COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS

CSTE update

Summer *2003*

Contents

Calling all Members

We would appreciate your feedback about the newsletter. Please email Shundra Clinton with comments, ideas or suggestions; sclinton@cste.org.

President's Message

Over the past months, many of us have been working frantically on bioterrorism issues. The grant applications for a second year of extra funding are the most complex I've ever seen, involving multiple functions and much coordination. With such tasks at hand, it's easy to become overwhelmed, but we shouldn't become frustrated or lose our focus. We must remember that this is a process of rebuilding the entire public health infrastructure as we address the threat of bioterrorism.

In this process, we have to prioritize our needs and keep everything in context. One of our greatest challenges is to use our funding wisely. For those of us who have been in public health for many years, the amount of new money available is almost like going from starvation to overeating, so we must be careful. We are striving to attend to today's threats, but also to rebuild areas throughout the public health system. Increased and continued funding can help us greatly in preparing for the future.

As we all continue to plan for the future of public health, I am finishing my term as CSTE president. The past year has gone by quickly. Working with you all as the organization's president has been very interesting and rewarding (and probably more work than I thought!), and I hope that I have been able to help CSTE improve and move forward.

I believe we made a lot of progress in the last year. We've worked to improve our relationships with CDC and other federal agencies and to reduce the number of missed opportunities to work together. We're seeing a continued increase in requests from these agencies for information and assistance.

On an internal level, we revamped the system for teams and consultants to make it more manageable and to make information more accessible and useful. While our numbers continued to grow, we also increased membership participation among all members. We have a wonderful national office and staff, but CSTE remains a structure of volunteers, and we need volunteer participation more now than ever.

I have enjoyed the year working with you all and I look forward to what the next year will bring the public health system. Thank you all for your continued support of CSTE.

June 2003
Gianfranco Pezzino, M.D., M.P.H.
State Epidemiologist, Kansas

Field EIS Recruiting

Each year in April, potential Field EIS Supervisors come in from state and large, local health departments to recruit incoming EIS Officers to their Field Assignments. The State Branch in the Division of Applied Public Health Training, EPO assists Field Supervisors with recruiting by facilitating opportunities for EIS recruits and state/local staff to meet one another, converse and share information.

Field recruiting activities at the conference include:

- a State Branch Break Room for state/local staff and recruits
- a bulletin board with contact information
- State Branch supervisors promoting Field Assignments and steering recruits and Field Supervisors to one another
- displays in the CIO Exhibit Room and in the State Branch Break Room
- brochures and information sheets showcasing Field EIS work
- social events for Field Recruiting

CSTE sponsors the two Field Recruiting social events – the Tuesday State Branch luncheon and the Thursday State/Local Health Department Pizza Party. This year both events were held on site at the Crown Plaza Ravinia conference location, which resulted in excellent attendance. At the luncheon, all the Field EIS Supervisors were given a chance to introduce themselves, and two enthusiastic first-year EIS Officers, Nolan Lee (Los Angeles) and Leigh Ramsey (New Hampshire), talked about why they enjoyed their field assignments. The Thursday Pizza Party was held in the hotel's Bistro 55 and was so well attended that we may need to find a larger room next year! Wonderful weather led to many attendees strolling on the adjacent patio as they discussed assignments.

So, how did Field Recruiters do this year? Well, the number of Field EIS Assignees for 2003-2004 will be the largest ever – a total of 50 in the two classes assigned to the Field, one more than the total for 2002-2003. These 50 Field EIS Officers are assigned to 39 localities – 34 states, four large cities/counties, and Puerto Rico. Field EIS Officers in these positions will be on the front line, handling a diverse and exciting range of opportunities, assuming leadership roles as field epidemiologists, and making a difference in their areas. The number of Field matches this year (17) is lower than last year, but that was to be expected because so many assignments (33) were filled in last year's match. "New" assignments that hadn't been filled in several years, but did fill this year, include Maryland and Puerto Rico.

EIS Supervisors and recruits enjoy a chance to socialize at the EIS Field Recruiting meeting held in April.

However, it is always disappointing to see that some excellent Field Assignments do not match. This year, seven Field Assignments did not match, including some that generated a lot of genuine interest during the week of the conference. Challenges to matching with an EIS Officer include being a "new" assignment, geography, the "home court" advantage of headquarters assignments, and the luck of the draw. The number of EIS assignments offered always greatly exceeds the size of the EIS class. The Field Supervisors for the unmatched assignments are encouraged to return next year to recruit, and the State Branch can offer suggestions on how to recruit best. The most important factors include a history of providing excellent assignments, having the primary supervisor at the start of the conference, and sending as many relevant state staff as possible. Field Assignments have to compete with headquarters assignments in Atlanta that can provide on site information about their staff and products.

Next year's EIS Conference will be held April 19-23, 2004. Stay tuned for the location. CSTE and the State Branch will be there, facilitating and rooting for more good matches for State and Local Field EIS Assignments!

Laura Fehrs, M.D.
Chief, State Branch, Centers for Disease Control and Prevention

Director's Message

What a great Annual Conference! One of the speakers, Rick Goodman, recalled that in 1981, when he attended his first CSTE Annual Conference in Jackson Hole, Wyo., the total attendance was fewer than 50 participants. In 2003, we had more than 200 speakers and our attendance included 553 registered conference participants.

If I were to use three words to describe the conference, they would be "collegial, inclusive, and stimulating." It truly was a fine conference and the speakers and participants should get high marks and kudos for their preparation and participation. It was clear that hours and hours of thought and hard work had gone into preparation for each and every presentation, from the Pre-conference Workshop, Plenary Sessions, Breakout Sessions and Roundtables to the President's Banquet. The CSTE National Office Staff made it look as if putting on a conference is an easy task. They all know how important this one event is to the membership and worked incredibly hard to make sure members felt welcome and supported. A big thanks to all those behind-the-scene organizers who made the conference special: the Program Chair, Program Committee, and support and operations staff.

The formal program concluded on Wednesday and was followed by the business meeting with 41 states and Puerto Rico present. For those of you who couldn't stay for the business meeting, its highlights included the election of a new President Elect and four new Executive Committee members:

President Elect - Christine Hahn, M.D., M.P.H.; Idaho

Environmental, Occupational, Injury Chair - Bob Harrison, M.D., M.P.H.; California

Infectious Disease Chair - Ellen J. Mangione, M.D., M.P.H.; Colorado

Executive Committee Member At Large - Matt Boulton, M.D., M.P.H.; Michigan

Executive Committee Member At Large - Bela Matyas, M.D., M.P.H.; Massachusetts

Additionally, CSTE Position Statements were debated, amended and voted on by the members present and the delegates from each state. A total of 18 Position Statements were passed, including the new SARS case definition and a joint CSTE/NASPHV Position Statement on restriction of the importation of exotic animals from other countries and the exportation of certain native animals. All the Position Statements are posted on the CSTE Web site.

The business meeting was also instructive for students of parliamentary procedure as our in-house CSTE experts (Steve Macdonald and Gianfranco Pezzino) guided us through the nuances of this highly ritualized exercise. Bob England (AZ) captured the parliamentary gymnastics shown below during this highly charged session.

Pat McConnon
Executive Director, CSTE

Policy Corner

Quarantine and Isolation

In light of the recent emergence of Severe Acute Respiratory Syndrome (SARS), the president has issued an executive order to add SARS to the directory of federally listed, detainable, communicable diseases. The list includes other illnesses such as plague, cholera, diphtheria, infectious tuberculosis, yellow fever, smallpox and viral hemorrhagic fever, such as Ebola.

Under this order, the Secretary of Health and Human Services is given the duty of preventing the introduction, transmission and spread of communicable diseases from foreign countries to the United States and within the United States and its territories or possessions. States have the right to isolate and quarantine suspected or infected individuals/groups through "police powers" in order to safeguard the health, safety and welfare of their citizens.

Quarantine and Isolation Are Not Synonymous

Isolation: the separation of people who have a specific infectious illness from healthy people and the restriction of their movement to stop the spread of that illness. Isolation is a standard procedure used in hospitals today for patients with tuberculosis and certain other infectious diseases. The last time isolation measures were enforced was in 1963; this involved a suspected smallpox case entering the United States.

Quarantine: the separation and restriction of movement of people who are not yet ill, but who have been exposed to an infectious agent and are therefore potentially infectious.

Both isolation and quarantine may be conducted on a voluntary basis or compelled on a mandatory basis through legal authority.

For more information, check out these Web sites:

www.cdc.gov/ncidod/sars/quarantineqa.htm – Federal SARS Executive Order Q&As

www.cdc.gov/ncidod/sars/factsheetlegal.htm – Fact Sheet on Legal Authorities for Isolation/Quarantine

CSTE Project Updates

Public Health Information Network

The NEDSS partners (APHL, ASTHO, CSTE, NACHHO, NAHDO and NAPHSIS) have developed a series of communication products to promote the Public Health Information Network (PHIN). These products include a PowerPoint presentation, newsletter article, flyer and brochure. The communications series addresses the purpose of PHIN and its role in the public and private sectors.

As noted in the brochure, "PHIN will be a live, secure, Internet-based network for exchanging comparable critical health information between all levels of public health (local, state and federal) and other critical information systems. A key PHIN building block is the adoption of IT standards and specifications so that public health and its partners can be connected and data can be readily shared and analyzed."

The brochure further details how the NEDSS partners evolved to form the PHIN partnership, and illustrates the building blocks used to support the concept of PHIN. As we know it, "PHIN is an electronic nervous system that supports monitoring of the public's health."

To view the brochure, please go to the CSTE Web site under the features section.

Data Release Guidelines

The CDC-CSTE Intergovernmental Data Release Guidelines Working Group (DRGWG) developed guidelines for the re-release of state data by CDC, which are included in their 86-page report, "CDC-ATSDR-CSTE Data Release Guidelines for Re-Release of State Data." The 22 guidelines themselves comprise 43 pages in the middle of the report. The purpose of the DRGWG guidelines is to impose minimum standards on CDC program units.

The guidelines may also serve as models for state programs in implementing administrative controls and methods to reduce disclosure risk in the release of their own state data.

The DRGWG document is a working draft. The Working Group is currently revising their report to address comments received from external and internal parties, and expects to submit the report through the CDC clearance process in early Fall 2003.

"CDC-ATSDR-CSTE Data Release Guidelines for Re-Release of State Data" is available for review in the "Members Only" section of the CSTE Web site, under publications.

Job Bank

CSTE has developed an Online Job Bank as a resource to help epidemiologists locate job availabilities at state agencies, and as a resource for state employers to post epidemiology position openings within their agencies. The job bank can be accessed by going to the CSTE home page and selecting the link entitled "Public Health Job Openings" or by going directly to www.cste.org/Employment/Employment.htm.

NNDSS

The results of the 2001 Nationally Notifiable Disease Surveillance System (NNDSS) Assessment have been displayed in a queriable database. State reporting profiles, as well as notifiable and non-notifiable disease/condition reporting patterns, can be viewed by accessing the link under "Features" on the CSTE home page, or by going directly to www.cste.org/NNDSSHome.htm. This assessment will be updated annually beginning in 2004. If you have any questions, please contact Rachel Barron-Simpson, Associate Research Analyst, at the National Office (rsimpson@cste.org).

Chronic Disease Epidemiology Capacity

The CSTE Chronic Disease Epidemiology Capacity assessment was sent to State Chronic Disease Epidemiologists (SCDE) and State Epidemiologists (for those states without a designated SCDE) for completion on May 19, 2003. For this assessment, chronic disease epidemiologists are characterized as persons who spend at least 50% of their time working at the health department as epidemiologists. However, at least 25% of their time must be spent working specifically on chronic disease epidemiology tasks.

The purpose of this assessment is:

1) To describe the chronic disease epidemiologic capacity of state and territorial health departments;
2) To identify additional resources needed to improve chronic disease capacity, and
3) To enable CSTE, CDC, state and territorial health departments, and other interested organizations to develop and implement plans to address their needs.

Findings and recommendations from this assessment will be compiled in a report at the end of the year. If you have any questions, please contact Rachel Barron-Simpson, Associate Research Analyst, at the CSTE National Office (rsimpson@cste.org).

Environmental Interns

(L-R) Deanna Williams, Shakirudeen Amuwo and Shannell McGoy have been selected for the CSTE/IMHOTEP internship program.

Two public health graduate students and one recent Master of Public Health graduate were selected for the CSTE/IMHOTEP internship program, which is sponsored by the Morehouse College Public Health Sciences Institute. The interns will spend the first two weeks of the program in an intensive, public health educational training program in Atlanta. For the remaining nine weeks, the students will work on various environmental/occupational epidemiology projects at Wisconsin and California public health agencies, gaining state-based, applied epidemiology field experience. At the end of the 11-week experience, interns will present the outcomes of their projects. CSTE would like to thank Henry Anderson, M.D. (WI) and Robert Harrison, M.D., M.P.H. (CA) for providing internship opportunities for these students.

HIPAA Survey

The CSTE National Office conducted a brief survey to rapidly assess the different approaches states are taking with respect to public health surveillance and the Heath Insurance Portability and Accountability Act (HIPAA). Under the HIPAA Privacy Rule, a state health agency will designate itself as a Covered Entity, a Hybrid Entity or a Non-Covered Entity. Since state public health authorities are part of state health agencies, each designation has different implications for public health surveillance, particularly with respect to tracking disclosures around Protected Health Information (PHI).

A total of 31 states participated in the survey. At the time of the survey, 20 states (63%) were classified as Hybrid Entity, seven (23%) as Covered Entity, two (7%) as Non-Covered Entity, and two (7%) as unknown or not yet determined. Of the 20 states classified as Hybrid Entity, 19 states (95%) will except the collection and use of public health surveillance data from HIPAA Privacy Rule coverage (Table 1), and 14 states (68%) will not track the disclosures of public health surveillance data to another entity under the HIPAA Privacy Rule (Table 2). Four states (57%) classified as Covered Entity will except the collection and use of public health surveillance data, and four states (57%) will track disclosures of public health surveillance data to another entity.

The majority of states indicated that when accepting disclosures from a Covered Entity, the state health agency would not require the authorization of the person who is the source of the PHI. In turn, there were no consistent patterns among states, whether classified as Hybrid Entity or not, to the excepting and tracking of public health surveillance data.

In response to an optional question to assess the process states used to classify their state health agencies, some states indicated that time and the number of programs covered by the HIPAA Privacy Rule were factors in determining their classification. One state reported that cost was a factor in the decision process.

This brief survey provides us with a snapshot of how states are classifying their state health agencies, and of the use of public health surveillance data. However, an in-depth survey is needed to examine the accessibility of and potential barriers to public health surveillance data from other Covered and Hybrid Entities. This information may help states illustrate to the Office for Civil Rights the impact HIPAA has on public health surveillance activity.

Table 1. Is your state health agency excepting the collection and use of public health surveillance data from HIPAA Privacy Rule coverage?

	Yes	No	Unknown	Total
Covered Entity	4	2	1	7
Hybrid Entity	19	1	0	20
Non-Covered Entity	1	1	0	2
Unknown*	2	0	0	2
Total	26	4	1	31

Table 2. Will your state health agency track disclosures of public health surveillance data to another entity under the HIPAA Privacy Rule?

	Yes	No	Unknown	Total
Covered Entity	4	2	1	7
Hybrid Entity	6	14	0	20
Non-Covered Entity	0	2	0	2
Unknown*	1	1	0	2
Total	11	19	1	31

* Not yet determined

State and Territorial Epidemiology Capacity

"Given the relative paucity of trained epidemiologists outside the infectious disease area, **there needs to be special emphasis placed on increasing the number of trained epidemiologists** in program areas such as environmental health, maternal and child health, injury and occupational epidemiology."

"States and territories need increased epidemiology capacity now: they need more highly trained epidemiologists in greater numbers to control and prevent common, endemic diseases as well as to respond to new and emerging health problems, health hazards, and outbreaks. Due to severe budgetary crises in states and territories, funding for increased capacity must come from the federal government."

These are just a few of the valuable recommendations found in the report "National Assessment of Epidemiologic Capacity in Public Health: Findings and Recommendations," which was released by CSTE in March 2003. The Epidemiology Capacity Assessment tool was administered in the winter of 2001 through the spring of 2002 to assess U.S. state and territorial health agencies' core and infectious disease epidemiologic capacity. A result of the collaboration of a workgroup of CSTE members with representatives from the CDC and other prominent public heath organizations, this report highlights the major findings of the assessment.

This assessment is the first comprehensive nationwide assessment of core epidemiology in the public health system. The baseline information obtained will be essential in evaluating the impact of future funding to build and improve epidemiology capacity in the United States. CSTE will repeat the assessment at two-year intervals in order to document changes in state agencies.

In addition, based on the demonstrated substantial need for individuals trained in applied epidemiology, CSTE is launching its Applied Epidemiology Fellowship Program in order to recruit and retain epidemiologists at the state and territorial levels.

An electronic version of the assessment can be found on the CSTE Web page at www.cste.org/pdffiles/ecacover.pdf. If you would like to receive a hard copy of the document, please contact Knachelle Hodge at the National Office at khodge@cste.org or (770) 458-3811.

Workforce Development Update: CDC/CSTE Applied Epidemiology Fellowship Program

In response to the need for a skilled workforce in applied epidemiology in state and local public health departments, CSTE has proposed a workforce development program. One component of this workforce development initiative includes an Applied Epidemiology Fellowship Program, a two-year training program that will be funded by the CDC. This program will give recent graduates from accredited schools of public health on-the-job training at state and local health departments. The goal of the program is to secure long-term job placement for the program's fellows at the health agencies to which they are assigned, thus contributing to a competent workforce at the state and local level.

Candidates for the program will undergo a thorough screening process and will be evaluated on criteria established to ensure that those selected for the program will be successful. During their tenure in the training program, fellows will be expected to achieve competencies related to epidemiologic methods, communication skills, practice, policy and legal issues. In addition, fellows will participate in core activities during which they can demonstrate acquired competencies. Full details of the fellowship program can be found in CSTE's recently completed implementation plan at www.cste.org.

While this fellowship program provides rigorous training for participants, it is also designed to satisfy the needs of the agencies in which the participants are placed. Fellows are carefully matched to agencies based on the interests and aspirations of the fellows and available opportunities of the host agencies. In this way, the Applied Epidemiology Fellowship Program provides a unique opportunity for health agencies to secure highly qualified epidemiologists trained to meet the specific needs of those agencies without having to invest in costly training. Because of the substantial investment into program fellows, host agencies will be selected carefully based on the agencies' eagerness for mentorship and ability to support fellows during the program.

The program is seeking state and local public health agencies that have an experienced staff epidemiologist with an advanced degree who is willing to serve as a mentor and provide supervision. Host agencies must be able to identify projects that fellows could assume during the program and describe available learning opportunities that will enable fellows to achieve the required competencies. Finally, as the ultimate goal of the program is to place fellows into permanent positions, each host agency should anticipate supporting a long-term working relationship with the fellow as an employee of the agency after the program is complete.

The first class for the fellowship program is expected to begin in October 2003. Information regarding how agencies can submit position proposals to participate in this innovative fellowship program is available on the CSTE Web site. Go to www.cste.org and click on the link "Health Agency Proposal Submission Information for the Applied Epidemiology Fellowship Program" to obtain application materials.

For further details about the fellowship program or for a complete copy of the implementation plan, please contact Jackie McClain at jmcclain@cste.org.

IT Corner

Did you know that you can update your CSTE contact information on our Web site?

To change your profile and/or contact information, simply go to the CSTE Web site at www.cste.org and log in as a member. Go to "Member Tools" at the bottom of the CSTE Members home page and click on "Update User Profile." From there, you can change any of your contact information easily.

Staff Directory

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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 Expiration
President	Dr. Matthew Cartter - CT	2004
Vice-President	Dr. Gianfranco Pezzino - KS	2004
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

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