



## update

Winter

2004

## Contents

- President's Message
- PHIN Conference
- Public Health Law Program
- New Member Reception at the CSTE Annual Conference
- WREN Conference
- IT Corner
- 2004 CSTE Annual Conference
- Director's Message
- Infectious Disease Update
- CSTE Fellows
- Read and Win
- CSTE Members Present at APHA Meeting
- Staff Directory
- CSTE Staff Update
- Executive Committee
- Occupational and Environmental Health Update

## Calling all Members

We would appreciate your feedback about the newsletter. Please e-mail Shundra Clinton with comments, ideas or suggestions; [sclinton@cste.org](mailto:sclinton@cste.org).

## PRESIDENT'S MESSAGE

**M**y first Executive Committee meeting as president of CSTE (the first time around) began on the morning of Sept. 11, 2001. In the two and a half years since then, the roles of epidemiology and public health in this country have changed rapidly and dramatically.

In epidemiology, we have responded by working together, sharing information and supporting each other even more so than in the past. Those of us who were at that Sept. 11 meeting formed a bond that helped us through the turbulent days that followed. For me, being part of CSTE has helped me keep a balanced perspective during these stressful times.

So it was with great sadness that I learned of the departure from state public health service of one of CSTE's most dedicated members and leaders, Gianfranco Pezzino, who has played a vital role in leading our organization through recent difficult times. Gianfranco was the State Epidemiologist in Kansas and was serving us well as vice president of CSTE. In that role, he was scheduled to leave the Executive Committee at the upcoming annual meeting.

As Gianfranco moves into his new role as director of Public Health Studies for the Kansas Health Institute, we will be missing more than a vice president. Gianfranco was always willing to step forward in any way he could – by serving on committees, helping workgroups and more – to help CSTE serve our members well and promote the development of our organization.

Personally, I will miss his day-to-day leadership and involvement in our organization. Congratulations on the new challenge you are undertaking, Gianfranco. We wish you all the best!

CSTE members continue to provide leadership and energy to our organization. The current Executive Committee members are doing an excellent job, and many of them will serve for several more years. At the conclusion of this year's annual meeting in June, I will become vice president of our organization, with one year left to serve on the Executive Committee. My challenge then will be to continue finding ways to stay engaged and provide leadership as a past president.

My challenge to you is to take a good, long look at the positions that are opening on CSTE's Executive Committee. We will hold elections at the annual conference in June. Part of our focus this year has been to continue developing the role of CSTE as a professional development tool. Serving as a committee member is a fantastic way to take advantage of that opportunity.

There are other ongoing needs in CSTE as well. Our committees and workgroups are always looking for new volunteers, and there are a variety of ways you can become more active as a CSTE member.

Your participation helps us improve CSTE. Thanks for everything all of you do already to make CSTE the thriving organization it is today. I look forward to working together as we continue to evolve and grow.

Matthew Cartter, M.D., M.P.H.  
CSTE President

## PHIN Conference

The second annual Public Health Information Network (PHIN) Conference will be held May 24-27, 2004 in Atlanta, Ga. The Conference will cover a wide range of PHIN-related issues including surveillance, alerting and communications, laboratory and clinical data management in both public and private sectors, and epidemiologic case investigation and management.

For more information, go to [www.cdc.gov/phn](http://www.cdc.gov/phn).



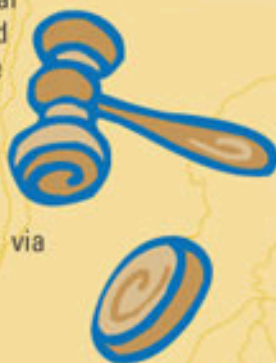


# PUBLIC HEALTH LAW PROGRAM

In this day and age, public health epidemiologists are confronted with issues such as mandatory disease/condition reporting, quarantine and isolation, and privacy laws to name a few, and all affect how we conduct surveillance. The CDC's Public Health Law Program (PHLP) offers a wide variety of features to assist public health epidemiologists with these issues. It is a resource for all who are interested in strengthening public health practice through better understanding and use of public health law.

The PHLP Web site offers a list of general legal materials from U.S. jurisdictions and other related legal material on emerging diseases and conditions (e.g., SARS, West Nile Virus, obesity, etc.). It also archives its collection of daily updates on legal activities in local, state, federal and international arenas. Users can join the listserv to receive daily updates via email on the PHLP Web site.

To access the PHLP Web site, go to [www.phppo.cdc.gov/od/phlp](http://www.phppo.cdc.gov/od/phlp).



## New Member Reception at CSTE Annual Conference



All new members, first-time attendees or those still feeling "new" are invited to attend the New Member Reception during the CSTE Annual Conference on Sunday, June 6 from 5:30 to 7 p.m. at the Grove Hotel. Learn more about CSTE and how to get involved in the organization. Meet "Welcome" committee members, current Executive Committee members and candidates for this year's elections.

The reception is informal and will include ice cream sundaes and smoothies.

## WREN Conference

The 22nd annual conference of the Western Regional Epidemiology Network (WREN) will be held May 13 through May 15, 2004 in Ashland, Ore. The conference will be hosted this year by the Environmental Health Investigations Branch of the California Department of Health Services.

WREN is made up of Western state and local health department staff members who are on the "front lines" of environmental health, toxicology and epidemiology. The annual conference serves as a forum to share experiences, present findings, and discuss work.

The presentations at the WREN conference are less formal than at most scientific or technical meetings, which can provide a greater opportunity to exchange ideas with your counterparts in other agencies.

## IT Corner

Notice any differences in your CSTE web experience? CSTE is constantly striving to improve the overall presentation and functionality of our Web site, and input from our members has led to several recent upgrades.

Our new Annual Conference pages and a new e-mail format have been directly influenced by your input. We have streamlined your e-commerce process so now you can renew your membership and register for the 2004 Annual Conference in Boise, Idaho all within the same transaction.

Many more changes are on the horizon! Stay tuned....

# 2004 CSTE Annual conference

*Balancing Tradition with the "New Normal" in Epidemiology.*

The 2004 CSTE Annual Conference will be held June 6-10 in Boise, Idaho. This year's theme, *Balancing Tradition with the "New Normal" in Epidemiology*, will encourage continued discussion of the rapidly changing roles and responsibilities in epidemiology.

Join us for Plenary Sessions, Breakout Sessions, a Pre-Conference Workshop, Roundtable Discussions, Position Statements and many exhibitors. For a complete overview of the conference, please visit [www.cste.org/annualconference/index.htm](http://www.cste.org/annualconference/index.htm).

Don't forget — you can take advantage of early registration 0263 and Member Discounts!

Go to [www.cste.org/annualconference/04boise/registration.asp](http://www.cste.org/annualconference/04boise/registration.asp) to register for the conference online.





# DIRECTOR'S MESSAGE

## GREETINGS!

CSTE hosted a rather unusual meeting ("Workforce Summit") this past January – unusual in the sense of the participant list. We all have recognized the wealth of talent, skill and experience among CSTE members. The challenge has been how to tap into this resource when people are incredibly busy and oversubscribed as key public health figures in their states.

CSTE invited a group of about 30 epidemiologists as a "council" to focus on workforce issues affecting the practice of epidemiology in state and local public health agencies. This select group of epidemiology leaders included the elected members of the CSTE Executive Committee, who represent over 650 current CSTE members. Also included were a second group of CSTE leaders who have been trying to reengage in CSTE activities – former Presidents of CSTE. The idea was to try to work through some of the most pressing issues facing the practice of public health epidemiology, seek solutions, identify leadership organizations for the issues and solutions, and identify CSTE's role for each.

For a little over a day and a half, this "Epidemiologic Loya Jirga" met with colleagues from CDC, APHA, ASTHO and ASPH and a facilitator to discuss key issues facing public health epidemiology. These included:

- Identifying the unique barriers to entry into public health epidemiology, retention and recruiting
- The need to establish public health competencies for epidemiologists, as well as to train and to certify these competencies
- The need to develop leadership at all levels of the practice of public health epidemiology
- How to fund workforce development to help expand and strengthen epidemiology capacity at state and local health departments
- The urgent need to establish "baseline capacity" to meet essential services for epidemiology
- Filling the pipeline and addressing the human resource gap needed to reinvigorate the practice of public health epidemiology

Each group used the following framework in their discussion of the issues described above:

- What are potential solutions that address this problem?
- Which organizations should be responsible for taking the

national lead in addressing these issues as well identifying potential partners and how should these partners be engaged?

- What is the role of CSTE?
- How do these objectives fit with other public health workforce initiatives?
- How do these issues relate to the other workforce issues identified by the workgroup?

We are working hard at the CSTE National Office to complete a draft strategy using the input of this group. We hope to have a draft "Workforce Summit Summary" finalized for distribution to the CSTE membership by the CSTE Annual Conference in June.

Most of us took a pledge not to say the overused phrase "low hanging fruit" ever again, but it does seem appropriate in sharing some of what you will eventually see in the final report. I hope we have some progress to report soon for the following items that will require CSTE action:

- CSTE and CDC taking the lead as co-conveners to establish public health epidemiology competencies
- Develop an application for advanced leadership training to the National Public Health Leadership Institute and UNC for a team of state epidemiologists
- Establish baseline epidemiology capacity measurements for states and measure that capacity at regular intervals
- Begin to address the "pipeline" issues regarding epidemiologists including expansion of the CDC/CSTE training fellowship program, collaboration with ASPH on placement programs, exploring alternative degree programs and credentialing requirements, and incentives for HDs to provide mentorship and training

If you have expertise and/or interest in any of these workforce issues, let me know by e-mail and someone will contact you about possibilities for participating in the further development of these areas of interest.

Best regards and see you at the CSTE Annual Conference.

Patrick McConnon



## INFECTIOUS DISEASE UPDATE

### HEPATITIS

CSTE is pleased to announce that we have selected six new states to receive funds for the development of written hepatitis program plans. The purpose of this program is to build and bolster hepatitis program planning in state public health agencies.

The selected states are Georgia, Illinois, Iowa, Nevada, Oregon and Utah. These states will join the eight other states that previously have been funded for the development of written hepatitis plans.

### POLICY NEWS

**SARS: Embargo on Importation of Civets to the United States**

Recently published scientific articles have been documenting isolation of a Severe Acute Respiratory Syndrome (SARS) – like

virus from civets, indicating a possible link to SARS transmission in China. To prevent the importation and spread of the virus, the Centers for Disease Control and Prevention (CDC) released an order "banning the importation of all civets immediately and until further notice."

The embargo of the mongoose-like animal applies to dead and live civets, as well as civet products. However, the ban does not apply to those persons who receive permission from the CDC to import the animal or its products for educational or scientific purposes.

For additional information regarding Questions and Answers on the CDC order, visit [www.cdc.gov/ncidod/sars/civetembargo.htm](http://www.cdc.gov/ncidod/sars/civetembargo.htm). To view the entire order, go to [www.cdc.gov/ncidod/sars/pdf/order\\_civet\\_ban\\_011304.pdf](http://www.cdc.gov/ncidod/sars/pdf/order_civet_ban_011304.pdf).



# CSTE FELLOWS: The Future of Applied Epidemiology

Orientation for the first class of the CDC/CSTE Applied Epidemiology Fellowship was held Jan. 12-16 in Atlanta. Ten fellows have been placed in state health departments with environmental health, infectious disease, maternal and child health, birth defects and developmental disabilities, and chronic disease programs (please see below for fellows' biographies and assignments).

During the orientation, speakers from CDC and state and local health departments discussed current topics in public health, as well as outbreak investigations, scientific writing, risk communication and public health law. Fellows toured CDC's new Director's Emergency Operations Center (DEOC) and a high containment laboratory. Fellows will convene again during CSTE's annual conference in June to present surveillance system evaluation projects.

Applications from host agencies and fellows for the class of 2004 were due March 15, and interviews for selected applicants will occur later this month. State health agencies were contacted in January to submit Letters of Intent and complete applications to host one or more fellows. Host agencies eligible to match with the next class of fellows were selected in March. Finalists for fellow positions will be selected in April and matched to a host agency in May. For more information on the application process, contact Angela Sylvester at [asylvester@cste.org](mailto:asylvester@cste.org).

## MEET THE FELLOWS:



**Tanya Bobo, MPH**  
**Place of Birth:** New York, NY  
**Highest Degree Obtained:** MPH, Infectious Diseases, University of California-Berkeley  
**Placement:** Virginia Department of Health  
**Subject Area:** Infectious Disease Epidemiology

**Primary Mentor:** Suzanne Jenkins, VMD, MPH

**Secondary Mentor:** Susan Davis, MD

**Future plans beyond the fellowship:** After completing this fellowship, I would like to work with governmental agencies to establish and execute programs that control infectious disease. I would also like to pursue a PhD, possibly in Epidemiology, to conduct research in Infectious Diseases.

**Why I chose the CSTE Fellowship:** I chose the CSTE fellowship because I wanted more experience in Infectious Diseases surveillance and Emergency Preparedness Planning. The CSTE fellowship provides one with the opportunity to work within the state and/or local levels of public health, and develop one's skills in applied epidemiology. The program also provides its participants with enough flexibility in the development of a project so that particular interests can be pursued and further explored.



**Barbara Frohnert, MPH**  
**Place of Birth:** Rochester, MN  
**Highest Degree Obtained:** MPH, Maternal and Child Health, University of Minnesota  
**Placement:** Minnesota Department of Health  
**Subject Area:** Birth Defects and

Developmental Disabilities Surveillance

**Primary Mentor:** John Oswald, PhD, MPH

**Secondary Mentor:** Myron Falken, PhD, MPH

**Future plans:** My plans for the immediate future primarily focus on developing a birth defects surveillance program for the state of Minnesota. Through this fellowship, I hope to draw on my compatible interests in informatics, public health journalism, and public policy while strengthening my epidemiological skills. In the more distant future, I plan to pursue a doctoral degree in epidemiology while continuing to work at a state health department. There are

many interesting opportunities for leadership in public health; I need a little more exposure before I set my sights on anything specific, but I plan to get the groundwork done so that I am prepared for any possibility.

**Why I chose the CSTE Fellowship:** The CSTE fellowship offered me an opportunity that was unique from other programs and fellowships I had seen. Most importantly, the CSTE fellowship focused specifically on applied epidemiology. I wanted to use the epidemiological concepts I had covered in my coursework so that I would truly understand how they functioned in real-life situations. By partnering with a state or local health department, I am able to experience a multitude of levels of surveillance and emergency preparedness and response. The CSTE fellowship's focus coincided with my needs perfectly and the mentor style structure was exactly what I was looking for. This is truly an ideal situation for all participants.



**Robbie Madera, MPH**  
**Place of Birth:** Southfield, MI  
**Highest Degree Obtained:** MPH, Hospital and Medical Epidemiology, University of Michigan  
**Placement:** Michigan Department of Community Health  
**Subject Area:** Infectious Disease Epidemiology

**Primary Mentor:** Mary Grace Stobierski, DVM, MPH

**Secondary Mentor:** Matthew Boulton, MD, MPH

**Future plans:** I hope to continue my work at a state or local public health department while pursuing a PhD in Epidemiology.

**Why I chose the CSTE Fellowship:** I believe the true and most thorough understanding of epidemiology is through public health practice. While my research in a pediatric infectious disease laboratory honed my investigative skills and my graduate public health program taught the basics of epidemiology, I felt an inadequacy in terms of my experience in applied epidemiology. Since I was interested in working in a public health department, the CSTE Fellowship was an excellent opportunity for a Master's level epidemiologist to gain quality experience in a public health department setting. I chose this fellowship because it was perfect meld of my interests, background and desire to further my

career goals. The expectations detailed in the CDC/CSTE Core Competencies demonstrated their dedication in training well qualified, public health department-oriented individuals. Both the mentor and fellow are responsible for living up to these standards. I admire the CSTE's motives to benefit health departments and epidemiologists and look toward the future of public health. I am excited to be at the Michigan Department of Community Health, Infectious Disease Section!



**TaTisha McCainey, MPH**  
**Place of Birth:** Tacoma, WA  
**Highest Degree Obtained:** MPH, Maternal and Child Health, University of Alabama-Birmingham  
**Placement:** Michigan Department of Community Health

**Subject Area:** Chronic Disease Epidemiology

**Primary Mentor:** Corrine Miller, PhD

**Secondary Mentor:** Matthew Boulton, MD, MPH

**Future plans:** After completing the program, I'd like to secure employment in a state or local health department as an epidemiologist working with racial health disparities and maternal and child health research areas. I also plan on returning to school to receive a doctoral degree.

**Why I chose the CSTE Fellowship:** I chose the CSTE/CDC Fellowship because of the wonderful opportunity that lies within this program. I'll be trained in the practical applications of concepts learned in graduate school and be exposed to advancements in the field. I also believe this program gives me the advantage of seeing how a state agency collectively functions to serve the local communities and the state as a whole.



**Kristen Malecki, PhD, MPH**  
**Place of Birth:** Milwaukee, WI  
**Highest Degrees Obtained:** MPH, Post Certified PhD candidate, Environmental Health Policy, Johns Hopkins University  
**Placement:** Wisconsin

Department of Health and Family Services

**Subject Area:** Environmental Health Epidemiology



**Primary Mentor:** Henry Anderson, MD  
**Secondary Mentor:** Lynda Knobeloch, PhD

**Future plans:** In the future I would like to continue my work in applied public health practice and research in either a federal or state government position, and ultimately combine this with a faculty position in an academic institution.

**Why I chose the CSTE Fellowship:** The CSTE fellowship is an excellent opportunity to gain skills and expertise regarding public health practice that cannot be obtained in the classroom. I am looking forward to applying the analytic tools and methodologies learned as part of my formal education to make real-life decisions that will make a difference in improving public health. In addition, I feel the CSTE fellowship will provide invaluable learning opportunities and insight into the public health practice field of applied epidemiology related to environmental health.



**Tierney Anne Murphy, MD, MPH**  
**Place of Birth:** Astoria, NY  
**Highest Degree Obtained:** MD, University of Massachusetts; MPH, Emory University  
**Placement:** New Mexico Department of Health  
**Subject Area:** Maternal

and Child Health Epidemiology  
**Primary Mentor:** Susan Nalder, EdD, MPH, CNM  
**Secondary Mentor:** Ssu Weng, MD, MPH

**Future plans:** After the fellowship, I plan to continue my work as a medical epidemiologist in a state or local health department, advocating for the health of the most vulnerable.

**Why I chose the CSTE Fellowship:** I chose the CSTE fellowship because of my desire to work at the local level in collaboration with other public health professionals and communities to improve the health of women and children. The fellowship provides a unique opportunity to work under the guidance of an experienced mentor to develop my epidemiology skills, to use my clinical background for health promotion and disease prevention in populations, and to apply evidence based knowledge to program planning and health policy.



**Michelle D. Payne, MPH**  
**Place of Birth:** Agana, Guam  
**Highest Degree Obtained:** MPH, Epidemiology, Texas A & M University  
**Placement:** North Carolina Department of Health and Human Services  
**Subject Area:**

Environmental Health Epidemiology  
**Primary Mentor:** Douglas Campbell, MD, MPH  
**Secondary Mentor:** Rick Langley, MD, MPH

**Future plans:** My future plans include continuing my education and becoming an epidemiologist at the state or federal level.

**Why I chose the CSTE Fellowship:** I chose the CSTE fellowship because it offered me the

chance to be active in the state public health system, allowing participation in many levels and areas of public health while receiving guidance from a mentor. The CSTE fellowship is a great starting point for epidemiologists interested in the application of their professional degree.



**Jamie Snow DVM, MPH**  
**Place of Birth:** Watertown, SD  
**Highest Degrees Obtained:** DVM, Iowa State University; MPH, University of Iowa  
**Placement:** Wyoming Department of Health  
**Subject Area:** Infectious Disease Epidemiology

**Primary Mentor:** Karl Musgrave, DVM, MPH  
**Secondary Mentor:** Scott Seys, MPH

**Future plans:** My future plans beyond this fellowship are to continue a career in public health and epidemiology. I will concentrate my efforts in infectious disease epidemiology. I would like to serve as a state public health veterinarian or work at a state health department in infectious disease epidemiology.

**Why I chose the CSTE Fellowship:** I chose this program because it provides on the job training with an opportunity to learn field epidemiology first hand. I also liked this program because it provides guidance from an experienced epidemiologist. Additionally, this program is unique in that it provides a vast range of opportunities so I am able to get a diverse background in public health.



**Nguyet Tran, MPH**  
**Place of Birth:** Saigon, Vietnam  
**Highest Degree Obtained:** MPH, Chronic Disease Epidemiology, Yale University  
**Placement:** Washington State Department of Health  
**Subject Area:** Chronic Disease Epidemiology

**Primary Mentor:** Juliet VanEenwyk, PhD  
**Secondary Mentor:** Amira El-Bastawissi, PhD

**Future plans:** My long-term goal is to become a respected public health professional, ideally working as an epidemiologist at the local or state level. I would like to continue to learn, to grow in a position of more responsibility and make a significant contribution to the practice of public health.

**Why I chose the CSTE Fellowship:** The CSTE fellowship allows for hands-on training in a competency based structure, but at the same time gives fellows the flexibility to work with multidisciplinary teams and explore various inter-related topic areas. Placement at the local or state level offers more of an opportunity to work on the front lines of public health where science research and practice comes together.



**Lee Anne Wallach, MD, MPH**  
**Place of Birth:** New York, NY  
**Highest Degrees Obtained:** MD, State University of New York; MPH, Harvard University  
**Placement:** Massachusetts Department of Health  
**Subject Area:** Environmental Health Epidemiology

**Primary Mentor:** Robert Knorr, PhD, MPH  
**Secondary Mentor:** Martha Steele, MPH

**Future plans:** Subsequent to the CDC/CSTE Applied Epidemiology Fellowship, I would like to work as an epidemiologist for the Commonwealth of Massachusetts, bringing medical and epidemiologic perspectives to a variety of public health issues. I hope that through my experience I will develop the knowledge and skills needed to be effective in a leadership role in some part of the public health system in Massachusetts.

**Why I chose the CSTE Fellowship:** I am a physician with a degree in public health, seeking practical experience and training in epidemiology. I am returning to the field after several years away raising children. The Center for Environmental Health at the Massachusetts Department of Public Health, the agency hosting my fellowship, is providing me the opportunity to train and work with experienced epidemiologists and environmental scientists on topics such as the development of a surveillance system for systemic lupus erythematosus, the ongoing surveillance of childhood asthma and amyotrophic lateral sclerosis/multiple sclerosis, investigation of identified clusters of disease, and investigations of indoor air pollution. The mentored practical experience and the well-defined expectations the CSTE fellowship offers are exactly what I am seeking to become up-to-date, proficient and productive in the field.

Don't Forget to  
**READ & WIN**

If you are a CSTE Membership Card holder, remember to look for your membership number as you read this issue. If you find your number, you win!

Contact Shundra Clinton at [scClinton@cste.org](mailto:scClinton@cste.org) to receive your prize.

Good luck!



# CSTE MEMBERS PRESENT AT APHA MEETING

CSTE members presented at the 131<sup>st</sup> APHA Annual Meeting and Exposition Nov. 15-19, 2003 in San Francisco. We have included a brief description of each presentation below for your information. Congratulations to all the presenters! And congratulations to CSTE member Bao-Ping Zhu, who received the APHA MCH Section's "Young Professional of the Year" award.

**Topic:** Addressing Environmental Risk Factors for Asthma in California Licensed Childcare Centers



**Purpose:** Surveys of site directors and staff

of licensed California childcare centers showed that environmental risk factors for asthma are common in centers and that asthma knowledge among staff is highly variable. The California Department of Health Services, Environmental Health Investigations Branch (EHIB), as part of the Childhood Asthma Initiative, addressed deficits regarding asthma policies and practices and staff asthma knowledge.

**Methods:** Stakeholders were convened to determine the best methods for improving practices and for dissemination of information, and to determine barriers to implementing environmental controls in childcare centers. Information from the two surveys and from stakeholders' contributions was used to develop policy and focused interventions.

**Results:** Based on the surveys and the reported childcare providers' needs, an educational and outreach program is being developed for childcare providers that addresses environmental risk factors for asthma. Fact sheets, newsletter articles, and educational websites were developed for distribution. Practice guidelines are being drafted; compliance will be voluntary. An asthma education program is being translated to video. Collaborating health consultants received education on environmental risk factors for asthma.

**Conclusions:** Survey findings and stakeholder needs were used to guide the development of policy and interventions aimed at reducing environmental risk factors for asthma in childcare settings. The surveys of site directors and staff should be re-administered to assess post-intervention asthma policies, practices, knowledge, attitudes and beliefs.

**Presenter:** Katherine Feldman, DVM, MPH  
Epidemiology Program Office, Centers for Disease Control and Prevention  
California Department of Health Services,  
Environmental Health Investigations Branch  
1611 Telegraph, Suite 1200  
Oakland, CA 94612  
Phone: (510) 625-7974  
e-mail: [kfeldman\\_ceip@mindspring.com](mailto:kfeldman_ceip@mindspring.com)

**Topic:** Catching your Breath: Strategies to Reduce Environmental Factors that Contribute to Asthma in Children

State health and environment agencies are increasingly recognizing the advantages of working together on environmental health issues. The Environmental Council of the States (ECOS) and the Association of State and Territorial Health Officials (ASTHO) sponsored an initiative to jointly identify steps that states can take to address indoor and outdoor environmental factors that contribute to asthma in children, with funding assistance from the U.S. Environmental Protection Agency and the Centers for Disease Control and Prevention. The results, "Catching Your Breath: Strategies to Reduce Environmental Factors that Contribute to Asthma in Children," provides a menu of concrete, workable actions that states can take.

**Presenter:** Environmental Council of the States (ECOS); Association of State and Territorial Health Officials (ASTHO)

**Topic:** Comparison of ISAAC and CSTE Definitions of Asthma in a Pediatric Population: The Maine Child Health Survey  
Measurement and comparison of asthma prevalence has been a challenge not only due to problems with clinical identification, but also because there has not been a standard definition used for surveillance. The International Survey of Asthma and Allergies in Childhood (ISAAC) developed a tool for identifying children with asthma at roughly the same time as the Council of State and Territorial Epidemiologists (CSTE) adopted a different definition for asthma.

We used data from the 2002 Maine Child Health Survey (MCHS) to compare the two definitions of asthma, both of which are based on caregiver reports of the presence and symptoms of asthma. The MCHS used a stratified, multi-stage design to sample students throughout Maine. 913 children

(40% overall response rate) 5 years of age on average completed the survey. Weighted prevalence estimates for asthma were similar using the CSTE (8.6%) and ISAAC (8.4%) definitions. Sixteen percent of children identified as having asthma using CSTE definition were not identified using ISAAC, and 9.7% were positive based on the ISAAC but negative based on the CSTE definition.

Further analysis examined the sources of discordance between the ISAAC and CSTE definitions, and compared their associations with demographic and clinical variables, such as wheezing and emergency room visits. Our findings contribute to understanding the similarities and differences between the ISAAC and CSTE definitions and to decision-making regarding which definition to use in asthma surveillance.

**Presenter:** Kathy Tippy, MPH  
Epidemiologist  
Maine Bureau of Health  
11SHS, Keybank Plaza, 4<sup>th</sup> Floor  
August, ME 04333  
Phone: (207) 287-4102  
e-mail: [kathy.tippy@maine.gov](mailto:kathy.tippy@maine.gov)

**Topic:** Correlates of House Staff Knowledge of Infectious Disease Reporting



House staff at three major teaching medical institutions in Pennsylvania were surveyed about knowledge regarding reporting of notifiable infectious diseases. A total of 244 house staff completed the survey, of whom 31.0% specialized in family practice or internal medicine, 11.1% in pediatrics, 4.4% in a medical subspecialty, and 8.9% in a surgical specialty. The remainder specified an "other" specialty category. Males comprised 58.0% of the respondents. Year of residency was categorized as follows: first year, 47.5%; second, 20.1%; third, 1.3%; fourth, 14.3%; and fifth or fellows, 16.8%.

Survey questions focused on knowledge about two categories. The Timeframe category asked respondents to identify whether or not a specific list of nine infectious diseases needed to be reported immediately. The Responsibility category



required respondents to identify the responsibility of six types of individuals for reporting diseases to health authorities. Summed scores were calculated separately for Timeframe and Responsibility, and normalized as unweighted proportion correct. The mean Timeframe score was 0.57 (SD=0.19), while the mean Responsibility score was 0.74 (SD=0.24). The scores showed significantly low correlation with length of time in residency (Timeframe  $r=0.13$ ,  $p<0.05$ ; Responsibility  $r=0.13$ ,  $p<0.05$ ), gender ( $p>0.05$ ), or specialty ( $p>0.05$ ).

These results indicate the need for improvement in education programs addressing disease reporting that focus on reporting certain infectious diseases rapidly and responsibility for reporting such diseases, especially given increasing bioterrorism vigilance. In addition, a single curriculum could address the needs of house staff in various specialties and at various times in their residency and even during medical school.

**Presenter:** Nkuchia Mikanatha, DrPH  
Bureau of Communicable Diseases  
Pennsylvania Department of Health  
P.O. Box 90, Health and Welfare Building  
Harrisburg, PA 17108  
Phone: (717) 787-3350  
e-mail: [nmikanatha@state.pa.us](mailto:nmikanatha@state.pa.us)

**Topic:** Geographic distribution of facilities that promote or harm cardiovascular health in the Jackson, Mississippi metropolitan area

Behavioral and lifestyle factors such as regular physical activity or exercise and a 'heart-healthy' diet are important individual-level risk factors for preventing the development of, and mortality from, cardiovascular disease (CVD). However, social and environmental determinants of CVD are also important, such as the availability of: public (non-paying) parks, bike paths, and walking trails; exercise and recreational facilities

Lack of availability of such facilities may be important barriers to cardiovascular health. An additional barrier may be the widespread availability of fast-food facilities, which offer inexpensive, high-fat food.

All fast-food facilities ( $n=148$ ) and exercise and recreational facilities ( $n=44$ ) and 49 (92%) of 53 parks in the Jackson, Mississippi metropolitan area were located, surveyed, and mapped. Parks, exercise and recreational facilities, and fast-food facilities are not distributed evenly across the metropolitan area; certain patterns and trends are apparent which are reasonably consistent. There are more fast-food facilities and parks and fewer fitness centers in

lower socioeconomic areas. Many parks were found to be small, poorly maintained, and not suitable for jogging, running, or biking. Only one third (16/49) had a concrete or asphalt path for walking, jogging, running, or biking; in ten this was a 0.5 mile loop, and in the other six this was a 1.0 mile loop. Three quarters of the parks with paths (12/16) had lighting that was considered poor or fair; only one quarter (4/16) had good or adequate lighting. There was a direct relationship between CVD mortality rates and the concentration of fast-food facilities and parks, with the highest concentration of fast-food facilities and parks being found in areas with the highest CVD mortality rates. There was no clear trend in the relationship between CVD mortality rates and the concentration of fitness facilities.

Health education and promotion policies and interventions to prevent CVD must take into account the availability and accessibility of fitness/recreational facilities, parks, and walking trails, etc. in communities. The availability of such facilities to the public is a necessary component of, and important stimulus to, individual behavior change, and lack of such facilities is an important barrier to individual behavior change. This is particularly important in lower SES areas, where the prevalence of CVD risk factors is higher. Health education and promotion messages encouraging regular physical activity/exercise will not work if suitable facilities are not available in the community.

The widespread availability of fast-food in all SES areas should also be considered in public health nutrition messages and policies to prevent CVD. In a free-market system, the distribution of atherosclerosis-promoting outlets (APOs) probably cannot be controlled, but public health policies should ensure that 'heart-healthy' foods are made equally available (and affordable) in all communities. Ways to encourage this should be explored.

**Presenter:** A.D. Penman  
Mississippi State Department of Health  
Physician Epidemiologist  
570 East Woodrow Wilson  
Jackson, MS 39215  
Phone: (601) 576-7842  
e-mail: [apenman@msdh.state.ms.us](mailto:apenman@msdh.state.ms.us)

**Topic:** Investigation of a community-acquired methicillin-resistant *Staphylococcus aureus* outbreak

This presentation discussed the outbreak identification, case finding methods, interventions and results of the investigation.

**Presenter:** Carmela Mancini, MPH  
Florida Epidemic Intelligence Service

Bureau of Epidemiology  
Florida Department of Health  
205 Dr. MLK St. N.  
Phone: (850) 251-6229  
e-mail: [carmela\\_mancini@doh.state.fl.us](mailto:carmela_mancini@doh.state.fl.us)

**Topic:** Legal, ethical, and programmatic issues from smallpox vaccination: Implications for public health programs

The reinstitution of a smallpox vaccination program has created unique ethical, political, and programmatic issues for public health programs.

The vaccination program was driven by factors external to public health. Many public health professionals were uncomfortable participating at a program designated as a "countermeasure." Although political realities often influence public health programs, this vaccination program magnified this influence and it appeared that public health was "following orders" rather than designing a policy based on the best science.

The nature of the smallpox vaccination risk-benefit equation with major variables determined by political and intelligence analysis was particularly uncomfortable to many health care professionals.

The program is being driven at a pace that precludes methodical planning. Technical information and policy were shifting sands.

Public health and health care personnel were in the unusual position of developing and implementing this program as well as being the targeted recipients of the intervention. Unresolved issues resulted in major unions taking positions against the program.

The difficult ethical and scientific issues polarized health care facilities, delivery systems, and even public health jurisdictions.

Massive redirection of resources at the federal, state, and local levels interrupted ongoing programs.

Adverse reactions to smallpox vaccine could impede our efforts to convince skeptical parents of the safety of our routine childhood vaccines. Worldwide polio eradication efforts are close to achieving success, however, immunization will have to continue due to the risk that the virus could be used as a bioterrorism agent.

**Presenter:** Howard Backer, MD, MPH  
Acting Chief, Immunization Branch  
California Department of Health Services  
2151 Berkeley Way, Room 7R  
Berkeley, CA 94704  
Phone: (510) 540-2382  
Fax: (510) 883-6015  
e-mail: [hbacker@dhs.ca.gov](mailto:hbacker@dhs.ca.gov)



# CSTE MEMBERS PRESENT AT APHA MEETING (continued)

**Topic:** Population-based incidence of on-the-job injury, 2002, New York City



**Background:** Local population-based estimates of the incidence of occupational injury are rare in the U.S. An opportunity to address this gap occurred when New York City conducted a comprehensive health survey of 9674 randomly-selected residents from May to June 2002, designed to provide neighborhood-specific data.

**Methods:** The target population was non-institutionalized adults age 18 and over with telephones. To assess the incidence of occupational injuries, the survey asked respondents, "In the past 12 months, have you had any on-the-job injuries that required medical attention other than simple first aid?"

**Results:** Overall, 5.1% reported an on-the-job injury. The highest incidence was among 18-44 year-olds (5.5%) while 45-64 year-olds reported the lowest incidence (4.0%). Men reported a higher incidence (5.3%) compared with women (4.8%). Hispanic workers reported the highest incidence (7.3%), followed by Asian (5.3%), African-American (4.9%), White (4.2%). Workers whose country of origin was the Caribbean had the highest incidence (7.2%), followed by East Asians (6.1%). Staten Island reported the highest incidence (5.8%), followed by the Bronx (5.6%), Queens (5.39%), Brooklyn (5.43%) and Manhattan (3.78%). Of New York City neighborhoods, East Harlem had the highest incidence (12.0%). Outdoor workers had a higher incidence (6.7%) compared with indoor workers (4.6%).

**Discussion:** The incidence of on-the-job injuries among New York City workers (5.1%) is similar to U.S. Bureau of Labor Statistics data (5.4%). These data will facilitate targeting of occupational injury prevention efforts to groups with the highest reported incidence, including Hispanic workers, workers from the Caribbean, and workers in the East Harlem.

**Presenter:** Jim Cone, MD, MPH

Environmental and Occupational Disease Epidemiology  
New York City Department of Health and Mental Hygiene  
253 Broadway, Room 602, CN34-C  
New York, NY 10007  
Phone: 212-676-2944  
e-mail: [jcone@health.nyc.gov](mailto:jcone@health.nyc.gov)

**Topic:** Programmatic and Epidemiologic Issues Integrating Child Health Information Systems

Integrated data system development is a difficult, costly endeavor that is too often unsuccessful. Even when it is successful, we may have the sense that we have lost what we intended to gain. The money is spent, the system maintenance is ongoing – usually at a higher level than we planned for – and the access to epidemiological data is slower and more complicated than ever. Or access for epidemiologists and researchers is quick and easy at the cost of access and usefulness for service assurance and facilitation of care.

These are the costs of getting more complete, timely data. Or are they? Does the data quality meet our minimum standards? Is the data collection process reliable, valid, and methodologically appropriate? What population is really represented in the analyzable data?

This presentation will examine these issues and how they played out in Oregon. Generic programmatic issues discussed will include data quality, data accessibility, and the priority accorded to infrastructure building. Maternal and child health (MCH) program issues will include relevance to program administration, to client outcomes, and to legislative or executive decision.

These MCH issues will be contrasted to epidemiological issues – relevance to surveillance goals and population health. Evidence-based approaches to dealing with these issues will be examined, along with ways Oregon is using to test the approach selected and, at the same time, build MCH program evaluation and population surveillance capacity.

**Learning Objectives:** At the end of the session, participants will be able to describe some of the major programmatic issues in integrating systems and how they are being addressed and describe how information from these systems can be used to improve health and health services.

**Presenter:** Sherry Spence, MA

MCH Data Systems Coordinator  
Oregon Department of Human Services  
Health Services, Office of Family Health  
800 NE Oregon St., Suite 825  
Portland, OR 97232  
Phone: (503) 731-4059  
e-mail: [sherry.spence@state.or.us](mailto:sherry.spence@state.or.us)

**Topic:** Rural prevalence of childhood lead poisoning in Minnesota

Most attention to the problem of lead poisoning has focused on urban areas. However, Minnesota is a largely rural state, with roughly half the population living outside the major metropolitan area of Minneapolis/St. Paul. We sought to rigorously characterize elevated blood lead prevalence in a representative rural area.

A comprehensive prevalence study was designed to test blood lead levels in all children up to 48 months old in a three-county area of west-central Minnesota. This area has a high proportion of homes built prior to 1950 and a relatively high rate of poverty, two of the major risk factors for elevated blood lead levels (EBLL, i.e. a blood lead level of 10 micrograms/dl or greater). Approximately 1,500 eligible families were asked to complete a one-page questionnaire about their child's possible exposure to lead poisoning risks and have their child's blood tested for lead. Recruitment of study participants occurred through a combination of mailed materials, face-to-face contact at WIC clinics, and media publicity. Local health clinics were also actively involved in recruitment during well-child and sick visits.

Blood lead tests were obtained for 75% of eligible children. EBLLs were observed in 2.1% of tested children, and 0.5% of children had blood lead levels above 20 micrograms/dl. Receiving Medicaid or WIC assistance and spending time in pre-1950 housing were important determinants of EBLL. We achieved greater awareness of lead issues by local physicians and the public, and developed a closer relationship with local public health and health care provider organizations.

**Presenter:** Erik Zabel  
Minnesota Department of Health

**Topic:** Smallpox Vaccination Program in California: lessons learned

**Presenter:** Howard Backer, MD, MPH  
Acting Chief, Immunization Branch  
California Department of Health Services  
2151 Berkeley Way, Room 7R



Berkeley, CA 94704  
Phone: (510) 540-2382  
Fax: (510) 883-6015  
e-mail: [hbacker@dhs.ca.gov](mailto:hbacker@dhs.ca.gov)

**Topic:** Surveillance for Smallpox Disease and for Smallpox Vaccine Adverse Events in California, 2003

Surveillance is a key component of the California Department of Health Services (CDHS) Smallpox Preparedness and Response Plan. The implementation of the CDHS strategies for 1) Enhancing the capacity of existing surveillance systems to detect vesicular rashes and to rule out smallpox; and 2) Strengthening the existing public infrastructure for outbreak prevention and control were discussed during the presentation, with a focus on smallpox surveillance and surveillance of smallpox vaccination adverse events.

**Presenter:** Celia Woodfill, Ph.D.  
Acting Chief, Surveillance, Investigations, Research and Evaluation Section  
Immunization Branch  
California Department of Health Services  
2151 Berkeley Way, Room 712  
Berkeley, CA 94704-1011  
Phone: (510) 849-5066  
Fax: (510) 883-6015  
e-mail: [cwoodfil@dhs.ca.gov](mailto:cwoodfil@dhs.ca.gov)

**Topic:** Understanding the prevalence of asthma in a community: Impacts of study design and definition

The purpose of this study was to investigate the prevalence of various symptoms that are associated with asthma in children, grades Kindergarten through 12, residing in 3 towns in Warren County, New Jersey — a region where prior surveys by local residents had indicated unusually high rates of asthma and respiratory problems.

Specifically, this study implemented several methodologies — surveys of all school children, review of school medication records, and follow-up parental phone interviews - to better understand:

- the advantages and limitations of each methodological approach in ascertaining asthma prevalence in a community.
- the factors that affect apparent asthma prevalence such as the definition of asthma and the transient nature of symptoms.

**Presenter:** Azadeh Tasslimi, BA  
Dept. of Preventive Medicine and Community Health  
UMDNJ — New Jersey Medical School  
30 Bergen St.  
Bldg 16, Suite ADMC 1614  
Newark, NJ 07107-3000  
Phone: (973) 972-4623  
e-mail: [tasslimiaz@umdnj.edu](mailto:tasslimiaz@umdnj.edu)

**Topic:** Using geographic information systems (GIS) for influenza pandemic planning

**Background:** Influenza vaccination of high risk populations (HRP) during a pandemic will require efficient use of resources. We evaluated the effectiveness of GIS to identify HRP and community resources within Boston.

**Methods:** HRP were defined as age >64 years. Percentage of HRP within each census tract was categorized as follows: >10% = high risk area (HRA), 5-10% = medium risk area (MRA), and <5% = low risk area (LRA). Data on income, race, disability, and language for HRP were obtained from Census 2000. For each category, the number of hospitals, health centers (HC), other immunization providers (OIP), and subway transportation were determined using GIS.

**Results:** Most HRP whites lived in HRA compared to MRA and LRA (54%; 38%; and 40% respectively). Disability did not vary by risk area category (HRA: 30%; MRA: 29%; LRA: 25%). HRP in MRA and LRA compared to HRA (14%; 15% vs. 7%) were more likely to be linguistically isolated and to have lower median incomes (\$23,884; \$20,713 vs. \$25,423). HRA had more OIP than MRA or LRA, but fewer hospitals or HC. Most subways were located in MRA or LRA.

**Conclusion:** High risk areas for influenza morbidity in Boston have fewer hospitals and health centers, but many OIP. Subway transportation in these neighborhoods is also limited. Pandemic influenza vaccination planning strategies for HRP in HRA needs to include OIP and access transportation issues. In MRA and LRA linguistic barriers need to be addressed. GIS is an emerging tool for public health planning.

**Learning Objectives:**

1. Describe how GIS can identify population patterns to use in decision-making and resource allocation.
2. Understand how GIS can be used to organize and present health data for planning purposes mass casualty events.

**Presenter:** Scott Troppy, MPH  
Surveillance Epidemiologist  
Boston Public Health Commission  
Communicable Disease Control Division  
1010 Massachusetts Avenue, 2nd Floor  
Boston, MA 02118  
Phone: (617) 534-5020  
Fax: (617) 534-5905  
e-mail: [scott\\_troppy@bphc.org](mailto:scott_troppy@bphc.org)

**Topic:** Varicella in a New Hampshire Elementary School: A Shift in Epidemiology.

The project described an outbreak of Varicella in an Elementary School. It showed higher attack rates in older students as well as an overall vaccine

efficacy in average consistent with national reports, but lower among older students.

**Recommendations:** To enact measures to improve vaccine coverage and to anticipate a shift in varicella morbidity from a younger to older population. Instituting statewide procedures such as mandatory diseases reporting and the development of standard procedures for cluster or outbreak investigations.

**Presenter:** Jose T. Montero, MD  
Chief  
Bureau Of Communicable Disease Control  
NH Hampshire Department of Health and Human Services

**Topic:** Dr. John Neuberger presented an overview of three prevalence studies of multiple sclerosis that are being conducted in areas of Ohio, Missouri, and Texas. The methodology for case finding and abstracting was developed with teams from all three sites. Preliminary results indicate that the latitude gradient persists, with the highest rates in Ohio and the lowest rates in Texas. The overall findings will eventually be published by the investigators and the Agency for Toxic Substances and Disease Registry, the funding agency. A subsequent case-control study is being planned.

**Presenter:** John Neuberger  
Department of Preventive Medicine and Public Health  
Professor  
University of Kansas School of Medicine  
3901 Rainbow Boulevard  
Kansas City, KS 66160  
Phone: (913) 588-2745  
e-mail: [jneuberg@kumc.edu](mailto:jneuberg@kumc.edu)



## Staff Directory

John Abellera: Associate Research Analyst  
E-mail: jabellera@cste.org

Shundra Clinton: Member Services  
Coordinator  
E-mail: sclinton@cste.org

Kevin Gibbs: applications Programmer  
E-mail: kgibbs@cste.org

Knachelle Hodge: Associate Research  
Analyst  
E-mail: khodge@cste.org

Tarajee Knight: Administrative Assistant  
E-mail: tknight@cste.org

Jennifer Lemmings: Associate Research  
Analyst  
E-mail: jlemmings@cste.org

Jackie McClain: Associate Research  
Analyst  
E-mail: jmcclain@cste.org

Pat McConnon: Executive Director  
E-mail: pmcconnon@cste.org

Beverly McLeod: Director of Operations  
E-mail: bmcLeod@cste.org

LaKesha Robinson: Director of Programs  
E-mail: lrobinson@cste.org

MarySue Shulin: Business Manager  
E-mail: mshulin@cste.org

Angela Sylvester: Program Administrator  
E-mail: asylvester@cste.org

Adrienne Wilschek: Administrative Assistant  
E-mail: awilschek@cste.org

## Executive Committee

CSTE is governed by a 10-member Executive Committee. Four members serve as officers, three as Members-at-Large, and three represent Infectious Disease Epidemiology, Chronic Diseases Epidemiology, and Environmental/Occupational/Injury Epidemiology. The 2003-2004 Executive Committee members are:

| Office                            | Name and State              | Term<br>Expiration |
|-----------------------------------|-----------------------------|--------------------|
| President                         | Dr. Matthew Cartter - CT    | 2004               |
| Vice-President                    | vacant                      |                    |
| President-Elect                   | Dr. Christine Hahn - ID     | 2004               |
| Secretary-Treasurer               | Dr. Steven Macdonald - WA   | 2005               |
| Members-At-Large                  | Dr. Matthew L. Boulton - MI | 2006               |
|                                   | Dr. Bela Matyas - MA        | 2005               |
|                                   | Dr. C. Mack Sewell - NM     | 2004               |
| Infectious Disease Epidemiology   | Dr. Ellen Mangione - CO     | 2005               |
| Chronic Disease/Oral Health/MCH   | Dr. Kenneth Powell - GA     | 2004               |
| Environmental/Occupational/Injury | Dr. Robert Harrison - CA    | 2006               |

## CSTE Staff Update



**Jennifer Lemmings** joined the CSTE staff in January 2004 as an Associate Research Analyst. She received her bachelor's degree from the University of Wyoming and holds an M.P.H. degree from the University of Alabama at Birmingham.

Before beginning her master's program, Jennifer worked as a research technician in a molecular genetics lab in Birmingham, Ala., working to identify candidate genes in Alzheimer Disease pathology. Her experience also includes working as a research assistant in a Developmental Biology Lab at the University of Colorado at Boulder.

## Occupational and Environmental Health Update

### OCCUPATIONAL HEALTH INDICATORS

Thirteen Occupational Health Effect and Biologic Exposure Indicators and six Occupational Health Risk Factor, Intervention, and Impact Indicators, along with their corresponding "how-to" guides, are undergoing final revisions. An updated version will be made available on CSTE's Web site.

The pilot test of these indicators, which originally included five states and expanded to include seven additional states, is now complete. The Occupational Health Workgroup is drafting a data document that details the 4999 results of this pilot and anticipates that it will be ready for publication by July.

The group will meet in April in Washington D.C to participate in a workshop sponsored by the Bureau of Labor Statistics to review various employment data sources that can be used to generate indicators and to conduct other occupational health surveillance activities in the states. The Workgroup will also continue to discuss the results of the pilot and plan for presenting the results during CSTE's Annual Conference in June.

### CSTE/EPA ENVIRONMENT AND AGING

The Environmental Protection Agency (EPA) recently launched the "Aging Initiative," which includes a national agenda

to better understand the environmental hazards affecting the health of older Americans. CSTE has recognized the need to become involved in addressing environmental issues for the aging population at the state and local level and is collaborating with the EPA to identify indicators of health risks to older Americans from environmental exposures.

Some of these indicators will be developed into questions suitable for conducting surveillance using the Behavioral Risk Factor Surveillance System (BRFSS). The Workgroup for this project met in Arizona in February to finalize questions to be included as state-added questions to the 2005 BRFSS. Five states will be chosen to pilot these questions.

### ENVIRONMENTAL HEALTH COMMITTEE

CSTE's Environmental Health Committee is planning a special pre-conference session during CSTE's Annual Conference in June. The Environmental Health Planning Committee is currently preparing the agenda for this meeting and plans to highlight the Environmental Public Health Tracking Program, including a roundtable discussion of grantees' lessons learned from evaluating and applying the CSTE/CDC Environmental Public Health Indicators.