoke-Free Workplace Law

The Public Health Council voted on July 2, 2005 to pass a Department of Public Health Regulation that helps to clarify certain sections of the Smoke-Free Workplace Law. The regulation is effective as of August 26, 2005 *(105 CMR 61.000)*. The regulation addresses the law's exemption language for membership associations (private clubs) and outdoor spaces.

The state law permits membership associations to allow smoking in an enclosed indoor space "if the space is restricted by the association to admittance only of its members, the invited guest of a member, and the employees of the membership association." *(G.L. ch. 270, § 22(c)(2)(ii).* Employees are only those individuals for whom the membership association pays payroll taxes. Independent contractors, such as a disc jockey, a caterer, or any other employee who does not receive a regular paycheck (often known as "W-2" or "salaried" employees) are not considered employees. If a membership association hires independent contractors, and not "W-2" employees, they must be smoke-free at all times.

Local boards of health and the Department of Public Health have been receiving complaints alleging that many membership associations are abusing this exemption by acting like public bars, not private clubs. For instance, there have been numerous reports of associations issuing one-day, social, or associate memberships that permit practically anyone to patronize membership associations that allow smoking.

The new regulation prohibits this type of activity. The presence of anyone in the membership association holding a membership that "differ[s] in duration, cost or privileges from the terms of a full membership in the association" means that the association must be smoke-free. This means that if one-day, social, or associate members are present in the private club, it must be smoke-free.

The new regulation also clarifies those outdoor spaces where smoking is permitted. The Smoke-Free Workplace Law permits smoking in outside areas that are physically separated from the enclosed workplace and where there is no migration of smoke into the enclosed workplace. The outdoor space may not be enclosed and must be "open to the air at all times" *(G.L. ch. 270, § 22(a))*.

Municipalities have been asked to approve the construction of outdoor spaces that look more like enclosed rooms than outdoor spaces. The regulation states that in order to meet the requirement that the space is open to the air at all times, the space must have "unobstructed circulation of outside air to all parts of the outdoor space." *(661 CMR 200(B).*

An outdoor space meets this test if: "(1) the space has a ceiling and at least one half of the total surface area of the walls and other vertical boundaries of the space permits unobstructed flow of outside air to all parts of the outdoor space." For example, a 10' by 10' deck with 8' walls and a roof cannot have walls that cover more than 160' of vertical space. Establishments must take into consideration the wall that attaches the deck to the establishment itself in making calculations.

An outdoor space also meets this test if: "(2) the space has no ceiling and no more than two walls or other vertical boundaries of the space that obstruct the flow of air into the space exceed eight feet in height."

For the purpose of the regulation, "ceiling" "shall include any top or covering that is placed or may be placed over a space, or any other structure or arrangement above the space (including substantial coverage by umbrellas or awnings) that may impede the flow of air into the space, regardless of the type or nature of the materials or the partial or removable nature of the covering."

The regulation also requires that the local board of health be notified in writing prior to initiating construction or renovation of an outdoor space for the purpose of permitting smoking if such construction or renovation requires a local building permit or local license.

If you have any questions about this regulation, please contact Cheryl Sbarra, J.D., Massachusetts Association of Health Boards, sbarra@mahb.org

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EEE Update

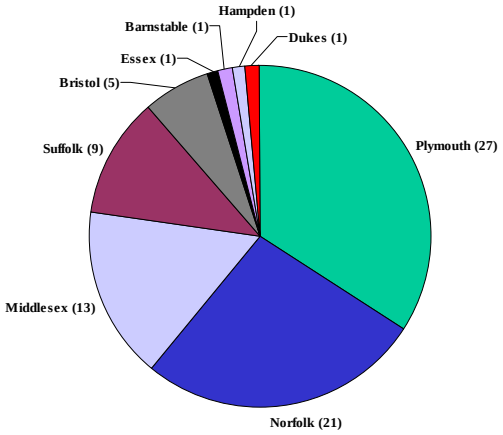
Eastern equine encephalitis (EEE) is a viral illness spread by mosquitoes. The mortality rate for those affected is high and survivors often suffer severe neurological damage. The first human case of EEE in the United States was identified in Massachusetts in 1938. Since then, 79 people in Massachusetts have been identified with the disease and over half of them have died.

Infection with EEE virus most commonly presents as encephalitis (inflammation of the brain). The incubation period is between 3-10 days. Symptoms of EEE typically include fever, headache, alterations of consciousness, lethargy, confusion and seizures. Since encephalitis can coexist with inflammation of the meninges (membranes surrounding the brain and spinal column), symptoms of meningitis, such as fever, headache and stiff neck, may be present. Any suspect case of encephalitis or meningitis should be reported as soon as possible to the Massachusetts Department of Public Health (MDPH), Division of Epidemiology and Immunization, at 1-617-983-6800 or 1-888-658-2850.

To assist in confirming suspect equine and human cases of EEE, veterinarians and physicians are encouraged to send in appropriate samples to the MDPH State Laboratory Institute (SLI) for testing. SLI conducts diagnostic serologic testing as well as viral isolation. Questions on submission of samples for EEE testing should be directed to the MDPH, Viral Serology Laboratory at 617-983-6396.

EEE is endemic in eastern and southern Massachusetts, specifically Plymouth, Bristol, Norfolk, Suffolk, and Middlesex counties (see pie chart below). The time of highest risk for EEE is normally from late July through September. People under 15 years of age or over 50 years of age are at greatest risk for serious illness.

Human Cases of Eastern Equine Encephalitis (EEE) in Massachusetts by County, 1938-2004



N=79

While EEE is relatively rare, Massachusetts has experienced periodic outbreaks of the deadly disease (see table below). In 2004, four human cases were identified, two of whom died from the infection. MDPH is particularly concerned about the potential for disease transmission in 2005. Outbreaks of EEE in the past have occurred in two-year cycles, with the second year being worse than the first. Given the cases identified in 2004, we may see a higher number of cases this coming summer. In addition, Massachusetts has been experiencing a winter with large amounts of insulating snow cover allowing for a larger number of mosquito larvae to survive. Winter surveillance of mosquito populations, conducted by MDPH, has indicated above average larval mosquito counts in EEE prone areas. These overwintering larvae may already be infected with EEE virus. The risk for EEE may be increased earlier in the season as these overwintering larvae emerge in the spring.

EEE in Massachusetts by Year, 1938-2004*

Year(s)	Number of Human Cases	Number of Deaths
1938-39	34	25
1955-56	16	9
1970	1	0
1973-75	6**	4
1982-84	10***	3
1990	3	1
1992	1	0
1995	1	0
1997	1	0
2000	1	0
2001	1	0
2004	4	2
TOTAL	**79**	44

* Years not shown had no reported cases.
** One case in 1973 consistent with exposure in NH
*** One case in 1984 consistent with exposure in NJ

Another finding from last year was the amount of EEE virus activity detected outside of the usual high-risk southeastern Massachusetts area. In 2004, two EEE virus positive mosquito pools, two positive horses and a positive alpaca were identified in northern Middlesex County. In addition, an EEE virus positive emu and horse were identified in Essex County.

A total of seven horses tested positive for EEE virus in 2004, all of which either died or had to be euthanized. A vaccine to protect horses from EEE virus infection is available. Horse owners are encouraged to vaccinate their animals and put safeguards in place that prevent animals' exposure to mosquitoes, as well as report any suspicious signs of EEE in animals to their veterinarian.

There is no human vaccine for EEE. The best protection is to reduce the chance of being bitten by a mosquito. MDPH recommends individuals take the following precautions if they live in or visit an area with mosquitoes:

· Avoid outdoor activities between dusk and dawn, if possible, as this is the time of greatest mosquito activity.

· Avoid swamp or marshland areas, as these are areas where mosquitoes that transmit the virus that causes EEE are likely to be.

· Wear a long-sleeved shirt and long pants and take special care to cover up the arms and legs of children when outside during high risk times or in high risk areas.

· Fix any holes in screens and make sure they are tightly attached to all doors and windows.

· Use repellents containing DEET (N,N-diethyl-m-toluamide) and choose a product that will provide sufficient protection for the amount of time spent outdoors.

Product labels often indicate the length of time that someone can expect protection from a product. DEET is considered safe when used according to the manufacturer's directions. The efficacy of DEET levels off at a concentration of 30%, which is the highest concentration recommended for children and adults. DEET products should not be used on children less then 2 months of age. Mosquito netting may be used to cover infant carriers or to protect other areas for children less than 2 months of age. The following precautions should be observed when using DEET products:

• Avoid using DEET products that combine the repellent with a sunscreen. Sunscreens may need to be reapplied too often, resulting in an over application of DEET.

• Apply DEET on exposed skin, using only as much as needed.

• Do not use DEET on the hands of young children and avoid applying repellent to areas around the eyes and mouth.

• Do not use DEET over cuts, wounds or irritated skin.

• Wash treated skin with soap and water after returning indoors and wash treated clothing.

• Avoid spraying DEET products in enclosed areas.

In additional to personal protection measures, people should take steps to reduce mosquito populations around their home and neighborhood by getting rid of any standing water that is available for mosquito breeding. Mosquitoes will begin to breed in any puddle or standing water that lasts for more than four days. Homeowners should dispose of or regularly empty any metal cans, plastic containers, ceramic pots, and other water holding containers (including trash cans) on their property.

Decisions about the need for pesticide spraying are normally made by local cities and towns (based on mosquito habitat and density, surveillance for EEE virus in mosquitoes, and the number of cases identified). Regional mosquito control projects are an excellent source for information regarding local mosquito surveillance and control efforts. If a city or town does not belong to a mosquito control project, but is interested in joining one, or creating one with other surrounding towns, they can contact the State Reclamation and Mosquito Control Board within the Massachusetts Department of Agricultural Resources at (617) 626-1777. More information on regional mosquito control projects, including contact numbers, can also be found on-line at www.mass.gov/agr/mosquito/index.htm.

The MDPH Arbovirus Surveillance Program and regional mosquito control projects routinely monitor mosquitoes throughout the season to assess mosquito population levels and EEE viral carriage in high-risk areas. Reports of positive mosquito pools, animals and humans are immediately communicated to the local board of health and are posted on the MDPH arbovirus website at www.mass.gov/dph/wnv/wnv1.htm. This online resource also contains educational materials on EEE as well as West Nile virus (WNV) for the general public, veterinarians, physicians and local boards of health.

CLAIRE MARANDA AND APOLLO

On March 3, 2005 MAHB Executive Board member Claire Maranda lost a long fight against pancreatic cancer. Claire was elected to five terms on the Canton Board of Health and for many years was a member of the Curry College nursing faculty, where she was the first professor of Pediatric Nursing and also taught Nursing Research .

"Claire was a very close friend and a beautiful human being who will be sorely missed - not only by the Board of Health but by everyone who knew her," said fellow board member James Marathas. A quiet, unassuming person who was passionate about public health and community service, she once remarked, "The things I've done to help people are the most important things in my life. I'm fortunate to be able to provide service to the town in the ways I am able to do" In addition to serving as past president of the local civic association, Eucharistic minister and provider of communion to those unable to attend her local church, Claire produced a long-running program "Claire Maranda's Health Concerns," using local access television for public health education. Her first program was on rabies, then followed many others on a wide range of topics, from melanoma, therapeutic massage, to teaching children how to safely approach dogs.

Claire was well known at local nursing homes, where she regularly visited with her therapy dog Apollo. "One time we went to see a resident who was very out of control and screaming," she recalled in a newspaper interview on pet therapy. "When I brought the dog in he completely changed. He smiled and petted the dog and calmed down. This is the kind of experience you don't forget - if I can bring five minutes of joy into someone's life that is basically joyless, it's a great feeling."

Claire faced her diagnosis with tremendous courage and chose to fight to prolong life, hoping that her battle at the Sidney Farber Center would in some way also help others. This winter, when she was no longer able to take care of Apollo, she was very pleased that he'd found a good home with a friend.

Continued from page 3

members of your emergency management response team. You should have an Infectious Disease Emergency Plan (IDEP). Roadblocks need to be identified and addressed. Above all, you need to develop a strong, supportive and mutually respectful relationship with your staff. In the event of a flu pandemic, chemical, nuclear or biological attack, your families and neighbors will be depending upon a combination of professional, trained staff and board leadership.

I strongly recommend *The Great Influenza, The Epic Story of the Deadliest Plague in History,* by John M. Barry. It is a disturbing wake up call that puts Preparedness into historical context. The 1918 pandemic was not public health's finest hour but the lessons learned - especially pertaining to risk communication - may prove vital if avian flu mutates into a pandemic strain.

Marcia Elizabeth Benes
MAHB Executive Director & Editor

Hepatitis Continued from pg.17

Many local health departments have been holding vaccination clinics at homeless shelters and substance abuse treatment facilities in their communities. The regional meetings were quite successful with over 250 attendees from 100 cities and towns. As a result of these meetings, several vaccination clinics were held and others are being planned. In 2004, over 17,000 doses of vaccine were provided to various community health centers, correctional facilities, and local health departments.

These vaccination efforts appear to be working, but it is important for local health departments to continue hepatitis A vaccination efforts by encouraging those who serve the at-risk population to help their clients get vaccinated, and, if possible, setting up vaccination clinics to assist. Vaccinating at-risk people will reduce the incidence of disease and decrease the chance that ongoing chains of hepatitis A transmission will become established increasing the risk for everyone.

At this time MDPH is able to offer a limited amount of clinic supplies such as syringes, that can be used by local health departments to run hepatitis A vaccination clinics if needed. In addition, MDPH public health nurses are available to answer technical questions regarding vaccination clinics. If access to nursing staff is a barrier, MDPH nursing staff may be available on a limited basis to assist in vaccine clinic staffing. If you need assistance, please contact your regional immunization nurse[1] or call the Division of Epidemiology and Immunization 617-983-6800.

While the recent decline in hepatitis A cases is encouraging, it is too soon to claim victory. Sustained vaccination and education efforts are needed to ensure that the decline continues. It is important to remember that hepatitis A vaccine can prevent the disease and reduce the burden on the community and agencies providing community-based services, as well as on health departments that do case follow-up, contact identification, contact treatment and interventions in food establishments.

[1] Information on how to contact your Regional Immunization nurse is available at http://www.mass.gov/dph/cdc/epii/imm/resources/nursingserv.htm.

SJC Case Continued from page 1

sion that because the state law specifies certain exemptions to the state law under very limited circumstances, the Legislature must have intended to preempt cities and from further regulating smoking.

The decision, while not binding on other counties, is a troubling one. The decision seems to ignore clear language in the state law that permits cities and towns to further regulate public health. Historically, state laws that address public health issues are considered "floors" rather than "ceilings." State laws, especially those laws with clear anti-preemption language, are considered minimum standards. Local governments may pass stricter public health laws through board of health regulations, ordinances and by-laws.

The decision is also troubling because it seems to suggest that, for some reason, membership associations or private clubs, are not subject to municipal regulation because they are allegedly private. Private clubs, like restaurants and bars, are regulated locally from door to dumpster. They must hold state and local liquor licenses, building permits, and occupancy permits. They cannot serve milk below a certain temperature, nor can they serve alcohol to minors.

Because the decision is so troubling, and because the decision might have far reaching implications on local authority to regulate public health, MAHB and the City of Boston Public Health Commission are providing assistance to the Town of Athol in its appeal of the superior court decision.

Athol applied to the Supreme Judicial Court for Direct Appellate Review of the lower court's decision. The SJC accepted direct appellate review. Oral arguments will be heard in October or November. The City of Boston will be writing a Friend of the Court brief in support of the Town of Athol.

MAHB will provide further updates on our website, www.mahb.org. Contact us if your city or town wants to sign onto Boston's brief.

Worker's Compensation during Non-Business Hours

by Laura Richards J.D.
Attorney Consultant, MAHB

Is a health agent who is "on call" covered by Worker's Compensation when he is in a motor vehicle accident on his way to responding to an emergency during non business hours?

In answering this question, one must first determine whether the city or town involved has accepted the provisions of M.G.L.A. c.152. Unlike private employers, cities and towns are not required to provide worker's compensation benefits to their employees. M.G.L. c.152, s.25B.

Assuming the city or town involved does provide worker's compensation, then M.G.L. c.152 s.26 states that "if an employee ... receives a personal injury arising out of and in the course of his employment, or arising out of an ordinary risk of the street while actually engaged, with his employer's authorization, in the business affairs or undertakings of his employer ... he shall be paid compensation ..." This section further states that "any person, while operating or using a motor or other vehicle, whether or not belonging to his employer, with his employer's general authorization or approval, in the performance of work in connection with the business affairs or undertakings of his employer ... and while performing such work, receives a personal injury, shall be conclusively presumed to be an employee."

It is well settled that a person does not have the status of "employee" and is not entitled to worker's compensation for personal injuries

"...where it was the employment which impelled the employee to make the trip, the risk of the trip is considered a hazard of the employment"

received while going to or coming from his place of employment. However, where the duties of a claimant require him to be on or about the streets during working hours a different result has been reached and compensation has been allowed. This is so even if the mission is performed outside normal working hours. Thus, where it was the employment which impelled the employee to make the trip, the risk of the trip is considered a hazard of the employment. Caron's Case (1966) 351 Mass. 406, 221 N.E.2d 871.

Although each case must be decided on its facts, it would seem that an employee "on call" would be covered by Worker's Compensation if injured while responding to an emergency. Since responding to the emergency would be in fulfillment of the employee's obligations to his employer and otherwise in accordance with the terms of his employment, it would seem that he was on an undertaking of his employer as required by statute.

Boasting about Successful Public Health Efforts is a GOOD thing!

Is your BOH involved in a project or program you would like to tell others about? Send a brief description to MAHB by sending an email to benes@mahb.org.

The message subject line should be 2006 Journal.

Of course, we also need to hear about your problems, especially if they involve new public health threats, legal issues or loss of authority.

Liability Protections for Municipal Employees and Volunteers

Questions frequently arise concerning liability protection for board of health employees. Since 9/11, the question has also arisen relative to potential liability for volunteers recruited in the event of a public health emergency. This article will attempt to describe five potential sources of protection for public employees and volunteers.

The Massachusetts Tort Claims Act (G.L. Chapter 258)

Public employers are liable for harm caused by the negligent or wrongful act or failure to act of any public employee who acted within the scope of his or her employment. Liability is capped at $100,000.00 per incident; and there is no individual liability for such negligence.

Public employers include the Commonwealth of Massachusetts, any city, town or county; any public health district, regional health district or regional health board, local board of health or any commission, committee or council "which exercises direction or control over the public employee.

In order to meet the definition of a public employee, the employee must be subject to the discretion and control of the public employer; and the act or failure to act must have been within the scope of the employee's employment. One need not be paid in order to meet the definition of public employee. A public employee may be elected or appointed, full or part time, temporary or permanent, and compensated or uncompensated. (G.L. ch. 258, §1).

In determining whether an employee is subject to the direction and control of a public employer, one must look at key factual issues. Paid employees doing regular job duties are generally considered to be operating under the direction and control of their public employer. Doctors at Boston City Hospital were held to be public employees because their duties demonstrated that they were "servants" of the hospital, even though they were also subject to the supervision of an attending physician who was not a public employer. *(Williams v. Bresnahan, App. Ct. 1989).* However, in a different case, the Court held that there was a dispute as to whether a Boston City Hospital resident who was on rotation at a private hospital worked for the city of Boston or the private hospital. *Kelley v. Rossi, SJC 1985).*

Mutual aid agreements should be careful to specify the direction and control to be exercised. The written agreement will be evidence that will help the Court determine which municipality exercised direction and control, and whether the employee was operating under that direction and control. For example, the agreement should contain language that says that an employee from Town A that is sent to help Town B "remains under the direction and control of Town A while in Town B."

Independent contractors, consultants and volunteers can be considered public employees if they are operating "under the direction and control" of public employers as well. An Attorney General opinion from 1983 found that student volunteers in the Governor's office were public employees because the Governor's office directed "what shall be done and how it shall be done."

In determining whether a public employee is operating within the scope of his or her employment a Court will consider whether the conduct in question was that which the employee was hired to do. Whether the conduct occurred during authorized time and space; and whether it was motivated by a purpose to serve the employer.

Normally, conduct occurring during travel to and from home is not considered conduct occurring within the scope of employment. The mere fact that one is "on call" does not place one "within the scope of employment." However, if an employee is on call and is traveling to the incident for which he or she was called, the travel time will commonly be considered to be within the scope of employment.

A public employee who is negligent while operating within the scope of his or her employment will not be personally liable for his or her actions or omissions. In addition, he

or she will be entitled to a legal defense from a city or town attorney or the Attorney General if the employee is a state employee.

The Massachusetts Tort Claims Act protects municipal employers and employees from claims that are based on the "performance or failure to perform a discretionary function . . . whether or not the discretion involved is abused." (G.L. ch. 258, §10). The government actor must have been acting within the scope of his or her employment. The purpose of this exemption from liability is to avoid allowing civil claims to be "used as a monkey wrench" in the machinery of government decision making." *Cady v. Plymouth-Carver Regional School District (1983).*

In determining whether an act is discretionary for the purpose of the statute, the Court will determine whether the government actor has any discretion at all, and whether it is the type of discretion that is protected, to wit, a high degree of discretion and judgment involved in weighing alternatives and making choices with respect to public policy and planning.

A city's exercise of its discretion in deciding not to incur the cost of erecting a fence on stairs near a children's playground, or to remove snow from the stairs, was based on a determination of allocation of limited resources, which was an integral part of its governmental policy making or planning function. Therefore, the tort action for the wrongful death of child when the child sledded down the snowy stairs into traffic and was killed was barred, *even if the city's decision was ill advised or unreasonable. Barnett v. City of Lynn (2001).*

In contrast, a claim that the public employee's negligent supervision of a truck driver's operation of a salt truck "does not appear to have a 'close nexus to policy making or planning.'" *(Ku v. Town of Framingham (2004).*

Chapter 258, Section 10(f) also protects government actors from ". . . failing to inspect, or inadequately or negligently inspecting real or personal property to determine whether the property complies with or violates any 'law, regulation, ordinance or code, or contains a hazard to health or safety. . . '" This statute is cited frequently by municipal attorneys. In fact, at a recent Board of Selectmen's meeting where members of a Board of Health and its health agent were questioned for closing a restaurant for violations of the state sanitary code, a selectman, reading from a letter from town counsel stated that "a town does not incur liability when it fails to inspect or enforce the sanitary code."

While this is the case, MAHB would argue that the opposite is also true. Cities and towns incur no liability from inspecting and enforcing laws as well, even if the inspections are "inadequate" or "negligently conducted." This statute should not be utilized to thwart Board of Health authority and obligation to protect public health. Rather it should be utilized to offer Boards of Health protection from liability in conducting inspections and enforcing state and local laws.

Finally, G.L. ch. 258, §13, in the extremely unlikely event of a successful claim, allows cities and towns to indemnify municipal officer, elected or appointed from any personal financial loss and expense, including legal fees, in an amount not to exceed $1 million.

Contractual Provisions

In addition to the Massachusetts Tort Claims Act, contracts themselves can provide protection from liability. Liability provisions can be written into contracts. For example, contacts between a Visiting Nurses Association or a home health agency and a city or town board of health can provide liability provisions. The language might read as follows: "The Agency and the Town shall each maintain professional malpractice and general liability insurance for itself and its employees." The contract might specify that the Agency is NOT an agent of the Town. The contract might also specify that the Town agrees to indemnify the Agency against claims caused by the negligence of the Town; and the Agency agrees to indemnify the Town for claims caused by the negligence of its employees.

Immunity of Physician or Nurse

G.L. ch. 112, §12C provides that "no physician or nurse administrating immunization or other protective programs under public health

programs shall be liable in a civil suit for damages as a result of any act or omission on his part in carrying out his duties." This covers both paid and unpaid doctors and nurses. It is not limited to emergency situations; however it would apply to emergency dispensing sites.

Good Samaritan Laws

G.L. ch. 112, §12B protects doctors, nurses and physician assistants who give **emergency care or treatment** from liability for negligence. The care must be given in good faith and as a volunteer, without a fee. It protects from liability for damages as a result of negligent acts or omissions and from liability for hospital expenses for negligently ordering or negligently causing hospitalization. §12BB of this same statute extends essentially the protection to respiratory therapists; and §12V extends it to individuals trained in CPR, AEDs or basic cardiac life support.

§12F protects doctors, dentists, and hospitals from liability for failure to obtain consent from a parent of a child, or spouse of a patient when delay would endanger the life, limb, or mental well-being of the patient. This protection covers emergency room treatment, as well as blood transfusions.

§12V ½ protects individuals trained in CPR and AED from liability for negligence in connection with rendering emergency CPR or AED through a public access defibrillation program, whether or not the individual is paid. Finally, G.L. ch. 111C, §21 protects certified, accredited or approved EMS personnel who "in the performance of their duties" render first aid, CPR, transportation of other EMS services.

Federal Volunteer Protection Act

The federal law provides immunity from liability for negligence for volunteers serving nonprofit agencies or governmental agencies under the following circumstances: the volunteer must have been acting within the scope of his or her responsibilities in the organization; the volunteer must have been properly licensed; the harm was not caused by willful, criminal or reckless misconduct or gross negligence; and the harm must not have been caused by the volunteer operating a motor vehicle, vessel or aircraft.

Liability protections for Massachusetts employees and volunteers are numerous. Legislation is currently pending in the Commonwealth that would extend these protections even further. If a public employee or employer is acting in good faith or performing a discretionary function, that government actor will be protected from liability.

Conclusion

Liability protections for Massachusetts employees and volunteers are numerous. Legislation is currently pending in the Commonwealth that would extend these protections even further. If a public employee or employer is acting in good faith or performing a discretionary function, that government actor will be protected from liability.

State and federal "Good Samaritan" laws provide additional protection for government actors, including physicians, nurses and others in the medical field. Fear of liability need not prevent good public health practices in Massachusetts.

This article is based on information presented by Priscilla Fox, MDPH and Cheryl Sbarra, MAHB in a recent training on Liability Protections. It is provided for educational purposes only and is not to be construed as legal advice.

2005 Certification Program

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Assisting Massachusetts Boards of Health
Through Training, Technical Advice and Representation

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- Brainstorming Staffing Issues

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November 12th - Holiday Inn Taunton off Rt. 495 Exit 9
December 3rd – Sheraton Framingham - 1657 Worcester Road (Rt. 9) From Massachusetts Turnpike – exit 12 bear left after toll. Sheraton Framingham is immediately on the right.

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