COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS

CSTEupdate

SPRING 2009

contents

CSTE president's message

Dear CSTE members,

How quickly things can change! Our last newsletter, following the 2008 annual meeting, reflected a tone of "work-as-usual" and was devoted to moving forward with confidence in the work of CSTE, drawing attention to new priorities and opportunities.

Since then, at least two momentous changes have occurred.

The first was the national election with the change in administrations. President Obama has promised that he will make health care reform a priority of his administration with a hope for increased access to care, as well as strong support for health information technology. If progress can be made in these areas, it could profoundly promote better public health through decreased disparities, improved long-term health through healthier lifestyles and preventive medicine, and increased, rapid public health access to more accurate health information at the population level.

On the other hand, the other major change since our last newsletter is the current dismal fiscal crisis, which now threatens our means to achieve progress in the public health areas on which we work so hard. The cuts in public funding threaten our public health programs, our staffing, our grants, and potentially even the viability of some of our departments. It is affecting travel and is likely to decrease attendance at national meetings, including our CSTE national conference in June. Anxiety is the norm now.

How should CSTE respond to these events? While change is difficult and the fiscal climate is very ominous, these events create an excellent opportunity for us all to reassess priorities and better focus our future work. Obviously, President Obama's interest in health issues will create a national discussion of ways to promote public health. And at the time of writing this message, even the fiscal crisis appears to likely result in significant one-time funding for public health through the stimulus package.

CSTE has a very credible national reputation for reasoned, science-based recommendations and consultation in developing national public health policy. Many of our current projects will continue to move full steam ahead. They include our work on the national public health surveillance bill, now entitled "Strengthening America's Public health System Act" which was recently introduced into the House of Representatives, the annual state reportable conditions assessments and revisions of the nationally notifiable conditions case definitions, the nation Epidemiology Capacity Assessment survey, and the public health indicators work.

CSTE is working hard to promote the interests of all of our members, and it is an exciting if challenging time to be involved in the process. If you have concerns, ideas, or time to offer, please let us know.

We'd like to hear from you.

Perry Smith
CSTE President

the national institute for occupational safety and health

The National Institute for Occupational Safety and Health (NIOSH) and the Council of State and Territorial Epidemiologists (CSTE) are pleased to announce the publication of the document Guidelines for Minimum and Comprehensive State-based Public Health Activities in Occupational Safety and Health.

The Guidelines were prepared collaboratively between the CSTE Occupational Health Surveillance Workgroup and NIOSH. They provide a useful framework for building state and local capacity in public health programs in occupational safety and health. They outline the minimum essential components that should be in place in state and local public health programs, even with very limited resources, and then go on to describe functions and activities of a comprehensive program.

The *Guidelines* are posted at www.cdc.gov/niosh/docs/2008-148/default.html. You can obtain a paper copy from CSTE by contacting Erin Simms (esimms@cste.org).

For comments and questions, please contact the lead author, Martha Stanbury, at stanburym@michigan.gov.

executive director's message

It's been an interesting few months, what with a new administration in Washington, D.C., and the continuing economic downturn. During all that's going on, CSTE is working to stay focused on our goal of providing support for our members and their activities.

We are also focusing on how the economy and potential changes in public health policy could affect your work environment and funding, which inevitably affects the overall impact made on public health efforts. With that in mind, there are opportunities arising from some of the turbulence.

A few unique opportunities are presented in the form of stimulus funds – some for public health directly and some that will indirectly translate into improved public health activities. A good deal of the public health and CDC funding is to go directly to states, though at this writing, it is still not clear what may be used for prevention and wellness programs.

The CSTE office and leadership are working with CDC and legislators on the Hill to discuss programs and resources that states and other organizations can support with this funding. We have attempted to make the case for supporting epidemiologic capacity in states for short-term hires and fellowships. For example, one idea is that the Applied Epidemiology Fellowship program could be extended to help state public health departments with potential budget-related staffing issues.

CSTE supports start-up healthcare associated infections (HAI) programs; a state role in surveillance and assistance is needed in healthcare areas to address this issue. We are also supporting the reinstatement of $30 million in the ELC program at CDC, which has been lost to states since 2002. Another activity we strongly support is the use of health information technology (HIT); it's critical that use of electronic lab reporting and other technology goes nationwide. The outcomes of these efforts and the results of the stimulus work are not known, but we will continue to advocate for these issues.

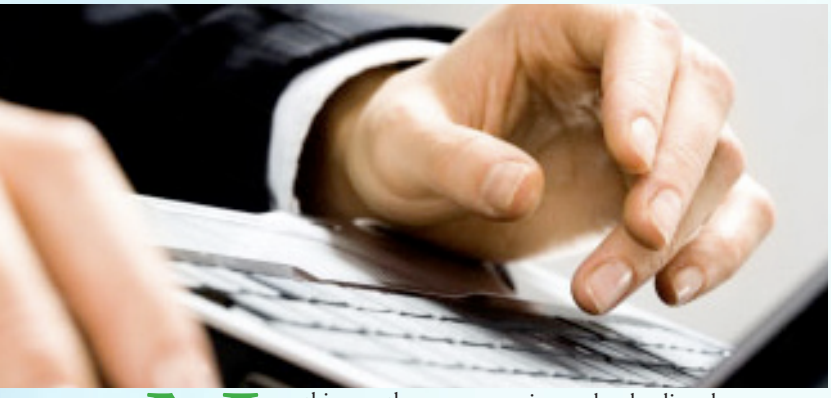
We are very fortunate to have a continued strong relationship with CDC and the ability to support activities at the state and local level through our partnership agreement with them. This includes grants for major projects in HIV/AIDS, environmental health, workforce development, maternal and child health, and information technology. It also includes a number of special programs in conjunction with CSTE's Annual Meeting, such as meetings for Environmental Health Tracking, Occupational Health, and state public health veterinarians. This year, we will add a special meeting of influenza surveillance coordinators as well, and we hope the list continues to grow. We know that it is especially important in this economy to support members' participation at the CSTE Annual Conference. We are working hard to make sure some funds are available for full and partial scholarships to support this important annual event.

Even during such unsettling times, CSTE as an organization is moving into 2009 on a strong footing with our primary public health partners, including federal agencies and other public health associations. We're looking forward to continuing our leadership in workforce and capacity development as well as many other areas of public health.

Pat McConnon

P.S. Stay tuned for the new epidemiologic capacity assessment, which will be coming your way this year. It has become a vital tool for CSTE to make our case to CDC and among other public health professionals. We need your support to make it successful!

new CSTE online discussion forums



New this month on the CSTE Web site (www.cste.org) is the CSTE discussion forums, a great hybrid of a discussion board and a listserv. Many subcommittees have already begun to take advantage of this great tool for posting minutes and agendas, discussing group topics, and uploading documents and resources. Members already have access to this wonderful new communication tool. Contact the CSTE staff if you have any questions.

Be sure to also check the CSTE Web site for the latest CSTE news, publications and more!

Masters joins CSTE staff

Amanda Masters joined CSTE in November 2008 as the new Workforce and Fellowship Coordinator. A native Georgian, she received her Bachelor's degree in Biology from the University of Georgia. Following that, she obtained her MPH in Health Policy from the Rollins School of Public Health at Emory University.

Amanda previously worked on Childhood Cancer Survivorship research and programming with Children's Healthcare of Atlanta. She is looking forward to working with the Fellowship program and is excited to be at CSTE.

Amanda can be reached at amasters@cste.org.

update: reformatting of nationally notifiable conditions position statements

CSTE has reformatted the Nationally Notifiable Conditions position statements to include condition-specific data elements, algorithms for case reporting and case classifications. Currently, all conditions have gone through extensive review by CSTE, CDC and APHL subject matter experts.

Background and Purpose: CSTE is responsible for maintaining and updating a list of reportable diseases/conditions for each state and territory as determined by the states and territories. In 2007, CSTE passed the position statement 07-EC-02 02 describing the recommendations made by the federal American Health Information Community (AHIC) to CSTE. In early 2007, the workgroup and AHIC adopted case-reporting recommendations which included:

- Recommendation 2.0 By April 30, 2007, CSTE, in collaboration with CDC, should define an on-going process to be used in establishing a common list of nationally notifiable conditions to be reported to all levels of public health and their associated standardized case definitions including the data elements to be reported.
- Recommendation 2.1 By August 1, 2007, CSTE, in collaboration with CDC, should provide to HHS the common list of nationally notifiable conditions and the first set of case definitions including the list of common and disease specific data elements to be reported. Subsequent sets of case definitions will be delivered on a scheduled basis as defined by the process resulting from Recommendation 2.0 above.

In 2008, CSTE passed the position statement 08-EC-02 describing the two separate mechanisms for notifying CDC of a case of immediate importance (Class A agents, eradicated and IHR conditions) or conditions meeting the standard notification process (all other conditions).

This process also merges with the work accomplished by the CSTE State Reportable Conditions Assessment (SRCA) to develop a knowledgebase of reportable and notifiable condition requirements.

Goal: This effort aimed to standardize the formatting and technical vocabulary so that case definitions used for state and local reporting and notifications to CDC can be accomplished electronically from and among contributors and users of these systems.

Public Health Impact: This establishment and maintenance of the CSTE official list of Nationally Notifiable Conditions, along with standardized reporting definitions, will help CSTE and CDC partners to achieve more complete and timely reporting of potential notifiable condition cases through expanded use of automated electronic case reporting. Public health not only has a responsibility to keep laboratories, hospitals, and healthcare providers serving the population of one state informed of their reporting requirements, public health also has a responsibility to keep laboratories and hospitals serving the needs of multiple states informed of those states' reporting requirements.

Methodology: Beginning in July 2008, CSTE contracted with a team of medical epidemiologists and a medical informatician to reformat (without modifying the case definition) into an approved format that was developed by the CSTE Surveillance Coordination Subcommittee and approved by the CSTE Executive Board. There are essentially three phases to accomplish the reformatting of over 70 position statements.

Phase I: The position statements were reformatted by the contractors and submitted for CSTE epidemiology and CDC and APHL subject matter expert (SME) review between July and November 2008. CSTE SMEs were authors of position statements related to the disease being reformatted and CDC and APHL SMEs were identified by their respective organizations.

Phase II: After each position statement was revised by the contractors for the final time in November 2008, the position statements were posted to the CSTE Position Statement Revision Forum in January 2009 for membership review and verification of content. At this point, all CSTE, CDC and APHL SMEs were emailed directions regarding access to the Forums, process for revising and submitting comments and provided the emails of each SME for each condition so that collaboration via email and phone could take place. CSTE hosted numerous conference calls, webinars and discussions to clarify the process and encourage cross-agency collaboration. During this process, CDC submitted Case Notification Requests (CNRs) that included information for the notification process from state health departments to CDC (either immediate or standard notification). This information needs to be incorporated into each position statement to specify the notification process.

Phase III. Position statements undergoing further revisions to the content and case definitions need to be submitted to CSTE electronically on the CSTE website (members only section). All position statements that underwent the reformatting process will be discussed at the Sunday preconference workshop at the June CSTE Annual Conference in Buffalo. The submitted position statements (with significant changes to the case definition) will be open for discussion at the individual steering committee sessions at the Annual Conference.

Technical Implementation Guides: The medical informatician developed an accompanying document including the LOINC, SNOMED and ICD-9 and ICD-10 codes for electronic laboratory reporting. The Technical Implementation Guides will not be reviewed at the annual conference but will be finalized three months after the approval of the final position statements.

At the annual conference: Reformatted NNC position statements will be discussed at the Sunday June 7th preconference workshop and allow for further collaboration between CSTE members and CDC colleagues. After further revisions and input, position statements will be brought before their respective individual steering committee reviews on June 9th and 10th (Tues and Wed) of the Annual Conference. Final voting of all position statements will take place on Thursday at the Executive meeting.

the council to improve foodborne outbreak response (CIFOR)

In the fall of 2005, CDC along with CSTE convened the Council to Improve Foodborne Outbreak and Response (CIFOR). CIFOR is a multidisciplinary working group organized to increase collaboration across the country, relevant areas of expertise and those affected by foodborne outbreaks to reduce the burden of foodborne illness in the United States. Currently, CIFOR members include representatives from:

- CSTE
- AFDO (Association of Food and Drug Officials)
- APHL (Association of Public Health Laboratories)
- ASTHO (Association of State and Territorial Health Officials)
- CDC (Centers for Disease Control and Prevention)
- FDA (Food and Drug Administration)
- NACCHO (National Association of County and City Health Officials)
- NASDA (National Association of State Departments of Agriculture)
- NEHA (National Environmental Health Association)
- USDA (U.S. Department of Agriculture)

CSTE and NACCHO are CIFOR co-chair organizations and have three representatives each. CSTE Members of CIFOR:

- Tim Jones (TN) - Co Chair
- Bela Matyas (CA) and Bill Keene (OR) - CSTE Council (CIFOR) representatives

Pat McConnon (CSTE) is the chair of the CIFOR Governance Committee.

CIFOR has identified several workgroups and projects.

- The CIFOR Guidelines workgroup is developing guidelines for foodborne disease outbreak detection and response. Targeted to pertinent local, state and federal agencies, the Guidelines will describe the overall approach to foodborne disease outbreaks, including preparation, detection, investigation, control and follow-up. The Guidelines will also describe the roles of all key organizations in foodborne disease outbreaks. The workgroup includes representatives from local, state and federal agencies with expertise in epidemiology, environmental health and laboratory science.

  The workgroup has reviewed existing guidelines and peer-reviewed publications to identify typical and emerging new practices in foodborne disease outbreak response. Technical experts from a number of foodborne disease programs around the country, as well as a variety of federal agencies, have also been interviewed to identify practices that may not have reached the literature. A public review and comment process on the draft Guidelines took place, and changes were incorporated into the document.

  The Guidelines are intended to be used as a reference document that complements existing procedures to fill gaps and update agency-specific procedures, to create missing procedures, and to target training of program staff. The Guidelines will be published in spring 2009 in electronic and hard-copy formats and made available at the CSTE Annual Conference in Buffalo.
- CIFOR's Food Safety Clearinghouse is an online repository of food safety resources developed by state and local health departments, laboratories, academic institutions, non-governmental organizations and governmental agencies to share knowledge across jurisdictions. Users can search for existing tools and resources as well as submit new tools and resources to CIFOR for review and posting. A workgroup composed of CIFOR member organizations monitors submissions to the clearinghouse.
- The foodborne illness complaint workgroup's objective is to obtain information about foodborne illness complaint systems, discuss the pros and cons of those systems, as well as those of any potential national system, and then make recommendations to CIFOR.
- The outbreak training workgroup evaluates various training courses that focus on foodborne disease outbreak detection and investigation. Using the information obtained, the workgroup provides recommendations to enhance each training program and then consolidates the knowledge gained through the evaluations to identify gaps.
- The epidemiology/laboratory reporting project is an ongoing project that seeks to design a system that produces daily epidemiology/laboratory reports using a standard format to allow report-sharing among jurisdictions. The effect of this new system on the speed of outbreak detection and successful investigation will be assessed after one year. If successful, such systems can be applied more widely. This project is supported by CSTE and APHL.
- The industry workgroup defines areas where food industry representatives and public health agencies can work together to improve foodborne outbreak response. Under its purview, a number of task groups are focusing on recalls, tracebacks and employee health.

CIFOR held its semiannual meeting in March in Salt Lake City, Utah, with a new sense of excitement as the Guidelines near conclusion. CIFOR has gained esteem at national conferences and events as a new solution to the gaps in foodborne outbreak response. Its projects and workgroups are making great progress, and its meetings and conference calls continue to be productive and include lively discussion. Additional information about CIFOR can be found at the CSTE Web site or at www.cifor.us.

the association of state and territorial dental directors

The Association of State and Territorial Dental Directors (ASTDD), which is one of the ASTHO affiliates, is a 501(c)(6) non-profit organization representing the directors and staff of state and territorial public health agency programs for oral health. In 2008 ASTDD celebrated its 60th anniversary with 54 members and 88 associate members – a small but very active membership.

ASTDD is governed by a nine-member Executive Committee comprised of five elected officers, three member directors and one associate member director. Ex-officio members include the executive director, the cooperative agreement manger and the editor of the newsletter. Most programmatic activities are accomplished through committees and consultants.

ASTDD members serve as committee chairs while consultants provide project coordination, report writing and technical assistance to states. Most ASTDD consultants have worked with the Association for 7-10 years – a major advantage for coordination, consistency and sustainability. ASTDD maintains three primary means of communication: a Web site (www.astdd.org), a member listserv and a quarterly newsletter.

ASTDD has five-year cooperative agreements with CDC's Division of Oral Health and HRSA's Maternal and Child Health Bureau. Most state oral health programs began with MCH funding; many continue to receive some monies through the Title V block grant and discretionary grant programs, but funding varies considerably across states. CDC now provides infrastructure funding to 16 state oral health programs, unlike other CDC programs that provide funding for all states. Lack of consistent funding continues to be a challenge in addressing the many oral health disparities documented through the ASTDD/CDC National Oral Health Surveillance System (NOHSS) and progress reports on Healthy People 2010.

> *"ASTDD looks forward to a continued relationship with CSTE and its memebers."*

Through partnerships with more than 20 national organizations and active involvement of its members, ASTDD:

- formulates and promotes the establishment of national dental public health policy;
- assists state dental programs in the development and implementation of programs and policies for the prevention and surveillance of oral diseases;
- builds awareness and strengthens dental public health professionals' knowledge and skills by developing position papers and policy statements;
- provides information on oral health to health officials and policy makers; and
- conducts conferences for the dental public health community.

Since January 2008, ASTDD has taken a lead role in helping to convene national workgroups to coordinate testimony at HP 2020 regional hearings and to develop oral health objectives.

A number of years ago ASTDD developed a relationship with CSTE when selecting indicators for inclusion in the National Oral Health Surveillance System. CSTE serves as an approval body for such indicators. The ASTDD Data Committee is in the process of evaluating the NOHSS and determining if/what additional indicators might be needed to track other oral diseases or population groups.

ASTDD also works with many state MCH epidemiologists on oral health needs assessment, analysis and interpretation of oral health data, and development of oral health surveillance systems. ASTDD created the Basic Screening Survey (BSS), which is used in states to collect oral health data in school-age children; recent revisions provide guidance for use with preschool populations. Future enhancements will include more information for state epidemiologists on sampling methodology and more effective data collection for adults and seniors.

ASTDD looks forward to a continued relationship with CSTE and its members.

2009 epidemiology capacity assessment

The 2009 Epidemiology Capacity Assessment measures the current status of epidemiologic capacity, competence-specific training needs, and barriers to recruitment and retention. This year's assessment was launched into the field on April 1, 2009. The Assessment includes components for tribal epidemiologists, local epidemiologists and modules for individual state-level epidemiologists, chronic disease and maternal and child health. Preliminary results will be presented at the 2009 CSTE Annual Conference. If you have any questions, please contact the epidemiology program staff.

policy: surveillance bill

Washington, D.C. is buzzing with activity this winter and spring as the city has been transitioning to the new administration. CSTE and Washington liaison Marcia Mabee along with the CSTE staff are keeping a close eye on the activity. The Executive Board meeting and Hill Day in March were a successful way to demonstrate CSTE to members of Congress.

As reported in the latest edition of the CSTE Washington Report, available at www.cste.org, public health organizations including CSTE worked to influence the stimulus plan and to seek increased funding. "CSTE is seeking a boost in one-time funding for several elements of the 'National Integrated Public Health Surveillance Systems and Reportable Conditions Act.'"

Please keep up to date on the latest news on the CSTE Web site.

HIV/AIDS surveillance coordinator orientation manual

The HIV/AIDS surveillance coordinators have developed an HIV/AIDS surveillance coordinator orientation manual intended for state, territorial and city surveillance coordinators.

The manual supplements CDC's Technical Guidance for HIV/AIDS Surveillance Programs. It serves as a quick guide to consult for an overview of the position of surveillance coordinator and walks through important meetings to attend, where to find resources and CSTE tools.

The surveillance coordinator orientation manual will be available electronically at www.cste.org. Chapters include:

- What is Surveillance?
- Budgeting and Resource Management,
- CSTE, and
- Resources and Tools.

CSTE is excited to make this orientation manual available to epidemiologists working in HIV/AIDS to increase knowledge and help surveillance coordinators be more effective in their positions.

the CDC/CSTE applied epidemiology fellowship update

The CDC/CSTE Applied Epidemiology Fellowship is a program developed to strengthen the workforce in applied epidemiology at the state and local level while providing advanced, on-the-job training to recent public health graduates during a two-year placement. Currently, there are 33 fellows from Classes V and VI placed in local and state health agencies across the country.

CSTE accepted applications for the new Class VII fellows from December 2008 to February 2009. Program areas available for Class VII fellows include Infectious Disease, Chronic Disease, Injury, Maternal and Child Health, Birth Defects, Environmental Health, and Substance Abuse. The CSTE National Office will complete the application process in early 2009 and new Fellows will be placed at their host agency between June and August 2009.

CSTE looks forward to another year of training future leaders in epidemiology and continuing to strengthen the applied epidemiology workforce through this distinguished Fellowship program.

CSTE members present at APHA meeting

CSTE members presented at the 136th APHA Annual Meeting and Exposition Nov. 3-7 in Washington, D.C. We have included a brief description of each presentation below for your information. Congratulations to all the presenters!

New Initiatives in HIV Surveillance – the Florida Perspective

Becky Grigg, Ph.D.
Surveillance Program Administrator
Florida Dept. of Health
Bureau of HIV/AIDS
4052 Bald Cypress Way, BIN#A09
Tallahassee, Florida 32399-1715

Topic
Research – Epidemiology and Surveillance

Learning Objectives:
1. Identify new initiatives in HIV surveillance
2. Describe the Medical Monitoring Project (MMP), HIV Incidence Surveillance, and HIV Resistance Surveillance
3. Identify uses for incidence, resistance, and MMP data

Background:
HIV surveillance no longer focuses solely on HIV and AIDS prevalence; it now encompasses incidence, HIV resistance, utilization of health care, and morbidity. The Centers for Disease Control and Prevention provides funding to the Florida Bureau of HIV/AIDS to integrate new HIV surveillance initiatives with ongoing HIV/AIDS case surveillance.

Methods:
Serologic testing algorithm for recent HIV seroconversion (STARHS) enables us to distinguish between recent and long-standing HIV-1 infection.

Variant, atypical, and resistant HIV surveillance (VARHS) evaluates the prevalence of HIV drug resistance among individuals newly diagnosed with HIV in public health settings.

MMP links patient-reported behavioral information collected by a questionnaire with clinical information abstracted from provider medical charts.

Results:
From October 2004 to June 2006, Florida has received results on 1,574 STARHS specimens. Of these results, 385 (24.4%) were reported as "Recent" infections, and 1,189 (75.6%) were reported as "Long-term" infections.

VARHS was implemented in three Florida counties in 2006. As of December 2006, we identified 63 specimens that meet the eligibility criteria for VARHS.

The Florida MMP team has begun surveying providers, and will begin interviews with patients and medical abstractions later this year.

Conclusions:
These new surveillance initiatives will allow public health officials to more effectively and completely monitor the epidemic, allocate resources, and plan and implement programs.

Light and Heavy Smoking During Pregnancy: Prevalence and Associations with Perinatal Risk Factors and Birth Outcomes, Maryland, 2001-2006

Lee Hurt, MS, MPH
Center for Maternal and Child Health
Family Health Administration
Maryland Department of Health and Mental Hygiene
201 W. Preston Street, Room 309
Baltimore, Maryland 21201

Background:
Smoking during pregnancy has been established as a risk factor for poor birth outcomes including preterm birth and low birth weight. The goal of this analysis was to understand the prevalence and perinatal risk factors of light and heavy smoking during pregnancy among Maryland women.

Methods:
Data were obtained from a stratified random sample of 9,225 mothers who delivered live infants during the years 2001-2006 and completed the Maryland Pregnancy Risk Assessment Monitoring System (PRAMS) survey. Descriptive and bivariate analyses were performed using SUDAAN. Smoking during pregnancy was based on the number of cigarettes smoked daily during the last three months of pregnancy.

Results:
In Maryland, of the 9.5% of mothers who reported smoking during pregnancy, 4.5% smoked ≤ 5 cigarettes/day (lighter smokers), and 5.0% smoked > 5 cigarettes/day (heavier smokers). Smoking was most prevalent among white non-Hispanics and mothers < 25 years of age.

Smokers were less likely than non-smokers to take pre-pregnancy folic acid daily (Heavier: 11.9%, Lighter: 21.7%, Non: 32.4%), more likely to report an unintended pregnancy (Heavier: 62.4%, Lighter: 49.7%, Non: 39.6%), and also more likely to receive late or no prenatal care (Heavier: 34.3%, Lighter: 28.3%, Non: 22.2%).

Smokers had higher percentages of low weight (< 2,500g) births (Heavier: 15.1%, Lighter: 11.3%, Non: 7.4%) and preterm births (< 37 weeks) than nonsmokers (Heavier: 14.3%, Lighter: 11.4%, Non: 9.4%).

Discussion:
This analysis indicates that both light and heavy smoking during pregnancy is associated with perinatal risk factors and poor birth outcomes.

Asthma Deaths in Hispanic and Asian Subgroups in California

Liza Lutzker, MPH
Epidemiologist, California Breathing
Environmental Health Investigations Branch
California Department of Public Health
850 Marina Bay Parkway, P-3
Richmond, CA 94804

Summary:
Over five million people have asthma in California. Asthma deaths represent more severe, uncontrolled disease. In California and nationwide, comparisons of asthma outcomes for sub-categories of minority race groups are seldom reported. This is despite the fact that almost half of California's population is of Hispanic or Asian descent. We examined asthma deaths in Hispanic and Asian subgroups in California using vital statistics data. Because asthma death is a rare event, we combined 2000-2004 data. There were substantial variations among the subgroups when age-adjusted asthma death rates were compared. Specifically, Native Hawaiian/Pacific Islanders, Filipinos, Vietnamese, Indians, and Puerto Ricans/Cubans suffer higher rates of asthma deaths that are masked when they are combined into the broader Hispanic or Asian categories.

Ninth U.S. Case of Vancomycin-Resistant Staphylococcus aureus - 2007

Jennie L. Finks, DVM MVPH
Epidemic Intelligence Service Officer
Michigan Department of Community Health
Communicable Disease Division
Lansing, MI 48913

Summary:
"Ninth U.S. Case of Vancomycin-Resistant Staphylococcus aureus - 2007" (abstract ID=190649) was presented at the Epidemiology Late Breakers Epidemiology Poster Session II. The poster presentation included details of the case and contact investigations as well as a comparison to previous cases.

CSTE members present at APHA meeting

(continued)

U.S.-Mexico Border HIV/AIDS Epidemiologic Profile

Lily N. Foster, MSPH
Program Manager
HIV & Hepatitis Epidemiology Program
New Mexico Department of Health
1190 St. Francis Dr., N1350
Santa Fe, NM 87502

Summary:
This presentation covered a multi-state and bi-national effort to create the first U.S.-Mexico Border HIV/AIDS Epidemiologic Profile that would provide a comprehensive description of the current status of the epidemic in the border region.

NVAC's Vaccine Finance Recommendations

Gus Birkhead, D, MPH
Deputy Commissioner, Office of Public Health
New York State Department of Health
Corning Tower ESP RM 1415
New York, NY 12237

Summary:
Gus Birkhead, in his role as the Chair of the National Vaccine Advisory Committee, presented on the NVAC's vaccine finance recommendations that were adopted at its September 2008 meeting. A summary of the recommendations is at http://www.hhs.gov/nvpo/nvac/VACVFWGRecSeptVote090808.pdf. The final report on vaccine finance with recommendations will be posted by the end of the year on the NVAC website. An MMWR Notice to Readers is planned.

Tobacco Control – New York State

Summary:
Dr. Birkhead also presented in a session on Tobacco Control on New York State's petition to the FDA to allow 1) nicotine replacement therapy (NRT) to be sold at all locations where cigarettes are sold, 2) all daily unit-dose packaging for NRT, and 3) to reduce the amount of information on nicotine in the NRT package insert to be more along the lines of the safety information now on cigarette packs. More information is available at http://www.health.state.ny.us/press/releases/2008/2008-01-28_commissioner_petitions_fda_to_make_nicotine_therapies_easy_to_buy.htm.

Rapid Response and Containment of a Cryptosporidium Outbreak in Sedgwick County, Kansas

Deborah B. Fromer, MT(ASCP), MPH
Epidemiologist
Health Protection and Promotion
Sedgwick County Health Department
1530 S. Oliver, Suite, 270,
Wichita, KS 67218

Summary:
From August to mid-October 2007, an outbreak of cryptosporidiosis resulted in gastrointestinal illness in 77 persons residing in Sedgwick County, Kansas. To disseminate prevention messages rapidly, local public health officials utilized the media via newspapers, radio and televised reports, notified area physicians through blast faxes, and advised all area pool managers and day care centers of the increased potential for cryptosporidiosis in the community.

Pertussis: A Cluster of Linked Cases in a Wichita, Kansas Primary School

From September 26 to October 29, 2007, an outbreak of Bordetella pertussis in a Kansas primary school with high vaccination rates was investigated. Twelve cases of confirmed B. pertussis infection were identified. The start of the outbreak could be linked to a specific second grade classroom. The Wichita experience with pertussis confirms the value of communication between local health departments and the schools, particularly school nurses, clear disease-reporting guidelines, community wide surveillance, and aggressive outreach.

California State Epidemiological Profile: Patterns of alcohol, tobacco and other drug (ATOD) consumption and consequences.

Stephen J. Wirtz, Ph.D.
Chief, Violent Injury Surveillance Unit
Injury Surveillance and Epidemiology Section, EPIC Branch
California Department of Public Health
MS 7214, P.O. Box 997377
Sacramento, CA 95899-7377

Authors: Steve Wirtz, PhD, Stephen Bright, PhD, and Anura Ratnasiri, MSc

Affiliation: Epidemiology and Prevention for Injury Control (EPIC) Branch, California Department of Public Health

Summary:
Presents a brief review of California's SAMHSA-funded (through Synectics) State Epidemiological Outcomes Workgroup (SEOW) Project, our process of creating state and county profiles and building capacity for ongoing surveillance, and selected data from the profile reports.

Improving California's Surveillance System for Fatal Child Abuse and Neglect

Authors: Steve Wirtz, PhD, Sibylle Lob MD, MPH, Dale Rose, PhD, Christine Brennan, MPH, and Patrick Fox, PhD

Affiliation: EPIC Branch (Wirtz) and Institute for Health and Aging, University of California San Francisco (4 other authors)

Summary:
Describes California's efforts to improve its Fatal Child Abuse and Neglect Surveillance system through the use of multiple-data state sources and data collected directly from county child death review teams (CDRTs). Results from the most recent "reconciliation audit" of all available sources using CDRTs as the "gold standard" show substantially more cases than any single source. Presents a new classification system developed to improve CDRT's consistency in defining and counting child maltreatment-related fatalities.

North Carolina Disease Event Tracking and Epidemiologic Collection Tool

Jean-Marie Maillard
Medical Director
North Carolina DHHS
1902 Mail Service Center
Raleigh, NC 27699

Summary:
A presentation was made at the APHA annual meeting in San Diego by Jean-Marie Maillard, MD, MSc, Medical Director, Communicable Disease Branch with the NC Division of Public Health. The topic was the North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT), a system that provides statewide early event detection and timely public health surveillance data to public health officials and hospital users. The presentation included examples of how NC DETECT has improved public health practice in North Carolina, and described how the system fits into an overall informatics strategy for the state health agency. The presentation focused on how NC DETECT has brought about system change in state public health, what challenges it has solved, and what challenges remain.

Illicit Drug Use on the US-Mexico Border: A Binational Problem In Need of Binational Solutions

Nina Shah
New Mexico Department of Health
1190 St. Francis Drive Room N. 1350
Santa Fe, NM 87502

The Presentation Panel

Mexico produces the majority of methamphetamine entering the U.S. as well as a third of all heroin sold, and serves as the principal source of foreign-produced marijuana to U.S. markets. It is also a major transit route for cocaine coming into the U.S. from South America. The substantial flow of illicit drugs northward from Mexico to the U.S. adversely affects the health of populations in both countries. The "spillover" effect from these large drug shipments has fueled increased drug use in northern Mexico.

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Although rates of illicit drug use in most of Mexico remain lower than those in the U.S., in Baja California the prevalence of illicit drug use is three times the Mexican national average, and it's largest city, Tijuana, has the fastest growing population of injection drug users in the country. On the U.S. side, New Mexico has led the nation in overdose mortality, Arizona has seen an increase in drug-related violence, and San Diego has the highest proportion of methamphetamine treatment admissions in the nation. In contrast, cocaine is the major drug problem on the Texas side of the U.S.-Mexico border. Illicit drug use in the U.S.-Mexico border region is a bi-national public health problem requiring bi-national solutions.

Session Objectives:
Characterize illicit drug use patterns in the U.S.-Mexico border region. Evaluate the effects of illicit drug use on health on both sides of the border. Identify bi-national interventions to reduce the impact of illicit drug use on health in the border region.

Unintentional drug overdose death trends in border and non-border counties of New Mexico, 2003-2007

Summary:
We analyzed medical examiner data for all drug overdose deaths in New Mexico during 2003-2007. We compared age-adjusted death rates for New Mexico border and non-border counties (the five border counties had significant population within 100 kilometers of the US-Mexico border). Statewide, there were 1,588 unintentional drug overdose deaths during these five years (16.5 deaths per 100,000). Compared to non-border counties, border counties had significantly higher death rates per 100,000 from all drugs, any prescription drug, prescription opioids other than methadone, and antidepressants. Death rates from heroin, cocaine, methamphetamine, methadone, tranquilizers and alcohol/drug combinations were similar. Highest rates of prescription drug overdose death, specifically from opioids other than methadone, were observed among decedents in New Mexico border counties. Proximity to Mexico may indicate increased prescription drug availability in bordering counties, and results may imply increased prescription drug abuse at the border. Preliminary treatment data also shows clusters of opioid abuse in the same area.

Infant Botulism Treatment and Prevention Program, California Department of Public Health (CDPH), Richmond, CA

Jessica Payne, MPH
Infant Botulism Treatment and Prevention Program
Division of Communicable Disease Control
Center for Infectious Disease
California Department of Public Health
850 Marina Bay Parkway, Rm E361

Authors: Jeremy Sobel, MD, MPH, Center for Disease Control and Prevention (CDC), Atlanta, GA; Stephen S. Arnon, MD

Background:
Infant (intestinal toxemia) botulism (IB) was first recognized as a novel infectious disease in 1976 in California that manifest clinically as an acute flaccid paralysis. Coincident with the recognition of IB, CDPH began surveillance and research activities to identify risk factors and modes of transmission that were subsequently continued jointly by CDPH and CDC.

Methods:
Complete case ascertainment in California has been accomplished through statewide diagnostic testing provided by the CDPH infant botulism laboratory. CDC identified cases in non-California states through a passive reporting system combined with providing diagnostic laboratory testing to approximately 30 states.

Results:
In the 30 years 1976-2006 a total of 2,417 laboratory-confirmed cases of IB were hospitalized in the U.S., nine outpatient cases were also recognized. Approximately 50% of hospitalized cases required intubation and mechanical ventilation. More than 91% of cases occurred between one week and six months of age in a unique age distribution. Formula-fed infants were significantly younger at onset of illness (8.1 wks, mean) than were breast-fed infants (15.6 wks, mean). Cases occurred in all major racial and ethnic groups. Incidence was higher in the western U.S., Alaska, Hawaii and five contiguous mid-Atlantic states. Feeding honey to infants was the only identified avoidable risk factor for contracting IB.

Conclusions:
Infant botulism occurs nationwide. Most cases were identified because their acute paralysis necessitated hospitalization. The full clinical spectrum of illness remains unascertained. The role of dietary influences, especially breast and formula feeding, awaits clarification through a California case-control study now undergoing analysis.

Gender Differences in the Progression to AIDS and Mortality in the Houston Surveillance Project

Raouf R Arafat MD, MPH
Director, Office of Surveillance and Public Health Preparedness
Assistant Director, Houston Department of Health and Human Services
8000 N. Stadium Dr.
Houston, TX 77054

Authors: Raouf Arafat, MD, MPH 1, Adebowale Awosika-olumo, MD MS MPH 2, Marcia Wolverton, MPH 3, James Gomez 2, Lydwina Anderson 2. (1) Houston Department of Health and Human Services, 8000 N Stadium Dr 8th floor, Houston, TX 77054. (2) Houston Department of Health and Human Services, Bureau of Epidemiology, 8000 N. Satdium Drive, Houston, TX 77054. (3) Bureau of Epidemiology, Houston Department of Health and Human Services, 8000 North Stadium 4th Floor, Houston, TX 77054.

Objective:
To examine the differences between genders in the progression to AIDS and early mortality in persons living with HIV/AIDS by racial/ethnic backgrounds.

Method:
We analyzed, from a multi-center hospital and clinic based cohort, 5,331 HIV-infected patients (ASD Project 1990-2001). The statistical analysis was performed using Kaplan-Meier, Log Rank test, and Cox proportional regression analysis for examining the effect of gender on the time to AIDS progression and consequent survival from AIDS.

Results:
Univariate analysis showed overall gender difference, that males progressed earlier to AIDS than females ($p < .001$). When gender differences were examined by individual race/ethnic groups, African-American males were more likely to progress early to AIDS ($p = .012$) including early mortality ($p < .001$) when compared to African-American females. Multivariate regression analysis, adjusting for gender, age, and social risk factors revealed the lower likelihood of prescribed anti-retrovirals to African-American males to be a predictor to early progression to AIDS (HR = 1.3; 95% CI 1.2 - 1.5). No significant gender differences in HIV progression were seen in White and Latino race/ethnic groups.

Conclusion:
The findings of this study indicate that African-American males are more likely than African-American females to progress earlier to AIDS and mortality. These results highlight the importance of, and the critical role antiretroviral therapy, and its relation to AIDS progression and mortality.

National Electronic Disease Surveillance Assessment: CSTE's Assessment of Electronic Disease Surveillance in the States

Lisa Dwyer
Associate Research Analyst
Council of State and Territorial Epidemiologists
2872 Woodcock Blvd. Suite 303
Atlanta, GA 30094

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Summary:
The poster displayed the August 2007 results of the CSTE NEDSS Assessment depicting the level of integration, status of development and interoperability of states' electronic disease surveillance systems.

Multi-jurisdictional Outbreak Investigation – Potential Mass Rabies Exposure

Kirstin Short, MPH
8000 N. Stadium Dr, 4th Floor
Houston, TX 77054

Summary:
This presentation discussed a multi-jurisdictional outbreak investigation in response to a potential mass rabies exposure. Investigations of rabies exposures are particularly complex as they require an analysis of animal behavior and there is no laboratory test for human disease. For this investigation, the outbreak team planned for a prophylaxis response that could have included over 200 individuals. Efficient communication between the involved agencies facilitated the timely development of a risk assessment tool and rapid mobilization of vaccine to prepare for a worst-case scenario.

Potential Impact of State Menu Labeling Law on Population Weight Gain – Los Angeles County

Paul Simon, MD, MPH
Director, Division of Chronic Disease and Injury Prevention
Los Angeles County Department of Public Health
3530 Wilshire Blvd., Suite 800
Los Angeles, CA 90010

Summary:
We conducted a health impact assessment (HIA) to quantify the potential impact of a state menu labeling law on population weight gain in Los Angeles County. The HIA utilized published and unpublished data to model consumer response to point-of-purchase calorie postings at large chain restaurants with 15 or more facilities. Sensitivity analyses were conducted to account for uncertainty in consumer response, and in the total annual revenue, market share, and average meal price of large chain restaurants in the county.

Assuming that 10% of the restaurant patrons would order reduced calorie meals in response to calorie postings, resulting in an average reduction of 100 calories per meal, we estimated that menu labeling would avert 40.6% of the 6.75 million pound average annual weight gain in the county population aged 5 years and older. Substantially larger impacts would be realized if higher percentages of patrons ordered reduced calorie meals or average per meal calorie reductions increased. These findings suggest that mandated menu labeling could have a sizable salutary impact on the obesity epidemic, even with only modest changes in consumer behavior.

Public Health Response to Intentional Inappropriate Vaccination Practices by a Pediatrician — New Jersey, 2008

Adam J. Langer, DVM, MPH, DACVPM
Preventive Medicine Fellow
Enteric Diseases Epidemiology Branch
Division of Foodborne, Bacterial, and Mycotic Diseases
National Center for Zoonotic, Vector-Borne, and Enteric Diseases
Centers for Disease Control and Prevention
1600 Clifton Road NE, MS A-38
Atlanta, GA 30333

Authors: Adam J. Langer, B. Montana, J. DeGraaf, E. Handschur, E. Boyd, D. Sarecha, A. Sorrells-Washington, B. Giudici, C. Tan, and E. Bresnitz

Background:
On December 31, 2007, local authorities notified the Ocean County Health Department and the New Jersey Department of Health and Senior Services (OCHD/NJDHSS) of intentional inappropriate vaccination practices (IVPs) by a pediatrician. IVPs, defined as any deviation from recommended practice, have necessitated revaccination of > 10,000 patients since 2004. IVPs can result in susceptibility to vaccine-preventable diseases (VPD) and cost up to $20 million/year. OCHD/NJDHSS investigated the physician's practice to identify the affected population and ascertain the need for a revaccination campaign.

Methods:
OCHD/NJDHSS analyzed 2001-2007 county-level VPD incidence data to identify trends; data before 2001 were unavailable. Investigators reviewed the physician's charts for patients vaccinated during 1999-2007 and collected recorded vaccination data (RVD). RVD (e.g., lot numbers) were matched to distribution records to obtain vaccine expiration dates.

Results:
Investigators identified no increase in VPD incidence. The physician administered 7,027 total vaccinations to 1,067 patients (median age: 8 years; range: 2 weeks-26 years, median vaccinations/patient: 4; range 1-25); 880 (13%) vaccinations were identifiable by using distribution records. Of the 880 vaccines, 77 (9%) vaccines, administered to 64 (6%) of the patients at risk, were expired when administered.

Conclusions:
Although no increase was observed in community VPD incidence, individuals might be susceptible. Because of limited RVD, and because at least 6% of the population at risk was affected, OCHD/NJDHSS assumed that all patients at risk were affected and implemented a revaccination plan. Continued emphasis should be placed on detecting IVPs to reduce the need for revaccination campaigns.

Learning Objectives:
1. Recognize the public health risk associated with inappropriate vaccination practices.
2. Analyze medical record data to determine the magnitude of inappropriate vaccination.
3. Assess the need for a revaccination campaign.

Potentially productive years of life lost due to pneumoconiosis mortality in the United States, 1968-2004

Jacek Mazurek, MD, MS, PhD
NIOSH, DRDS, Surveillance Branch
Mailstop HG 900.2
1095 Willowdale Rd.
Morgantown, WV 26505

Summary:
To describe potentially productive years of life lost due to premature mortality in the U.S. working-age (15-64) population attributed to asbestosis, coal workers' pneumoconiosis (CWP), and silicosis during 1968–2004. Years of potential life lost before age 65 (YPLL-65) were calculated using the National Center for Health Statistics' annual underlying cause-of-death data for 1968–2004, using standard methodology (for 5-year age groups). Industry and occupation information was available for a subset of 26 states for some years during 1985–1999 (n=536). Overall, deaths from asbestosis (n=1,131), CWP (n=3,952), and silicosis (n=1,985) resulted in 46,596 YPLL-65 (mean 6.6 years per death). Of the total YPLL-65, CWP accounted for 48% (22,569 YPLL-65; mean 5.7), silicosis for 36% (16,989; 8.6), and asbestosis for 15% (7,038; 6.2). Deaths in young adults (ages 15–44) resulted in 6,354 YPLL-65, with silicosis deaths accounting for 73% (4,665 YPLL-65; mean 26.5), CWP for 20% (1,245; 24.4), and asbestosis for 7% (444; 24.7). Industry and occupation information was available for 153 asbestosis, 235 CWP, and 148 silicosis decedents. The leading industry and occupation causes of YPLL-65 attributed to asbestosis were construction (244 YPLL-65; mean 5.7) and insulation workers (112; 5.9), to silicosis were construction (263; 10.1) and miscellaneous metal and plastic processing machine operators (174; 21.8), and to CWP were coal mining (945; 5.6) and mining machine operators (842; 5.5). Although CWP deaths resulted in the highest overall YPLL-65, silicosis resulted in the highest mean YPLL-65 and the highest mean and overall YPLL-65 among young adults.

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Varicella Surveillance in Virginia

Laura Ann Nicolai, MPH
Division Epidemiologist, Division of Immunization
Virginia Department of Health
James Madison Building, Room 314 West
109 Governor Street
Richmond, Virginia 23219

Summary:
The goals of the presentation "Varicella Surveillance in Virginia" were to describe surveillance activities, provide an overview of the epidemiology of varicella in Virginia, and discuss the benefits of implementing case-based surveillance for varicella. While young children ages 5-9 years still make up the majority of all cases in Virginia, a greater proportion of cases are now being seen in the 10-14 year age group. Although vaccination rates are high in younger children, some adolescents (those born before 1997) have been able to reach an older age without immunity. They've received some protections because a large proportion of their peers are vaccinated and there is less circulating virus. However, these adolescents are most at risk for developing chickenpox in their teen or adult years when the occurrence of complications is greater. Ideally these adolescents should be identified and vaccinated when they present for other adolescent vaccines such as Tdap. In addition, a large proportion of reported cases have received one dose of vaccine, indicating that a one-dose vaccination recommendation is not sufficient to eliminate transmission. As a result and in accordance with the 2007 ACIP recommendation, Virginia has implemented a two-dose school requirement that will go into place prior to the 2009-2010 school year. Lessons learned through implementation of case based reporting include the importance of close communication with school nurses, as 41% of varicella reports in Virginia come from schools.

staff directory

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

Edward Chao
Associate Research Analyst
E-mail: echao@cste.org

Beverly Christner
Director of Operations
E-mail: bchristner@cste.org

Stephen Clay
Information Technology
E-mail: techsupport@cste.org

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

Tarajee Curry
Administrative Assistant
E-mail: tcurry@cste.org

Lisa Dwyer
Associate Research Analyst
E-mail: ldwyer@cste.org

Kevin Gibbs
Information Technology
E-mail: techsupport@cste.org

Jennifer Lemmings
Epidemiology Program Director
E-mail: jlemmings@cste.org

Amber Leonard
Administrative Assistant
E-mail: aleonard@cste.org

Amaanda Masters
Workforce and Fellowship Coordinator
E-mail: amasters@cste.org

Ryan O'Neill
Information Technology
E-mail: techsupport@cste.org

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

Lauren Rosenberg
Associate Research Analyst
E-mail: lrosenberg@cste.org

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

Erin Simms
Associate Research Analyst
E-mail: esimms@cste.org

Shannon Whittington
Part-Time Accountant
E-mail: swhittington@cste.org

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Tom Safranek - Nebraska
Member-At-Large
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Duc Vugia - California
Member-At-Large
E-mail: duc.vugia@cdph.ca.gov