



CATTARAUGUS COUNTY BOARD OF HEALTH

1 Leo Moss Drive, Olean, NY 14760, Tel. (716)373-8050, Fax (716) 701-3737



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

Established 1923

David L. Smith, President

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Joseph Bohan, MD

Zahid Chohan, MD

Thomas Spigel, MD

Kathryn Cooney Thrush, NP, MSN

Shane Pancio

Theresa Raftis

Legislator Ginger D. Schroder, Esq.

MINUTES

June 3, 2026

The 943rd meeting of the Cattaraugus County Board of Health (BOH) was held at the Old Library Restaurant on June 3, 2026.

The following members were present:

Kelly Andreano, Legislator

Dr. Joseph Bohan

Kathryn Cooney-Thrush, NP, MSN

Also present were:

Kevin D. Watkins, MD, MPH, Public Health Director

Erin Whitcomb, County Attorney

Bob Clark, Olean Times Herald

Richard Helmich, Legislator (Virtual)

Ray Jordan, Senior Public Health Sanitarian (Virtual)

Debra Lacher, Secretary to the Public Health Director

James Lawrence, Emergency Preparedness Director

Rick Miller, Olean Star

Lynne Moore, Director of Nursing

Dave Porter, Hearing Officer

Robert Ring, Environmental Health Director

Gilbert Witte, MD, Medical Director

Theresa Raftis

David Smith

Dr. Thomas Spigel

President Smith called the meeting of the BOH to order and welcomed attendees. A roll call was conducted, confirming that a quorum was present.

President Smith called for a motion to approve the May 5, 2026 BOH meeting minutes. A motion was made by Dr. Spigel, seconded by Ms. Raftis and unanimously approved.

DIRECTOR'S REPORT: Dr. Watkins reported that the New York State Department of Health (NYSDOH) has recently issued several public health advisories regarding two communicable diseases. Although these diseases have resulted in very few cases within the United States, recent outbreaks in other parts of the world have increased the potential for their introduction into the country. One of the communicable diseases is called Hantavirus. Hantaviruses belong to the order Bunyavirales and possess a tri-segmented, negative-sense RNA genome.



These viruses encode five viral proteins and replicate within the cytoplasm of infected cells. Hantavirus is a zoonotic viral disease primarily transmitted to humans through exposure to infected rodents, particularly the deer mouse, which is the principal carrier in North and Central America. Infected rodents shed the virus in their urine, feces, and saliva.

Transmission most commonly occurs when rodent urine, droppings, or saliva are disturbed, causing virus-containing particles to become airborne and inhaled. The greatest risk for infection is associated with entering enclosed or poorly ventilated buildings, such as homes, sheds, barns, or cabins, where rodent activity is present or has occurred. Dr. Watkins emphasized the importance of properly ventilating these areas and avoiding activities that may aerosolize contaminated rodent excreta before cleaning. Although inhalation of aerosolized rodent excretions is the primary route of transmission, infection may also occur through contact with contaminated food or, less commonly, through rodent bites or scratches.

While hantaviruses are generally not transmitted from person to person, the Andes virus (ANDV) is a notable exception, as it is the only hantavirus species known to be capable of limited human-to-human transmission which has been documented, primarily in Argentina and Chile, among individuals with close, prolonged contact. Such exposures may include household contact, intimate contact, caregiving without appropriate personal protective equipment, or extended exposure in crowded or poorly ventilated environments. Dr. Watkins reported that the rodent species known to carry the Andes virus (ANDV), the long-tailed pygmy rice rat, is not found in the United States.

Symptoms of hantavirus infection generally develop between (9 to 33) days after exposure, although illness has been reported as early as (7) days and as late as (56) days following infection. The reported incubation period for the Andes virus ranges from (4 to 42) days after exposure. Early symptoms are nonspecific and commonly include fever, fatigue, muscle aches, headache, nausea, vomiting, diarrhea, and dizziness.

The two most common disease associated with hantavirus infections are: Hantavirus Pulmonary Syndrome (HPS), and Hemorrhagic Fever with Renal Syndrome (HFRS). The HPS, which is found in North and South America, is a severe and potentially fatal respiratory disease. There is a viral deposit in the alveoli or terminal bronchioles which causes a fluid buildup, causing the patient to be short of breath and excessive coughing. The virus causes blood vessels to weaken and leak. In contrast, hantavirus found in Europe and Asia are known to cause HFRS which initially presents as a flu-like illness with fever and can progress to acute kidney injury, severe thrombocytopenia, anemia, and coagulation abnormalities. The febrile phase typically lasts three to seven days and is characterized by fever, flushing of the face, neck, and chest, subconjunctival hemorrhage, and bradycardia, with acute kidney injury often developing toward the end of this stage.

Dr. Watkins reported that there is currently no specific cure or vaccine for hantavirus disease. Early recognition and prompt supportive medical care are critical and can significantly improve patient outcomes. Treatment is primarily supportive and may include oxygen therapy, intravenous fluid management, medications to maintain blood pressure, mechanical ventilation for respiratory failure, dialysis for kidney failure, and, in severe cases, extracorporeal membrane oxygenation (ECMO). Diagnosis is based on a combination of clinical findings, exposure history, and laboratory testing. Blood tests can detect antibodies produced in response to hantavirus infection using enzyme-linked immunosorbent assay (ELISA), with positive results confirmed by immunoblot testing.

Dr. Watkins shared a report that occurred in April 2026, that described an outbreak of Andes virus (ANDV) infection, which was identified aboard the expedition cruise ship MV Hondius. The vessel departed Ushuaia, Argentina, on April 1st with (114) passengers and (61) crew members on an Antarctic sightseeing expedition that included visits to several remote islands. The first fatality occurred on April 11th, when a 70-year-old Dutch passenger died aboard the ship.

His body was removed in Saint Helena on April 24th, where (30) passengers, including his wife, disembarked. His wife died two days later in a hospital in Johannesburg, South Africa. On April 27th, a British passenger on the ship was medically evacuated to Johannesburg in critical but stable condition, and on May 2nd, a German passenger died aboard the vessel. On May 6th the South Africa's National Institute for Communicable Diseases confirmed that the British patient had hantavirus infection and sequencing had identified the Andes strain (ANDV) in both the British and the Dutch woman who died in Johannesburg.

As the outbreak investigation expanded, passengers disembarked in Tenerife, Canary Islands, on May 10th and were repatriated to six European countries and Canada under public health monitoring. Among those evacuated was Dr. Stephen Kornfeld of Bend, Oregon, who, along with (15) other Americans, was transported to the University of Nebraska Medical Center. Because an initial nasal swab produced inconclusive results, Dr. Kornfeld was temporarily admitted to the hospital's specialized biocontainment unit before later rejoining the remaining U.S. travelers in the National Quarantine Unit for observation.

The MV Hondius arrived in Rotterdam on May 18th, where all remaining passengers and crew were retested before they disembarked. Twenty-three crew members from four countries entered quarantine, the body of a deceased passenger was removed for cremation, and the vessel underwent extensive disinfection before returning to service. As of May 29th, three New York State residents who had been passengers aboard the ship had completed evaluation in Nebraska. Two returned to New York, while one remained to complete the recommended (42-day) monitoring period, which concluded on June 22nd.

Local County Health Departments will follow those (2) individuals until their quarantine ends. It is speculated that the initial deceased patient and his wife were likely exposed to the infection in Argentina before boarding the cruise ship, while bird watching.

Dr. Bohan noted that Pennsylvania experienced cases of hantavirus exposure several years ago that were associated with hunting camps. Dr. Witte added that the wife of actor Gene Hackman reportedly died following a hantavirus infection. Dr. Watkins clarified that, to date, no cases of infection with the Andes virus have been confirmed in the United States in connection with the recent cruise ship exposure. Therefore, there is currently no immediate risk to the general public related to that event.

The second communicable disease that NYSDOH issued several public health updates on was Ebola. Dr. Watkins provided the Board with an overview of Ebola virus disease. He explained that Ebola viruses belong to the order Mononegavirales and the genus Orthoebolavirus. These are enveloped, non-segmented, negative-sense RNA viruses. The name "Ebola" originates from the Ebola River in the Democratic Republic of the Congo, where the virus was first identified. Recognized Ebola virus species include Zaire ebolavirus (EBOV), Sudan ebolavirus (SUDV), Bundibugyo ebolavirus (BDBV), Taï Forest ebolavirus (TAFV), Reston ebolavirus (RESTV), and Bombali ebolavirus (BOMV).

Dr. Watkins explained that fruit bats are believed to be the primary natural reservoir of the virus. Animal-to-human transmission can occur through direct contact with infected fruit bats, non-human primates, or while handling bushmeat. Bushmeat commonly includes wild animals such as primates (monkeys and apes), bats, rodents, and, in some regions, small birds and reptiles.

He further noted that human-to-human transmission occurs through direct contact with the bodily fluids of an infected person, including blood, vomit, diarrhea, saliva, sweat, urine, semen, and breast milk. The incubation period ranges from (2 to 21) days, with an average of (8 to 10) days. Early symptoms typically include fever, severe headache, muscle pain, fatigue, and sore throat. As the disease progresses, patients may develop vomiting, diarrhea, abdominal pain, and rash. Severe illness can result in internal and external bleeding, multi-organ failure, and shock.

Laboratory diagnostic methods, including reverse transcriptase polymerase chain reaction (RT-PCR), antigen detection testing, viral isolation, and serologic testing for IgM and IgG antibodies.

Dr. Watkins reviewed current treatment and prevention strategies for Ebola virus disease. He explained that treatment is primarily supportive and includes aggressive fluid replacement, correction of electrolyte imbalances, oxygen therapy, blood pressure support, organ support as needed, and treatment of secondary infections. For infections caused by the Zaire ebolavirus species, approved neutralizing monoclonal antibody therapies, including mAb114 and REGN-EB3, have demonstrated improved patient outcomes. He also noted that a licensed vaccine, the recombinant vesicular stomatitis virus-Zaire Ebola virus vaccine (rVSV-ZEBOV), also known as the "Ebola Zaire" live vaccine, is available to help prevent disease caused by the Zaire ebolavirus species.

He emphasized that the critical public health measures used to control Ebola outbreaks, included the appropriate use of personal protective equipment (PPE), strict infection prevention and control (IPC) practices, prompt isolation of infected individuals, early case identification, comprehensive contact tracing, and the implementation of safe and dignified burial practices.

Dr. Watkins provided an update on the current Ebola outbreak occurring in the Democratic Republic of the Congo (DRC) and Uganda. He reported that this event represents the (17th) documented Ebola outbreak in the DRC. On May 15, 2026, health authorities confirmed the outbreak was caused by Bundibugyo virus disease (BVD), a species of Ebola virus first identified in the Bundibugyo District of Uganda, from which it derives its name.

Affected areas include Ituri Province, North Kivu, and South Kivu in the DRC, as well as neighboring Uganda. Dr. Watkins noted that, in the DRC, the majority of reported cases have occurred among individuals between (20 and 39) years of age, with approximately two-thirds of cases reported among female patients.

As of June 2, 2026, the DRC had reported (344) confirmed cases, (116) suspected cases, and (60) confirmed deaths. During the same period, Uganda reported (15) confirmed cases, one suspected case, one confirmed death, and one suspected death.

Dr. Watkins stated that previous Bundibugyo virus disease outbreaks in 2007 and 2012 had case fatality rates ranging from approximately (30%) to (50%). He further noted that there is currently no licensed vaccine available for the prevention of Bundibugyo virus disease.

Dr. Watkins reported that a U.S. physician providing care to an Ebola patient in the Democratic Republic of the Congo contracted Bundibugyo virus disease (BVD). The physician tested positive on May 17, 2026, after developing severe symptoms that left him barely able to stand without assistance. He was medically evacuated from Uganda to Charité University Hospital in Berlin, Germany, where he received specialized treatment in a high-containment isolation unit.

Dr. Watkins also informed the Board that, as part of enhanced surveillance efforts, U.S. citizens returning from the Democratic Republic of the Congo, South Sudan, and Uganda are being routed through designated U.S. airports for public health screening. These airports include Washington Dulles International Airport, Hartsfield-Jackson Atlanta International Airport, George Bush Intercontinental Airport in Houston, and John F. Kennedy International Airport in New York.

In summary, Dr. Watkins noted that the substantial number of reported cases, combined with delays in implementing public health interventions and the absence of a licensed vaccine for Bundibugyo virus disease, suggests that the outbreak may continue for several months. He emphasized that healthcare workers remain at particularly high-risk during Ebola outbreaks and that early case identification, prompt isolation, and aggressive supportive care are critical to improving patient outcomes. He further stated that effective public health responses should prioritize rapid contact tracing, active monitoring of exposed individuals, and timely isolation of suspected cases. Finally, Dr. Watkins emphasized that continued international collaboration remains essential to limiting the global spread of the disease and recommended that local agencies review and update their emergency preparedness and infectious disease response plans.

Dr. Witte shared that in 2014 there were a number of Ebola cases in the US.

Dr. Watkins followed up on the Board's discussion from the previous meeting regarding the potential adoption of a local law establishing a vape product registry. He informed the Board that legislation has been introduced at the state level in the form of Senate Bill S902 and Assembly Bill A4593, which would establish a comprehensive statewide regulatory framework for vapor products.

Dr. Watkins explained that the proposed legislation would create a New York State Vapor Product Directory identifying products that may be legally sold within the state. The bill would also require vapor product manufacturers and distributors to obtain state permits, prohibit the sale of illicit vapor products, restrict retail sales to products listed in the state directory, and strengthen enforcement actions against unauthorized products. He noted that the legislation is currently under consideration by the Senate and Assembly Health Committees.

Dr. Watkins stated that after consulting with the county attorney, he would like to propose that the Board maybe consider postponing any local legislative action until the status of the proposed state legislation is determined. Following discussion, the Board agreed that it would be prudent to wait for further action on the state legislation before pursuing a local vape registry law and will continue to monitor the bill's progress.

NURSING DIVISION REPORT: Mrs. Moore reported that the current Certified Home Health Agency (CHHA) census stands at (88) patients.

During the month of May, a total of (109) blood lead tests were conducted. One child was identified with an elevated venous blood lead level (BLL) of 22.8 µg/dL (reference level: <5 µg/dL). Department staff made initial contact with the family, who were in the process of relocating, and confirmed their new address to ensure appropriate follow-up. The next highest BLL recorded was 21.0 µg/dL; a home environmental assessment had not yet been completed at the time of the report.

Three additional children had elevated BLLs of 18.9, 18.0, and 16.6 µg/dL, respectively, all of which represented improvements from their previous test results. Two additional children had BLLs of 14.0 and 11.0 µg/dL. Nine children recorded BLLs between 5.0 and 8.5 µg/dL, while the remaining (92) children tested had blood lead levels at or below 5.0 µg/dL. The department's active Childhood Lead Poisoning Prevention Program caseload currently includes (53) children.

Mrs. Moore reported that renovations at the Salamanca clinic on Iroquois Drive continue to progress and that staff are hopeful the clinic will be completed soon in order for them to return to the site.

During May, the department performed six HIV tests, including four in Olean and two in Salamanca. No HIV testing was conducted in Machias during the month. All test results were negative.

Rabies Prophylaxis: Mrs. Moore also provided an update on rabies prophylaxis activities. No pre-exposure rabies vaccinations were administered during May. Seven individuals completed post-exposure rabies prophylaxis, including one individual following a cat bite, two individuals following separate bat exposures, and a family of four who had their initial vaccines in another county but were visiting Allegany State Park and needed their next dose of a rabies post-exposure prophylaxis (PEP) series while here on vacation.

Reportable Diseases for May included: Chlamydia: (9) cases; Gonorrhea: (1) case; Syphilis: (3) cases; Campylobacteriosis (1) case not confirmed at this time; Lyme: (25) probable cases; Hepatitis C: (3) Chronic cases; Anaplasmosis: (8) suspected cases; Influenza A: zero cases; Influenza B: (6) cases; COVID-19: (14) cases; RSV: (3) cases; Candida Auris: (1) case; Ehrlichiosis: (1) case; E. Coli Shiga: (1) case; and Salmonellosis: (2) cases (1) source unknown, and (1) potentially undercooked meat.

During the discussion of the Childhood Lead Poisoning Prevention Program report, Dr. Bohan noted that the number of elevated blood lead level (EBLL) cases appeared to be high and asked how Cattaraugus County compares to other counties.

Dr. Watkins responded that Cattaraugus County's experience is consistent with that of many rural counties across New York State. He explained that the prevalence of older housing stock, particularly homes built before 1978 when lead-based paint was commonly used, contributes to higher rates of childhood lead exposure throughout rural communities.

Dr. Spiegel asked at what blood lead level is treatment provided for affected children. Mrs. Moore explained that the primary intervention focuses on identifying and eliminating the source of lead exposure.

Environmental Health staff conduct home investigations for children with elevated blood-lead levels to identify environmental hazards. Once the source of exposure is removed, blood lead levels typically begin to decline. Parents and caregivers also receive education on proper cleaning techniques, reducing household dust, hand hygiene, and other measures to minimize ongoing exposure.

Dr. Watkins added that New York State currently requires public health follow-up for children with blood lead levels of 5 µg/dL or greater, a threshold that has been lowered over time from the previous level of 15 µg/dL.

He noted that the Centers for Disease Control and Prevention (CDC) uses a blood lead reference value of 3.5 µg/dL as a threshold to identify children needing education and environmental investigations. He emphasized that there is no safe level of lead exposure for children because even low levels of lead can adversely affect brain development, learning, behavior, and other developing organ systems. Chelation therapy is generally considered for children with blood lead levels of approximately 35–45 µg/dL or higher, depending on the child's clinical presentation, symptoms, and the treating provider's medical assessment.

ENVIRONMENTAL HEALTH REPORT: Mr. Ring reported that bat activity has increased during this time of year, resulting in a higher volume of calls regarding potential bat exposures. He noted that New York State is conducting a public awareness campaign on rabies prevention, including billboards displayed along Interstate 86. While only an estimated (1–2%) of bats carry rabies, any potential exposure should be taken seriously and reported to the Health Department for evaluation.

Mr. Ring also provided an update on the federal oral rabies vaccination program administered by the United States Department of Agriculture (USDA). As part of this initiative, aircraft distribute oral rabies vaccine baits wrapped in a sweet-scented coating designed to attract raccoons and skunks, helping to reduce the spread of rabies among wildlife populations.

The mosquito control program is also underway. Larvicide applications are planned for wetland areas in the southern portion of the county, where mosquito breeding is most prevalent. President Smith asked about the anticipated treatment date for the Allegany River area. Mr. Ring responded that the schedule is weather dependent. Dr. Watkins added that treatment was expected to occur as early as the end of the following week, but no later than June 24th.

Mr. Ring also updated the Board on the Lead Hazard Reduction Program. One lead hazard control project, totaling approximately (\$50,000), is scheduled to begin and will include the replacement of doors, windows, and other friction surfaces containing lead-based paint. These improvements provide a long-term solution to reduce lead exposure risks for young children. Two additional homes are ready to go out for bid, and seven households have been determined eligible for assistance. All projects are expected to be completed by the end of October.

Finally, Mr. Ring reported that the Community Development Block Grant (CDBG) program is scheduled to conclude in November. Funding remains available for an additional two to three projects. To date, approximately (25) households have benefited from assistance through the current grant cycle.

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Old/New Business: President Smith stated there is no old or new business. There is no BOH meeting in July, the next BOH meeting will be held on Wednesday, August 5, 2026. Dr. Watkins has indicated that he would like to get a Board of Health picture at the next meeting.

A motion to adjourn was made by Dr. Bohan, seconded by Ms. Raftis, and unanimously approved.

Respectfully submitted,

A handwritten signature in blue ink that reads "Kevin D. Watkins, M.D." The signature is written in a cursive, flowing style.

Kevin D. Watkins, M.D., M.P.H.

Secretary to the Board of Health