



update

Third Quarter

2001

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c a l l i n g a l l
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We would appreciate your feedback about the newsletter. Please email Beverly McLeod with comments, ideas or suggestions; bmcleod@cste.org.

CSTE Environmental
Internship Program

What's the best way to guarantee a steady supply of well trained, highly qualified epidemiologists? Train them, of course! That's exactly what the Council of State and Territorial Epidemiologists is beginning to do through the Environmental Internship Program – a project developed in cooperation with Morehouse College's Project: IMHOTEP and the Centers for Disease Control and Prevention.

History

Project: IMHOTEP was started in 1981 to help train African American undergraduate students in biostatistics and epidemiology and was expanded in 1994 to include occupational safety and health. The 11-week summer internship program includes training courses as well as hands on work experience at CDC headquarters and at the laboratories of the National Institute for Occupational Safety and Health. In 1988, the CDC entered into a cooperative agreement with Morehouse to establish a Public Health

Sciences Institute, which administers and supports a variety of public health activities within the Atlanta University Center, including Project: IMHOTEP.

CSTE's Program

CSTE saw the opportunity this type of internship program could provide for its environmental health team and public health departments throughout the country. Working closely with Morehouse, CSTE created an internship program specifically for those students interested in learning more about occupational and environmental health issues and practices. The pilot program for CSTE was launched this summer with three interns: Desmond Harper, Ilze Jekabsone and Keisha Miller.

The interns spent two weeks in classes with the CDC and Morehouse College reviewing epidemiology, biostatistics, and occupational safety and health.

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p r e s i d e n t ' s m e s s a g e

This quarter's message from President Matthew L. Carter, MD, MPH will not be included in this issue of our newsletter because of recent events.

Matthew L. Carter, MD, MPH
Epidemiology Program Coordinator
Connecticut Department of Public Health
President, Council of State and Territorial Epidemiologists

CSTE Environmental Internship Program

(Continued from page 1)

Harper then worked for nine weeks with the CSTE national office, while Jekabsone and Miller interned with the Bureau of Environmental Health at the Wisconsin State Department of Health and Family Services. Jekabsone and Miller were the first students placed in a state health department through such a program.

CSTE program director Crystal James, a graduate of the original Project: IMHOTEP, is excited about the partnership. "This is an opportunity to form a relationship with good people while they're still in school," she says.

James is responsible for managing CSTE's infectious disease, environmental and occupational health projects, so the desired outcome of the program – a qualified workforce interested in the field – is definitely important to her. "Research is what most students are being trained for," she says. "We can show them that while academia and research are great, there are other options."

Intern Keisha Miller believes she gained valuable experience during her weeks with Wisconsin's state health department. She appreciates the opportunities the interns had to contribute to the department while learning. "We had an essential role in research at the state health department," she says. "It was a won-

derful experience to work with people who cared about the state and its people."

It's not just the interns who benefit from the program. The hands on approach of having the interns do "real work" under the guidance of experienced epidemiologists benefits all involved. The interns' work and research contribute to the overall efforts of the departments they work for and learn from. However, if interns do hit problems in research or data analysis, program consultants are available to help them learn new processes or work through difficult areas. This way, full time staff members are able to maintain work on their own projects and spend focused mentoring time with the interns.

Successful Beginnings

Dr. Henry Anderson, State Environmental and Occupational Disease Epidemiologist with the Wisconsin Division of Public Health, was eager to have interns in his department. He supported the idea of the Environmental Internship Program from its inception. When funds were approved, he had projects in mind and was ready to host interns.

"This type of program can be a component of good capacity building," says Anderson. "The interns get good exposure to state health departments, and we get interns with good skills who are independent workers." He believes this independence makes the Environmental Internship Program different from other internship programs. "The interns were a net gain for the department while they were here. They came in with good analytic skills and did good work – and not just

good work, but useful work that we needed to have done," he says. "We would do it again in a minute."

An example of this "useful work" is Miller's research on lead poisoning trends in young children in the state's W.I.C. program. Her snapshot of "Elevated Blood Lead Levels in the W.I.C. Population" in 2000 was included in a report sent to the CDC. "They had never run figures on this population before," says Miller, "so I know that I expanded their thoughts...and that they will continue the work that I started over the summer."

Regan Walsh, a public health educator with the Wisconsin Division of Public Health, worked closely with Miller during the program. She understands that the benefits of having interns are not always obvious to an understaffed department because of the time involved, but having participated in the program, she knows the interns made real contributions. "The project Keisha chose had been on a 'wish-list' for some time," she says, "and her desire to pursue it made it a reality." The department is now meeting monthly with the W.I.C. program to explore further collaboration, and a new EIS officer in the department plans to continue the work Miller began. "Without the push Keisha provided, these things would not have happened," Walsh adds.

Anderson thinks that the program can be very useful moving forward. "We could definitely look at it as a good capacity building tool. We can look at what types of projects the interns could

do in just about any state, and send them to states that have good projects – projects that can provide important information for the states,” he says.

Program Benefits

With the continued success of CSTE’s Environmental Internship Program, everyone will benefit. Interns get the chance to explore the opportunities

available for careers in occupational and environmental public health; at the same time, they receive valuable training experience they can take into many fields. State health departments benefit on two levels as well; they gain effective research assistance for the present while preparing a potential workforce for the future.

“We can build a workforce within CSTE and the states,” says CSTE program associate LaToya Osmani, who works with James on projects related to Food Safety, Environmental and Occupational Health. “With the Environmental Internship Program, we can spark the interest of the best available students. Everyone wins.”

“We can build a workforce within CSTE and the states,” says CSTE program associate LaToya Osmani. “With the Environmental Internship Program, we can spark the interest of the best available students. Everyone wins.”



Left to right: Crystal James, LaToya Osmani, Ilze Jekabsone, Keisha Miller, Reghan Walsh and Dezmond Harper.

2001 Pumphandle Award Winner

The "Pumphandle Award" of the Council of State and Territorial Epidemiologists is awarded annually for outstanding achievement in the field of applied epidemiology.

The 2001 Pumphandle Award winner, Dr. James Marks, didn't set out to become an epidemiologist. In fact, in 1973 he got his M.D. and became a pediatrician. It was through chance airplane scheduling that Marks found the opportunity to pursue a life and career in public health.

"At the time, I was taking care of the infants of teen moms, and I was discouraged by the prospects the moms had," says Marks. "I'd ask them, 'What do you read for fun?' and if the answer was 'Nothing,' then I'd work more closely with those mothers." Working with Planned Parenthood to help other teens not become mothers like the ones whose babies he treated interested Marks in community and public health. So when he saw the opportunity to participate more fully, he took it.

As the old joke goes about the Delta Air Lines hub city, you've got to go through Atlanta to get there – no matter where you're going. Marks had a layover in Atlanta, and spent the day with a friend who was in the Epidemic Intelligence Service (EIS) program with the CDC. He liked what his friend, Walt Orenstein, had to say about the program, so he found out more and applied. He was accepted and spent two years as an EIS officer with the Ohio Department of Health. It was the beginning of a career that would lead through many twists and turns to his present position as the director of the CDC's National Center for Chronic Disease Prevention and Health Promotion.

"I've been fortunate to work on a variety of issues," says Marks. He says his interest in many different topics

has led to "a dilettante's career," but those who know his work understand the impact he has made on applied epidemiology.

During his time in Ohio, Marks began looking into non-infectious public health issues. He says, "It was clear that chronic illness was the real burden in public health, and we needed to address that." Over the years, he played a large part in the development of widely used risk assessment tools, including the Behavior Risk Factor Surveillance System (BRFSS), the Pregnancy Risk Assessment Monitoring System (PRAMS), and the Youth Risk Behavior System (YRBS), which are used to measure the connection between modifiable behaviors, such as smoking, exercise and drinking, and health issues. He saw the importance of these tools being used not just at a national level, but having their best, highest use at the state level. He believes that, "national surveys don't drive local policy and energies, so the states need to have their own data and research."

Marks emphasizes, "We need to be thinking about where the rubber meets the road – in the states." This is where information is disseminated to the public, those who are affected by the risks and the illnesses. For example, a PRAMS analysis in West Virginia found that 10 percent of the Medicaid patients surveyed cited transportation problems as a reason they didn't go to prenatal appointments. This had been "common knowledge" for years, but the hard data on it made it possible for the state to find the dollars for the transportation.

One part of the BRFSS analysis has looked at how many people were smoking in each state. This state specific information, along with Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) software, enabled the states to compile data that was used to sue tobacco companies for the public money spent treating these diseases.

Marks believes that soon there will be another shift in the focus of public health. The first shift came when the epidemiology world realized that chronic health issues needed to be addressed as well as infectious diseases. He believes

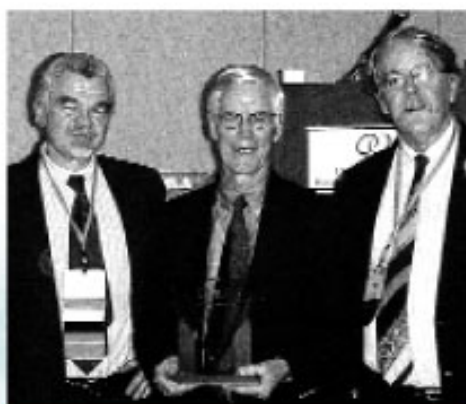
the focus will now evolve to include quality of life measures, not just mortality rates. "Even if public health is completely successful – nobody smokes, everyone exercises – we're all still going to die," he says with a wry smile. This realization, which is becoming more common, will move our society to focus on making our quality of life as good as possible and to measure it so we can assess progress.

In his current position at the National Center for Chronic Disease Prevention and Health Promotion, Marks and his staff work to determine the major risk factors for cancer, heart disease, stroke and diabetes in key populations. In addition, they are working with the factors contributing to arthritis, which is a chronic disease that doesn't kill, but definitely affects quality of life. "It's the largest disability-causing disease in people over 15," he says, "but it gets limited attention. With aggressive early treatment, you can slow the degeneration process." They've begun work with the national Arthritis Foundation to expand education programs and policy and to influence care.

Marks cites the CSTE as a leader in the shift toward recognition and earlier diagnosis for chronic diseases using local data. The CSTE work on the indicators for surveillance of chronic diseases and their risk factors is a landmark. He believes this is important for getting results, but also that using state data can serve as a way to audit how well the public health system is functioning. "We need to go from the bench to the trench, meaning to those communities that are distant from top universities, and look at the quality of care," he says. "We need to get [the information] out there, to those who never made it to the door" of the doctor's office. He believes this is one of the failures in our health care system that public health can address.

"I couldn't have asked for a better career and career path," Marks says. He has made his way with "flying" colors, ever since he had to stop over at the Atlanta airport. CSTE congratulates Dr. James Marks on his recognition as the 2001 Pumphandle Award winner.

Third Annual Jonathan M. Mann Memorial Lecture



Left to right: Dr. Jerry Gibson, Dr. Thomas M. Vernon, and Dr. Richard Hopkins

The Jonathan M. Mann Memorial Lecture is held at the annual conference of the Council of State and Territorial Epidemiologists. The lectures are sponsored by the Hoffman Family Foundation through the CDC Foundation in recognition of Dr. Mann's exemplary work as New Mexico's State Epidemiologist.

As the 2001 Jonathan M. Mann memorial lecturer, Dr. Thomas M. Vernon spoke of the perspective he has gained through his work over the years in public and private health organizations. "Having moved from the public sector to the private sector of public health, I am fortunate to have gained perspectives different from many other people," Vernon says. "I have seen both 'sides' of the public health picture, and I can better understand where each is coming from." His career path has given him a unique knowledge of the public/private partnership needed for success in preventing and curing disease.

In his current private sector position, Vernon is the vice president for Policy, Public Health and Medical Affairs for the Merck Vaccine Division. He is responsible for policy matters as they relate to state, federal and international public health agencies, including state health departments, the CDC and the World Health Organization.

Vernon was in the public sector for most of his career. He spent several years with the CDC as an epidemiologist (he was an EIS officer) – including two years in Nepal as a part of the global malaria eradication effort. He also worked with

the State Health Department in Colorado for many years, first as state epidemiologist and later as the department's executive director.

"There is often a different philosophic underlay to people going into public health versus business, and it sets a pattern of different motivations," says Vernon. "Sometimes it is hard for people to see the other side. Philosophical and experiential differences sometimes lead to tension and misunderstandings." And yet, in the effort to achieve universal immunization, the public, private and non-profit sectors do come together and are highly interdependent in what he calls the "immunization enterprise."

Vernon believes that our nation's near-universal commitment to childhood vaccination for all has been complicated in recent years. "The natural tensions between public and private sectors have been exacerbated to the detriment of our ability to vaccinate our children," he says. In his lecture at the June annual conference in Portland, Oregon, he spoke of four perspectives that when woven together create a challenge for everyone in public and private health:

"First, evident to all of us in the 'immunization enterprise,' are the successes of the last decade. They have been remarkable. The achievements aren't yet what they can be – measles as well as polio, and chicken pox for that matter, are eradicable – but we can be proud of the accomplishments.

"The participants in the 'enterprise' are highly interdependent: public, private and non-profit [he notes that advocacy groups are crucial to the cause].

"The 'immunization enterprise' is fragile. The tensions among the participants are especially on how vaccines, as a social good, should be priced and distributed. Unfortunately disagreements are too often *ad hominem* – expressed as personal attacks – complicating the fragility.

"In the present time of attacks by persons and groups opposed

to immunization – those we call the 'anti-vaccine movement' – the fragile 'enterprise' is in danger of splintering."

Vernon says he hopes and believes the public and private sectors will pull together and continue to work in partnership. Without public and private health working together, he believes it is difficult to achieve the end result – high quality vaccines, recommendations for their widespread use, requirements for their use when appropriate, and, most importantly to Vernon, health care and budget policy that assures coverage for those who cannot afford vaccinations. In this way, all children are protected.

Vernon encourages partnership in his current work in the Merck Vaccine Division. "What makes my position so highly satisfying is the quite close congruence between policy that is good for children and policy that is good for Merck," he says. "Because the ultimate goal of the private and public sectors is essentially the same, when we at MVD are actively working toward policies such as a school requirement of a vaccine, we always work with the knowledge of the state public health department and in support of the medical community and grass roots citizens' organizations."

Vernon summed up his feelings during the end of his lecture at the conference – a call for all sides to set aside any misunderstandings and tension and work together toward a common goal. "For those of us who are partners in this fragile enterprise, it is imperative that we respect our intellectual and philosophical differences, but also respect our partners' motivations, ethics and integrity. Above all, it is imperative that we treasure our common mission to eliminate the childhood vaccine-preventable diseases."

For the complete text of the third Jonathan M. Mann Memorial Lecture, given by Dr. Thomas M. Vernon on June 13, 2001, visit the CSTE Web site at www.cste.org.



CSTE Hepatitis Survey

Did you know that CSTE created and sent out a survey on the states' programmatic hepatitis issues? The CSTE hepatitis survey was conceived in late spring 2001 as part of the cooperative agreement between CSTE and CDC. The survey itself was developed by the CSTE hepatitis workgroup of the Infectious Disease Committee under the direction of Steven Wiersma, MD, MPH. Prior to sending the survey out to the 57 states and territories, external partners were asked to comment,

and a final survey was fielded as a web-based application in early summer.

It was envisioned that the survey would provide a baseline to determine activities of states with respect to hepatitis prevention and control issues. Furthermore, the impetus behind the survey was to attain information that will be utilized by CSTE to develop small competitive grants for hepatitis planning. The web-based survey, which was sent out to the state epidemiologist in each state and territory, returned with a response rate of about 70 percent! The data was summarized and presented at the National Hepatitis Conference in Richmond, Virginia this past June. The presentation also provided a forum for suggestions and feedback regarding

various state hepatitis programs, and clarified which areas need the most help and attention.

CSTE is currently in the process of drafting a request for proposal (RFP) for states that may want to apply for funding. We are planning on funding five or six selected states beginning in late fall 2001.

The summarized survey results, in PowerPoint format, are now up on the CSTE website: www.cste.org/hepatitis_survey/cste_hepatitis_survey_results.ppt. If you have any questions regarding the survey itself, or would like to know how to apply for a grant, please do not hesitate to send us an email!

Epidemiology Capacity Assessment Tool

The Epidemiology Capacity Assessment (ECA) Tool project is funded by the Centers for Disease Control and Prevention (CDC), Epidemiology Program Office (EPO). This instrument was originally developed in 1997 and piloted in 10 states for the purpose of self-assessment – the .pdf version of the tool and an associated final report may be downloaded at www.cste.org/resources.htm.

The revision of the ECA Tool was prompted by the HP 2010 Objective 23-14 – calling for CSTE to provide a broad snapshot of epidemiology capacity in states to perform essential public health services, including monitoring health status, diagnosing and investigating health problems and health hazards, and conducting evaluation and research.

In January 2001, a small advisory group was organized under the charge of the CSTE Executive Committee to begin the revision process. The current

tool includes five modules (Core, Infectious Disease, Chronic Disease, Maternal and Child Health, Environmental Health, Occupational Health, and Injury Control), and all are formatted to the framework of the Ten Essential Services of Public Health. Each module will be administered using a web-based system, which is currently being constructed.

To date, representatives from other national organizations and a few states have reviewed the Maternal and Child Health assessment tool for revision. Several pilots in states of varying MCH epidemiology and data capacity will be conducted. Each state's information is crucial to the success of this important national initiative, and will provide policymakers and federal and state partners the information they need about the status of epidemiology capacity in the nation's health departments.

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Bioterrorism Testimony

Quinisk believes that we must remember to prepare for "high probability, low consequence" events as well as more extreme possibilities. She says, "We need resources to address all scenarios – both the extreme ones and the smaller, higher probability scenarios."

Dr. Patricia Quinisk testified before the Congressional Subcommittee on National Security, Veterans Affairs and International Relations in July 2001 concerning public health aspects of terrorism. The following article was written prior to the events of September 11 and the bioterrorist acts involving anthrax that have occurred since that time.

After a simulated test in June of a biological weapons attack with smallpox — "Dark Winter" — many experts and legislators are calling for an increased focus on public health and on preparedness for such emergencies.

Quinisk cited recommendations from the Advisory Panel to Assess Domestic Response Capabilities for Terrorism Involving Weapons of Mass Destruction, on which she serves. Specific recommendations in the public health arena included:

- improving coordination with public health agencies in planning, training, and exercises
- establishing national standards and protocols for surveillance, identification, palliation, and follow-up
- establishing national standards and protocols for reporting

critical information, including mandatory reporting procedures

- clarifying the authorities and procedures for public health involvement in terrorist events, especially biological terrorist events

Quinisk also stressed the importance of clear, fast communication and a larger role for public health.

Communication between public health entities and other response agencies, as well as the public, limits terrorists' ability to create panic in the public arena. Increasing public health's role in state and federal emergency plans and training exercises will lead to better communication and coordination, which in turn will create improved response to crises.

Another recommendation in Quinisk's testimony is to include allied fields, such as laboratory, veterinary and medical. Public health laboratories need to be able to quickly identify potentially dangerous organisms and communicate to the appropriate medical and public health officials. These laboratories also need "surge capacity" to handle large numbers of specimens sent during a crisis. Veterinary laboratories should be integrated into the system since animals may become ill before humans, acting like the proverbial canary in the mine.

In a recent interview, Quinisk reemphasized one of her main testimony points, that federally funded surveillance and communications systems are invaluable and serve not only during emergencies, but for everyday work in public health. "Unlike programs designed only for emergency events, these systems can be used for work all the time," she says. "Improved infrastructure, like surveillance, communications, hospitals, laboratories can

definitely help us with crises. But if we have the appropriate infrastructure in place, other things can be taken care of as well — pandemic flu, West Nile Virus, salmonella outbreaks." This may save more lives in the meantime, while ensuring that the systems are well used, and that public health officials are well prepared to use them during an actual emergency.

Quinisk believes that we must remember to prepare for "high probability, low consequence" scenarios as well as more extreme possibilities. She says, "A large scale weaponized anthrax emergency, or something like that, is possible, but it's not probable. We're much more likely to have low consequence scenarios — the kind of thing that the guy down the street will do if he's mad at his neighbors or the IRS, and that won't be anthrax. You can't do smallpox or weaponized anthrax in your garage."

"We need resources to address all of these types of scenarios — both the extreme ones and the smaller, higher probability scenarios," says Quinisk. She also believes that by talking only about extreme examples, we are discouraging the public and many public health officials from addressing the issue appropriately. "It's easier for hospitals and other agencies to think about preparing for small to medium crises. This will also start them preparing for the larger scenarios," she says.

By working toward a comprehensive, integrated public health system that will be used for more common diseases and situations, Quinisk believes that we will be better prepared if a terrorist event occurs.

Quinisk is the Medical Director and State Epidemiologist for the Iowa Department of Health, and is a past President of the Council of State and Territorial Epidemiologists.



Please save the following dates
for the 2002 CSTE Annual
Conference in Kansas City, MO:

June 9 – 12, 2002
The Westin Crown Center
Kansas City, MO

See you there!

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 Epidemiology. The 2001-2002 Executive Committee members are:

Office	Name and State	Term Expiration
President	Dr. Matthew Cartter - CT	2002
Vice-President	Dr. Jerry Gibson - SC	2002
President-Elect	Dr. Gianfranco Pezzino - KS	2002
Secretary-Treasurer	Dr. John Middaugh - AK	2002
Members-At-Large	Dr. Jesse Greenblatt - NH	2003
	Dr. Bela Matyas - MA	2002
	Dr. C. Mack Sewell - NM	2004
Infectious Disease Epidemiology	Dr. Suzanne Jenkins - VA	2002
Chronic Disease/Oral Health/MCH	Dr. Ursula Bauer - FL	2004
Environmental/Occupational/Injury	Dr. Steven Macdonald - WA	2003



Council of State and Territorial Epidemiologists

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