Council of State and Territorial Epidemiologists

CSTE UPDATE

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CSTE ANNUAL MEETING SLATED FOR VAIL COLORADO MAY 15 - 19!!

The Westin Resort in Vail, Colorado will be the site of this year's CSTE annual meeting to be held jointly with the National Association of State Public Health Veterinarians. This very attractive venue has been arranged by Dr. Richard Hoffman, President-elect of the Council. Registration will begin on Sunday, May 15 and the last session is expected to be completed by 1:00 p.m. on Thursday, May 19. Communications have gone out to Centers/Institutes/Offices at CDC to submit proposals for subjects to be discussed at the meeting.

This has been a very busy year for CSTE. Issues impacting the nation's health are becoming more and more complex, and the pivotal position of state epidemiologists in dealing with problems extending from expanded immunization programs, HIV prevention activities, injury control, health care reform and a myriad of other topics adds a special relevance to this year's annual meeting. It is anticipated that attendance will be heavy and we look forward to productive discussions on a large variety of topics.

Announcements on registration, hotel accommodations, transportation and other logistics associated with travel to Vail will be available in the near future. Meanwhile, if there are questions concerning the annual meeting please contact Dr. Richard Hoffman, Colorado Department of Health (303-692-2662 (t), 303-782-0904 (f)) or the CSTE national office in Atlanta (404-982-0878 (t), 404-982-0576 (f)). Make your plans now to come to Vail and participate in what promises to be a very special event.

PRESIDENT'S CORNER

If one attempts to define a "state epidemiologist," you will find little guidance from such notable sources as *The Oxford English Dictionary, The Webster's Dictionary,* or even standard public health text books. In fact, CSTE as the professional organization of state and territorial epidemiologists has never defined who or what a state epidemiologist is or what they do. Rather, the organizational title of state epidemiologist and CSTE were born out of efforts by the late Alex Langmuir in the early 1950's to create a position in each state health department for the purpose of formalizing communication with the then "Communicable Disease Center." Over the years there have been many discussions regarding the primary role of the state epidemiologist and CSTE. In their early years, state epidemiologists had as their primary responsibility the area of infectious diseases. Just as the Communicable Disease Center evolved into the Center for Disease Control and

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later into the Centers for Disease Control and Prevention, so too the roles of the state epidemiologist have evolved. While we still have a primary role in the area of infectious disease epidemiology and control we are also increasingly responsible for or work with many non-infectious issues.

As President of CSTE, I can attest to the fact that CSTE has become a virtual "clearinghouse" for a number of national and state-based public health concerns. During the past six months, the CSTE national office has been involved with at least 30 different topic areas ranging from injury surveillance, epidemiology capacity training, the role of EIS officers the control of TB in the health-care setting, HIV prevention/community planning, emerging infections, and asthma surveillance. With the establishment of our national office in Atlanta, the number of requests for CSTE consultation has increased dramatically. This has caused the CSTE Executive Committee to begin an examination of who and what we should be as an organization. For example, with the 1994 CDC/CSTE Cooperative Agreement, we have made a conscious attempt to prioritize the activities that we believe CSTE can and should be involved with as state epidemiologists. In addition, Reg Finger (KY) is currently chairing a subcommittee of the Executive Committee to review and consider the role of CSTE consultants to the CDC and other federal organizations. Reg will present findings from this effort at our annual meeting in May. Together, these discussions will provide the framework for determining the role of CSTE well into the next decade. I think back to the days in the early 1980's when being a state epidemiologist meant being involved primarily with a limited number of programs related to infectious disease control. Today those roles have changed for many of us and likely will continue to change well into the future. Although such change can often be disconcerting and threatening, it provides the stage for some great opportunities. We look forward to some very frank and productive discussions regarding the future of CSTE at our May meeting. In the meantime, the Executive Committee welcomes your thoughts regarding this very critical and timely issue.

As I mentioned in my previous column, health-care reform must be a primary consideration for all of us in the public health arena. Since the time that those words were written, it has become increasingly clear that public health will not automatically have a seat at the table where health reform will be considered. Again, I urge all state epidemiologists to involved themselves at the local and state levels in discussions regarding health reform and the public health agenda. Frankly, I am increasingly concerned that public health will not be a player in the health reform movement, let alone a power broker, if we continue to watch others make decisions about the reform of services to ensure the "public's health." Since health reform starts in everyone's own back yard, I urge each state epidemiologist, through their health officers, to actively participate in helping frame the decisions about health reform in each of your states. At the same time, health officers through the Association of State and Territorial Health Officers must continue to press forward on a national agenda. In several years we will look back and critique our efforts in this most important of social/political movements. I do hope and believe that public health will have earned its rightful place in this effort.

Michael T. Osterholm

CSTE EXECUTIVE COMMITTEE MEETING JANUARY 12-13, 1994

The CSTE Executive Committee (EC) had its quarterly meeting at the CSTE office in Atlanta on January 12-13, 1994. Attending were Dr. Osterholm (MN) President, Dr. Hoffman (CO) President-elect, Dr. Perrotta (TX) Vice President, Dr. Gensheimer (ME) Secretary-Treasurer, and Committee members Dr. Birkhead (NY), Dr. Finger (KY), Dr. Fleming (OR), Dr. Hadler (CT) and Dr. Meriwether (NC). The agenda was broad and comprehensive. The meeting opened with Dr. Osterholm providing a

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President's Report on current activities and issues including budget support for EC Meetings; CSTE support for national *Aedes albopictus* control; chronic disease issues at the CSTE annual meeting; relationships with ASTHO and NASTAD; CSTE organizational issues; and a status report on membership dues payments.*

The first major item on the agenda was a discussion of the **CSTE/CDC Cooperative Agreement.*** Emphasis was placed on the development of a timeline for project development and review, core funding issues and current project status.

Surveillance was a subject that received a considerable amount of attention. Dr. Birkhead brought the committee up to date on current levels of activities of the multiple systems that are being considered for public health surveillance.

NCID issues were the focus when Drs. Hughes and Berkelman joined the EC for a discussion of a variety of subjects in which CSTE and NCID share interest. Included were the growing level of assistance requests to CSTE and emerging infectious diseases.

Immunization* topics were addressed by Drs. Walter Orenstein, Melinda Wharton and Donald Eddins. The discussion was oriented around the President's national immunization initiative. Surveillance problems and training and technical support to the states were emphasized. Dr. Finger provided the EC with a summary of highlights of the Immunization Grantee Working Group meeting which was held in Atlanta on January 11-12, 1994.

CSTE consultant activities were reviewed by Dr. Finger who chairs the committee (Drs. Hoffman, Meriwether and Osterholm) dealing with this subject. The multiple ways in which CSTE members contribute to CDC are an important part of the relationship. The committee dealing with this subject is seeking ways in which the appointment and function of CSTE consultants can be standardized.

The status of the **Annual Meeting*** was reviewed by Dr. Hoffman. Arrangements are progressing well and we look forward to an exciting and well attended program in Vail.

EPO/EIS issues were discussed with Ms. Holloway, Ms. Herndon and Dr. Ward Cates. The EIS class for 1994* (See accompanying article by Dr. Ward Cates) is viable in spite of rumors to the contrary. The "50 mile rule"* has been re-examined and there will be a more lenient interpretation in the future. Each case will be handled individually and EPO continues to feel that in general, it is best for an EIS fellow not to take an assignment in his/her home area. The rating system to be used by officers was also discussed.

The EC had an opportunity to hear a presentation by Dr. Phil Lee, Assistant Secretary for Health on **Health Reform.** Dr. Lee was visiting Atlanta and made a special presentation at CDC on the health reform issue as seen by the Clinton Administration.

Tuberculosis surveillance was the subject of a session attended by Drs. Castro, Onorato and McCray from the Division of Tuberculosis Elimination (DTBE), CPS. Particular emphasis was placed on surveillance software programs and the information needs of DTBE. These discussions were helpful and solutions are being sought to some of the multiple data entry and system compatibility problems experienced by the states.

Community planning for HIV prevention was the main subject of a discussion with Drs. Buehler, Jaffee, Valdiserri, Ms. Altman and Mr. Conrad who joined the EC for a review of this very important issue. Particular emphasis was placed on the implementation of the program and the associated need for technical assistance to states in this process.

The meeting was busy, but very productive. The comprehensive nature of the topics discussed and reviewed emphasize the importance of these sessions on a quarterly basis.

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*Indicates subject areas with additional information in this issue of the CSTE UPDATE.

COOPERATIVE AGREEMENT: REVISED SCHEDULE FOR PROJECT DEVELOPMENT AND REVIEW

The CSTE/CDC Cooperative Agreement continues to be a vital part of the functional activity of the organization. This agreement supports a number of projects which are carried out at the state level by members of CSTE and provides the basic financial support for the national office in Atlanta.

The development and review of project proposals is a major part of the effort associated with the Cooperative Agreement. The CSTE Executive Committee has dealt extensively with this issue in two consecutive meetings. The following time line for working with projects has been approved by both the EC as well as CDC. All state epidemiologists should have received an invitation to submit project concepts for inclusion in the Cooperative Agreement for 1994-95. The schedule for action on these proposals is presented below.

CSTE/CDC COOPERATIVE AGREEMENT SCHEDULE FOR PROJECT DEVELOPMENT AND REVIEW

February 01	o Requests for proposals (RFPs) from CDC are due. o Requests for Unsolicited Proposals go to the states.
February 04	o RFP's go to the Executive Committee for review.
February 14	o CDC RFP's are reviewed by the CSTE Executive Committee to determine which are acceptable or unacceptable (EC members will receive materials in advance. Review via conference call.)
February 21	o Approved RFP's are sent to state and territorial epidemiologists.
March 01	o Notify Primary Investigators (PI's) of current projects of the need for (1) Renewal proposals to be submitted by June 1 and (2) Progress reports for inclusion in renewal proposal due on July 8. o Unsolicited proposals from CSTE membership (concept only) are due. o Draft of the core funding proposal completed.
March 03	o Unsolicited proposal concepts from the States are sent to the Executive Committee. o Draft of core funding proposal is sent to Executive Committee.
March 21-22	o Unsolicited proposal concepts submitted by the States are sent to the Executive Committee for review. (EC Meeting to be held in Atlanta)
March 23	o Approved unsolicited proposal concepts are sent to CDC for funding potential assessment.
April 01	o States notified as to whether unsolicited proposals were approved by EC and the potential for funding by CDC for approved projects.
May 09	o Solicited and unsolicited proposals are due in final form.
May 11	o Solicited and unsolicited proposals are sent to members of the Executive Committee.

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Lead reviewers for each project will be identified.

o Revised core funding proposal sent to members of the Executive Committee.

May 15-19 o The Executive Committee will review and finalize all proposals. (EC members to receive materials in advance.) (Review at the Annual Meeting.)

o The core funding proposal will be finalized.

June 01 o Final proposals for continuation projects are due.

July 08 o Completed progress reports for active projects are due.

July 30 o Renewal proposal for Cooperative Agreement sent to PGO.

September 15 o Final negotiations will take place for renewal of the Cooperative Agreement.

CALL FOR UNSOLICITED PROPOSALS IN COOPERATIVE AGREEMENT

The CSTE/CDC cooperative agreement provides an opportunity of support for special projects to be conducted at the state level. There are two pathways through which such projects can be initiated. The first is through the development and distribution of requests for proposals from various Centers, Institutes and Offices (CIO's) at CDC. These are processed through the Epidemiology Program Office at CDC and distributed to all state epidemiologists for evaluation and a decision as to whether they would like to prepare a project proposal in response to the query.

The second pathway is the means by which the states have an opportunity to develop unsolicited project proposals that are specifically oriented toward their state's needs and are considered to be amenable to study/investigation directly by the state epidemiologist and his or her staff.

Consideration of the latter pathway is important because it provides direct access to the cooperative agreement by each state epidemiologist and his or her colleagues in the state health departments.

It is requested that each state epidemiologist consider this prospect and think of investigative needs in his or her state that could be pursued with a reasonable amount of funding support. In order to compete for grant support, the individual issue would have to be developed into a concept paper. This document should include a title, a **brief statement** of the proposed project concept, the objectives that are expected to be achieved, an indication of the process that would be used to carry out the project and the CDC Center/Institute/Office that would be expected to respond. It will be necessary to provide some insights as to the benefits that would come to your state as a result of this effort. It will also be important to indicate how the results of the project can be used by other state health departments.

These concept papers will be returned to the CSTE office by March 1, 1994. They will then be reviewed by the CSTE Executive Committee and those that are approved at this level will be sent to CDC where the appropriate CIO's will evaluate the concepts for possible funding. Proposers will then be informed as to the perceived potential for support their concept has received. Those who wish to pursue this issue further will then prepare a full proposal to be submitted for competitive review by a panel at CDC. Guidelines for the preparation of project proposals will be provided by the CSTE office.

The timeline for this process is as follows:

o March 1, 1994 - Brief concept paper due at CSTE office

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- March 21-22, 1994 - Executive Committee Review of submitted concept papers
- March 23, 1994 - Approved concept papers to CDC for funding potential
- April 1, 1994 - Funding potential responses from CDC
- April 4, 1994 - Notification to state proposers
- May 9, 1994 Full proposals due at CSTE
- May 19, 1994 - Executive Committee reviews and finalizes proposals
- July 30, 1994 - Cooperative Agreement renewal proposal to CDC
- September 15, 1994 - Final negotiations for funding of Cooperative Agreement

If there are questions regarding the development and submission of unsolicited proposal concepts, please contact the CSTE national office at (404) 982-0878.

WALTER DOWDLE TO RETIRE FROM CDC

Dr. Walter Dowdle, Deputy Director of the Centers for Disease Control and Prevention has announced that he will retire at the end of March 1994. Dr. Dowdle has invested 33 years in CDC during which time he served in a variety of positions including Assistant Director (CDC) for Science; Director, Center for Infectious Diseases; Deputy Director (CDC) and Acting Director (CDC). In 1986 he was appointed Deputy Director (AIDS) and served as coordinator of AIDS activities for the Public Health Services in Washington, DC.

As a professional microbiologist, Dr. Dowdle concentrated on a laboratory research career in the respiratory viruses and was Director of the World Health Organization Collaborating Center for Influenza from 1968-79. He was elected president of the American Society for Microbiology in 1989, and is currently President of the Armed Forces Epidemiological Board and Chairman of the Working Group on HIV Development and International Field Trials of the Federal Coordinating Council on Science, Engineering and Technology.

Dr. Dowdle has been a tireless resource for advice, counsel and science, and he will be sorely missed by his colleagues, both at CDC and in state and local health departments. He has assured us that he will continue to be active but is not sure in what capacity. We at CSTE wish him well and hope that his future activities will provide an opportunity for further contact.

VACCINE PREVENTABLE DISEASES UPDATE

The events in the world of immunizations - from the national policymaking level, to implementation in states, from the increasing involvement of private corporations and foundations to the individual heroics in local communities - are proceeding at a breakneck pace. On January 11 and 12, CSTE was represented at the Immunization Grantee Working Group meeting at which ten persons from states and local areas provided input to CDC and to the National Vaccine Program Office on each of the major issues. Following, is a brief update for that meeting on each:

Immunization Schedules

The American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP) of the PHS have agreed on moving the 3rd oral polio dose to 6 months; on allowing flexibility for MMR dose #1 from 12-15 months; and that DTP dose #5 is still necessary. The working group believed that there should be one immunization schedule, that it be made as simple as possible, and that it should, if feasible, be published jointly by AAP and ACIP. Dr.

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David Smith of Texas, is sending a letter to this effect to the PHS.

Surveillance

Dr. Melinda Wharton of CDC issued a strong call for enhanced surveillance of vaccine preventable diseases (VPD) in states. She is working on a list of guidelines which will cover both "indicators to evaluate the quality of surveillance systems" and "methods for investigating VPD outbreaks." This package will be shared with CSTE soon, and hopefully finalized in time to be considered for approval at the May CSTE annual meeting.

Registries

A much clearer and immunization-specific core data set for exchange of information among state registries has been created by CDC. The working group gave its strong approval to this Data Set, and will be submitting final comments on details by January 25. Plans for immunization information systems - which must accommodate this core data set - are due from the states June 1. In addition, Dr. Rebecca Meriwether (CSTE Executive Committee member, NC) attended a meeting of the National Vaccine Advisory Committee - Subcommittee on registries January 5 and returned with much helpful information. Confidentiality concerns and interlinkage with data sets for national health care reform are under intense discussion.

Vaccines for Children Program

This program, which will entitle an estimated 61% of American children to federally purchased vaccines, is hastening towards implementation. Collated data from the recent surveys to states were presented. If states are able to implement the program as per their plans, the new program will purchase 54% of childhood vaccine doses, with states paying for 10%, the existing federal grants for 14%, and 22% remaining in the private sector. Twenty-seven of the 57 project areas desire to purchase vaccines for their entire childhood populations. The survey called for a total of $132M to remain in the grant program for vaccines compared to $212M currently. Staff from PHS stated that figure is reasonably close to that requested in the President's budget for FY 1995.

Considerable discussion ensued regarding shipment of vaccines to private physicians. Vaccine manufacturers are said to have enough leverage with Congress to have the law amended so that they will be able to ship to state or regional depots rather than to each physician. The establishment of a single federal depot to handle shipping is under discussion.

Reginald Finger, KY

COMMUNITY HEALTH INFORMATION SYSTEM

Historically public health officials have had difficulty accessing current data on disease rates, guidelines for prevention and other up to date information. This problem is particularly acute in rural local health departments where access to medical experts, medical libraries and computerized data bases is limited. To address the need in Georgia, the Robert W. Woodruff Foundation awarded a $5.2 million grant to support implementation of the Georgia Information Network for Public Health Officials (INPHO).

Together with the Woodruff Foundation, project partners include the Georgia Division of Public Health (GDPH), the Medical College of Georgia (MCG), the Georgia Center for Advanced Telecommunications Technologies (GCATT) including Georgia Tech's Multimedia Lab, the Emory University School of Public Health, and the federal Centers for Disease Control and Prevention (CDC).

Building on the CDC system, the Georgia INPHO project will provide access to timely, relevant, accurate, and authoritative prevention information, and a mechanism to share information throughout the public health system over an advanced electronic communications network.

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Key components of the system are:

o A unified community health information system to serve the needs of state and local health departments and create a unified approach to health monitoring by CDC. The system will give local public health leaders a powerful new ability to deliver prevention services designed to address community needs.

o Emergency reports on public health issues which require immediate action by local and state agencies, reports of epidemic investigations; and reports on the status of local and national programs for prevention of illness and injury.

o Authoritative guidelines for delivery of preventive health services (e.g., cancer screening guidelines, immunization and childhood blood lead testing recommendations, environmental and occupational health regulations) and for development of community-based prevention programs.

o Training resources for public health practioners to gain and continually enhance the knowledge and skills needed to provide preventive services to their communities.

o Electronic mail capability through which public health officials can communicate with each other, with CDC, and with others in the nation's public health system.

Milestones in 1993 include:

o Design and installation of the INPHO network in the Division of Public Health headquarters at Two Peachtree Street, Atlanta.

o Completion of programming for the Prevention Guidelines Database and Training Resources Directory.

o Prototype development of the Community Health Information System.

o Training for district and local public health staff, conducted by Emory University's School of Public Health, in Epi Info, a CDC-developed software program used to analyze epidemiological data and identify local health trends and problems.

o The Emory University School of Public Health designed and initiated formal evaluation of the project.

The community health information system currently being piloted may be of most interest to epidemiologists. The Georgia INPHO system resembles PC WONDER's data query capabilities, utilizes infectious disease, vital statistics and other Georgia data sets. Local health departments can access the data from a file server and produce their own graphs and tabulations, without accessing the raw data files. The state Division of Public Health will update these data sets on a weekly or monthly basis as appropriate.

The Woodruff Foundation expects the Georgia State government to maintain the INPHO system on a permanent basis and to make it an integral part of the information resources available to local and state-level public health.

For further information, contact:

Mark Oberle, MD, MPH
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Centers for Disease Control and Prevention
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Internet MW01@PHPPO1.EM.CDC.GOV

Mark Oberle, PHPPO

UPDATE ON PUBLIC HEALTH SURVEILLANCE

A number of initiatives and reviews related to the future of public health surveillance are underway at the national level and have had some CSTE involvement. Some are focussed at improving the current public health surveillance system but the bulk are directed at discussing how surveillance will fit into the new era of health reform. Of course, CSTE has had a key

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role in national discussions on surveillance since it was designated by ASTHO in 1951 as the organization to work with CDC in the maintenance of the National Notifiable Disease Surveillance Systems (NNDSS).

The current efforts include: 1) A Steering Committee for Public Health Information and Surveillance System Development has been formed at CDC with Martha Katz of the Director's office as the chair. This committee is charged with describing a comprehensive national public health information and surveillance system within the context of health care reform. The committee met internally at CDC in the fall and had its first meeting with outside consultants (including Gus Birkhead (NY) representing CSTE) on December 3. At that meeting there were presentations on Minnesota's universal health claims data base, Missouri's plans for a unified health data base distributed through out the health care community including hospitals and doctor's offices, and Georgia's INPHO project essentially setting up a state-based version of the WONDER system. Many states are now planning or developing health data systems that are variations on these themes. The possibilities of conducting surveillance using these futuristic systems were discussed. There is concern that none may meet three important surveillance criteria: diagnostic accuracy, timeliness, and access. This may be particularly true at the local health department level. However, the extensive computer systems that will be developed and supported under health care reform linking the various segments of the health care community, may present an opportunity for public health to piggy-back on surveillance and other core public health data systems.

Following this meeting, the CDC committee met internally for a full week to develop a draft national surveillance plan. This draft will be presented to CSTE and other consulting organizations in approximately two months.

2) A Work Group on Data Systems Oversight and Development has been convened by the Joint Council (ASTHO, NACHO, and USCLHO) under a grant from the Public Health Foundation from HRSA and CDC. The group met twice during this past summer. The work group is charged with developing a white paper on the need to improve the public health information infrastructure and to propose a conceptual framework for a model public health information system. In the process it will define core public health functions, identify information needs, define required data items, examine current data systems, and determine where the current gaps are in public health data. Plans include developing a marketing strategy for the final proposal, linking the proposal to training and educational needs in public health, making recommendations for interconnectivity of emerging national, state and local electronic public health data systems, and to work with CDC and the Public Health Foundation to enhance the communication highways currently available through the Public Health Network and the WONDER/INPHO system. The committee is continuing to meet this year.

3) CDC continues to fund six states through National Center for Health Statistics' (NCHS) Assessment Initiative to review existing surveillance systems, identify gaps and develop a plan to address such gaps. Hopefully, the lessons learned from this process will begin to be shared with other states who are facing the same need to evaluate their surveillance efforts.

4) Funding for the decayed surveillance infrastructure in the notifiable disease area, shown so starkly in Mike Osterholm's survey of states presented at the last annual meeting of CSTE, may begin to be addressed. Limited amounts of National Immunization Program funds have been made available to states for general surveillance. In addition, the emerging infections initiative from the National Center for Infectious Diseases holds out the promise of more infrastructure support. Clearly, the public health community needs to make its infrastructure needs known in the health care reform debate.

5) CSTE awaits with interest CDC's formal response to its 1993 Position Statement

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recommending that surveillance coordination at CDC be placed at the level of the Director's office. The CSTE membership felt that oversight at this level was necessary to assure better coordination of the large number of surveillance systems and surveillance software packages being promulgated by CDC. While the surveillance steering committee mentioned in #1 above may eventually fulfill this role, it currently has not been given this charge.

Guthrie S. Birkhead, NY

THE "NEW" EIS FOR THE CLASS OF 1994

In Al Gore's terms, it is "reinventing EIS." In influenza terms, it is an antigenic shift rather than an antigenic drift. Finally, in CDC terms, it is the "new" EIS Fellowship Program.

How about a time, place, and person description? All these EIS changes have occurred within the last several months, when the process of corporate downsizing finally caught up with the Federal government. CDC was no exception, and many of its Centers/Institutes/Offices found themselves well-over the FTE ceiling. As a result, a hiring freeze has been imposed on CDC; unlike in the early 1980's, the EIS was not granted a waiver.

To allow CDC to continue the essential EIS Program, a new administrative structure, the EIS Fellowship, has been approved to make EIS officers FTE-free. In 1994, all members of the incoming class will enter EIS through the Fellowship Programs, regardless of degree, citizenship, or health status. The stipend for this Fellowship will be $57,000.00, a level similar to the average amount of salary provided under the current Commissioned Corps/Visiting Scientist programs. The administration of these fellowships, at least for the Class of 1994, will be by CDC. Legislative authority to both formalize the program and to allow CDC sponsorship is pending. This change in the EIS program is solely administrative in nature. The structure and content of the training process will remain the same for the Class of 1994.

Ward Cates, EPO

"REINVENTING" THE 50-MILE RULE

At a recent meeting between the CSTE Executive Committee and EPO staff, guidelines regarding the revised "50-mile rule" for EIS fellow recruitment and matching were clarified. In the past, EPO required incoming EIS fellows to rank only assignments in a state different from the one in which they currently resided, or assignments outside a 50-mile radius of the current work location. This has been infamously referred to over time as the "50-mile rule." Beginning in 1993, EPO revised its policy (e.g. "reinvented") on the 50-mile rule. Persons selected for EIS will, with proper personal or professional reasons, be allowed to compete for an assignment within a 50-mile radius of his/her current work location. This will be viewed especially favorably if the candidates wish to remain in "hard-to-fill" states. However, because of the competitive nature of the EIS fellow match system, EPO cannot guarantee the fellow will indeed match with that assignment. In fact, in the eyes of the local supervisor, other incoming EIS fellows may be a better match for that field assignment.

EPO will continue to encourage EIS applicants to match with assignments outside their immediate geographic area so they can use the EIS experience as a means of broadening their horizons, learning more about American pluralism, and avoiding geographic parochialism. EPO is open to suggestions for other ways in which it can improve its EIS training program and better help contribute to state epidemiologic infrastructures.

Ward Cates, EPO

HEMOPHILIA SURVEILLANCE SYSTEM

CDC recently awarded 6 cooperative agreement awards to Colorado, Georgia, Louisiana, Massachusetts, New York, and Oklahoma for the establishment of a hemophilia surveillance system (HSS). Hemophilia is a sex-linked genetic bleeding disorder affecting approximately 1/5,000 males (total U.S. patient population of approximately 20,000). Approximately 45% of hemophiliacs in the U.S. became infected with HIV prior to 1985 due to infusion with contaminated clotting factor. Approximately, 85% of U.S. hemophiliacs are now seropositive for hepatitis C virus. Comprehensive hemophilia treatment centers (HTCs) provide medical treatment and support to approximately 3/4 of U.S. hemophiliacs. Costs for hemophilia care are extraordinary. Yearly costs/patient for infusion therapy alone may exceed $100,000.00 The principal non-HIV complications experienced by hemophiliacs include joint and liver disease.

Surveillance for this chronic disease should provide important information for public health intervention efforts and assess the effectiveness of programs, identify areas for future research, and describe and monitor the disease. Please direct questions/comments regarding this surveillance system to Dr. Scott J.N. McNabb, Centers for Disease Control and Prevention, 1600 Clifton Rd., Atlanta, GA 30333 Mailstop E-64. telephone (404) 639-6173.

Scott McNabb, NCID

COMPUTER-BASED EPIDEMIOLOGIC CASE STUDY

The Epidemiology Program Office and the Public Health Practice Program Office at the Centers for Disease Control and Prevention have developed a computer-based epidemiologic case study, "Investigating an Outbreak: Pharyngitis in Louisiana," to teach public health workers skills in outbreak investigation. The case study uses the computer to simulate an outbreak investigation in which the student plays the role of the lead investigator.

In the case study, the student's goal is to determine the source of the outbreak. Just as in an actual investigation, information is gradually uncovered. The student decides who to contact, where to go, what resources to use, and what data to collect and analyze. The case study is being brought to life with engaging graphics and life-like characters. By doing the case study, the student learns to apply outbreak investigation practices and to perform epidemiologic tasks such as creating a line list, developing a case definition, and calculating attack rates. The student also learns about Epi Info and how to interpret the results of Epi Info analyses.

Even though the case study is an enjoyable learning experience for many, it has been designed for public health workers who are likely to lead or participate in an outbreak investigation. To run the program, the student will need an IBM-compatible computer running Dos 3.31 or higher with 3 megabytes of disk space free and a VGA monitor.

The case study will be available beginning March 07, 1994, at a cost of $20.00 plus shipping and handling. Students can receive Continuing Education Units or Continuing Medical Education credits by enrolling with the CDC Distance Learning Program. For more information or to order the case study call 1-800-41-TRAIN (1-800-418-7246).

Jeanette Stehr-Green, NCPS

REGIONAL EPIDEMIOLOGY GROUPS IMPORTANT PART OF CSTE'S ACTIVITY

Regional meetings and activities make a significant contribution to the overall goals of CSTE, for this reason, the national office in Atlanta is eager to support these programs in any way possible. We would like to take this opportunity to invite the regional epidemiology groups to keep the office in Atlanta informed of meeting dates and locations and any special notes on other activities. This information will appear in the CSTE UPDATE.

MEMBERSHIP DUES STATUS

As of February 1994:

27 States have paid dues
24 State Epidemiologists have paid personal dues
17 Non-State Epidemiologists have paid personal dues

OPPORTUNITIES FOR EPIDEMIOLOGISTS

I would like to take this opportunity to communicate to CSTE members about EIS officers and epidemiology training.

This has been a tumultuous year at CDC with new leadership and new programs, but frozen employment opportunities for this year's EIS graduates. It is expected that there will be no positions at CDC for either the 16 preventive medicine residents or the 65 EIS officers graduating in June. Consequently, members of the class are diligently looking to other areas for their next opportunities, and for some this will mean positions with real opportunities for the enhancement of their epidemiologic skills. The EPI MONITOR currently lists about 140 jobs and indications are that this number is rising. In an effort to keep job information current and available, the EPI MONITOR (Roger Bernier), the Epidemiology Program office (Lyle Conrad) and the CSTE office are combining resources.

The staff of the EPI MONITOR follow the job market closely and provide a free listing in the job bank. Information on available positions will be shared among the three offices. Ward Cates will also see that announcements appear in the EPI BULLETIN. I will continue to use the E-Mail system at CDC as another means of rapid communication on this issue. In this way, job descriptions are available very quickly. To make this program effective, there is a need for participation from every state epidemiologist. All available jobs need to be listed and those that are filled or dropped need to be removed from consideration as soon as possible. Senior epidemiology positions should be included since there are a number of career officers looking for other opportunities.

I believe we can all benefit from the current situation. States can enhance their epidemiology staffs, officers can continue to develop their professional skills, and CDC will be able to maintain contact with working epidemiologists. Send information to any of the three offices listed by any means of communication available. We will all meet April 18-22 to assess the situation and plan for the future.

Lyle Conrad

POSITIONS AVAILABLE

o Three of Florida's largest local health departments are looking for epidemiologists. Two are specifically looking for physician epidemiologists, while a third is looking for a well-trained person with any of a wide range of backgrounds. Dade County Public Health Unit, 1350 NW 14th Street, Miami, FL 33125-1696 has two medical epidemiologists who handle the routine infectious disease epidemiology, and is looking for someone with broad interests to take an overall look at health status and health problems and help with health planning issues. Contact person is Dr. Eleni Sfakianaki, 305-324-2400. Broward County Public Health Unit, 2421 A SW sixth Avenue, Ft. Lauderdale, FL 33125, is looking for a medical epidemiologist to direct all infectious disease epidemiology activities. Contact Dr. Robert Self, 305-467-4826. Duval County Public Health Unit , 515 W. Sixth Street, Jacksonville, FL 32206-4397, is seeking a supervisory medical epidemiologist. Contact Dr. Jeffrey Goldhagen, 904-630-3240. In addition to the three positions in County Public Health Units, the Florida HRS State Health Office will soon be recruiting for a chief for its environmental epidemiology activities. The position is located in Tallahassee. The environmental epidemiology program reports to the state director of environmental health Dr. Richard Hunter. Responsibilities include surveillance for and workup of foodborne

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outbreaks due to all agents, investigation of apparent clusters of environmentally induced disease, including cancer and birth defects, monitoring of groundwater pollution with gasoline and other substances, and childhood lead poisoning surveillance. Contact is Dr. Richard Hunter or Mr. Phil Reeves at, 904-488-6811.

o The Illinois Department of Health is seeking an epidemiologist to perform epidemiologic activities for a collaborative project called Illinois Project for Local Assessment of Needs. The purpose is to conduct community health needs assessments and community health plans to address priority health problems. Responsibilities include data analysis from a wide variety of sources, technical assistance to local and state health department staff in interpreting health data, design and conduct studies on health problems, report writing and develop components of the state health plan. Requires master level degree. Resume should be submitted to Angela Oldfield, Chief, Division of Health Policy, Illinois Department of Public Health, 525 West Jefferson, Springfield, Illinois 62761, Phone (217) 782-6235.

o The Kansas Department of Health and Environment is searching for two positions. The first is a Deputy State Epidemiologist. This individual will be responsible for direct outbreak investigations, serve as epidemiologic and medical consultant for communicable disease control programs, and supervise staff in the epidemiology section. The deputy state epidemiologist will be able to work in other areas of epidemiology as time and interest permit. Appointment to medical school faculty is possible. Advancement to position of state epidemiologist likely to occur in mid-1995. Applicant qualifications include an MD or DO with training and experience in epidemiology. The second position is for an Assistant State Epidemiologist to perform disease outbreak investigations and provide epidemiologic support for communicable disease control programs. While focus of position is on infectious disease control, the assistant state epidemiologist will be able to work in other areas of epidemiology as time and interest permit. Appointment to University faculty is possible. Applicants must have an RN, DVM, DDS, or PhD with training and experience in epidemiology. For further information on either position, please contact Andrew Pelletier, Bureau of Disease Control, 109 SW 9th Street, Topeka, KS 66612-1271, (913) 296-5586 (t).

o The New York City Department of Health - Bureau of Immunization has an immediately available position for a medical epidemiologist to work primarily in the area of disease surveillance. The Bureau of Immunization has responsibility for surveillance of vaccine preventable diseases including measles, mumps, rubella, congenital rubella, pertussis, tetanus, and diphtheria. The Bureau is enhancing its surveillance of pertussis and measles, incorporating elements of active surveillance with hospitals and laboratories. The Bureau is also beginning the implementation of an immunization registry beginning with infants and preschool children. The registry will be considered as part of the surveillance of immunization levels which will be compared to disease incidence. The applicant should have either a masters degree in epidemiology/preventive medicine or at least two years of experience in working in the disease surveillance and control. The position will be supported by federal grant funds. Personal computer and mainframe computer access are available. Applicants should contact Dr. Stephen Friedman, New York City Department of Health, Bureau of Immunization, 311 Broadway, 3rd floor, NY, NY 1007, or call 212-285-4640.

o The Vermont Department of Health is seeking a state epidemiologist, supervising a 27 member epidemiology division responsible for infectious and noninfectious disease identification and control. Division programs include infectious and chronic disease epidemiology; AIDS, STD, and TB control; immunization; and cancer control. The position requires an MD and three years of professional level experience in epidemiology; or an MD and an MPH including training in epidemiology and biostatistics, with two years of experience in epidemiology; or a PhD, ScD, or DrPH, in epidemiology, with five years experience in public health. Experience in infectious disease epidemiology is required. Under Department auspices, part-time faculty appointment with the nearby University of Vermont College of Medicine is possible for a qualified individual. Apply by sending resume, and salary history to: Personnel, Vermont Dept. of Health, PO Box 70, Burlington, VT 05402.

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o The Washington State Department of Health, located in Olympia, WA, is searching for qualified candidates to fill a new position of State Epidemiologist. This position will direct the Office of Epidemiology and is exempt from the civil service. The Director will provide the agency, local health organizations, health care providers, and elected officials with expert advice and consultation on epidemiologically impacted health issues. The Director also serves with a faculty appointment to the University of Washington School of Public Health and Community Medicine as either an assistant, associate, or full professor depending upon credentials and qualifications. The Director is also expected to be an expert witness in pertinent legislative testimony. The successful candidate must possess a Ph.D. in epidemiology or MD degree and license to practice in Washington State. Completion of one clinical year and at least one graduate year of training in public health, preferably with an advanced degree in epidemiology, is mandatory. The position also requires four years of professional experience including two years of public health experience in epidemiology and two years of epidemiology program management which may have been gained concurrently. If the Director is a medical doctor, he or she will also serve as the Deputy State Health Officers working closely with the State Health Officer. The State Epidemiologist reports to the Assistant Secretary for the Division of Epidemiology and Health Statistics and is exempt from the state civil service system. Maximum annual compensation for this position is $87,432. The state offers an excellent benefit package. Interested applicants should contact Ted Koska, Executive Recruiter, Department of Personnel, 600 South Franklin, Olympia, WA 98504-7530, (206) 664-0394 (t) by February 18, 1994.

The following positions are available but the CSTE national office does not have the details:

o Arizona State Department of Health is recruiting for an Infectious Disease Epidemiologist. Contact Dr. Komatsu at 602-230-5932.

o Georgia Division of Public Health has four positions: (1) Cancer epidemiologist for a breast and cervical cancer project. Contact Dr. Carol Steiner at 404-657-6606; (2) Injury epidemiologist. Contact Dr. Nancy Stroup at 404-657-6448; (3) Trauma epidemiologist. Contact Dr. Nancy Stroup at 404-657-6448 and (4) HIV/AIDS epidemiologist. Contact Dr. Kathleen Toomey at 404-657-2588.

o Louisiana State Health Department is recruiting for two positions (1) Chronic disease epidemiologist and (2) injury epidemiologist. Contact Dr. Thomas Farley at 504-568-5005.

o Pennsylvania is recruiting for two positions, (1) Acute disease epidemiologist and (2) Chronic disease epidemiologist. Contact Dr. Noonan at 717-787-6436.

o Wyoming is recruiting for an Immunizations Epidemiologist. Contact Dr. Stan Music at 307-777-6004.

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