Second Quarter 20

# CSTE update

## Council of State and Territorial Epidemiologists



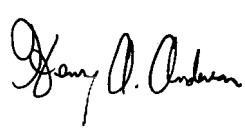
## President's Message

As my year as CSTE President comes to a close, I find myself alternating between doing the "Dance of Joy and Relief" and early entry into the 12-step program developed by previous presidents to deal with separation anxiety! The Executive Committee had a big task in front of them this year, to conclude the makeover of CSTE. Although there have been and will continue to be some rough spots, I hope you won't be disappointed with the final outcomes.

New members of the Executive Committee learned how rapidly CSTE is evolving. The evolution began four years ago and reached the final stages this year. You have had the strategic plan and other advances presented at previous annual meetings. Our National Office management staff – and especially our Executive Director, Donna Knutson – are now seasoned veterans. We have continued to mature as an organization, becoming increasingly multifaceted. We have achieved a new national stature that has placed our organization and members in greater demand to participate in national decisions and has stretched our resources. We made difficult organizational decisions that were necessary to position CSTE to better manage its interests and cooperative agreement responsibilities while maintaining support for individual members' needs. Try as we might we can not be "all things to all people!"

We have found that there are simply too many issues to have the work of CSTE handled only by the Officers and Executive Committee, a few dedicated consultants and specialty committee work during the annual meeting. Similarly, there is simply not enough time at the annual meeting to address all the topics that members would like to present and hear about. We examined the advantages and disadvantages of re-working our organizational structure to include standing committees, teams, subcommittees and individual consultants. After careful analysis, many teleconferences and much e-mail traffic, we settled upon proposing a standing committee structure that we feel creates more opportunities for member leadership development, connects the cooperative agreement activities to the strategic plan, and provides a better link between members and the CSTE staff. We also want to preserve the integrity of the recognized CSTE consultant system to provide members the opportunity to serve as topic and content experts and for other members to participate on topic area teams.

What follows on page 4 is the proposed committee structure for CSTE. The Executive Committee will be proposing the adoption of such a structure through a position statement at the Business Meeting. We will also spend some time at the Annual Meeting explaining the structure and seeking input on ways to improve the opportunities to participate for all members.



# A Letter from the Executive Director

For the past two years the Executive Committee, CSTE members, our funders and staff have been traveling down a road that takes us from where we are to where we want to be in the future. Although it feels like we have been driving forever, we have made remarkable progress in our journey, and we would like to share it with everyone.

CSTE has a vision that places its members and the organization in a position to influence public health at the federal, local and state levels. We have been working to implement our strategic plan, which has created many opportunities for change — in the way the organization works, and the way that the staff works for the organization. I'd like to outline some of the more significant changes we've made in the way the staff works for the organization.

CSTE currently has two sources of funding — the funds collected from states and individual members through dues and the proceeds of our annual conference, and our cooperative agreement with the Centers for Disease Control and Prevention. While some staff expenses are funded from dues and conference proceeds, fully 98% of the staff expenses are funded through the cooperative agreement. In the past, the staff positions were closely aligned with "projects" from various Centers/Institutes/Offices (C/I/O) at CDC and were geared toward helping CDC and states meet specific program goals through cooperative agreements that CDC has with states. A good example of this relationship is the work CSTE employees have done as "guest staff" of CDC in the Diabetes Prevention and Control Program. CSTE staff have contributed to MMWR's, the national diabetes surveillance report and other documents by analyzing data from the states while working closely with CDC.

While this cooperative agreement relationship was of great benefit to both CSTE and CDC, we felt that we could better manage this resource to accomplish CSTE's organizational goals. Our decision to proceed in this direction was pushed along by our Grants Management Officer at CDC/PGO, who required several changes in the type of work performed by and physical location of CSTE staff.

The CSTE Executive Committee and management staff have worked hard to provide a strong backdrop for the new vision. We have included our member leaders in many of our planning meetings and have shifted our focus from working




CSTE Update is a quarterly publication from CSTE National Headquarters.

Editor: Susan Reu, Diverse Communications Inc.
Designer: Stephanie Troncalli, Lazer Age Inc.

Issue No. 00-2

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directly with CDC to working directly with members. As we go into our tenth funded year, the CSTE staff and projects will provide support and resources for our members and states to assess and increase epidemiologic capacity, build a stronger workforce, and create a stronger vision for surveillance in state and federal public health agencies. We want to provide the tools necessary for members to leverage state and federal resources to build strong public health programs, based on science and data.

As is inevitable in periods of change, CSTE has lost some good people who made decisions to pursue other avenues of employment. The roster of those that have left CSTE employment is long, but rest assured that many, if not all, are continuing their work in epidemiology as CDC employees or as contractors to CDC. We feel like CSTE has served as an EIS program for CDC employees! Having worked with states is a valuable experience. Since the last newsletter, the following staff members have moved on to different employment or activities:

Kathy Getz, former CSTE Program Director –
now part-time medical recruiter, full-time mom
Joyce Neal, Epidemiologist – CDC
A.D. McNaghten, Epidemiologist – CDC
Sandy Roush, Epidemiologist – CDC
Dogan Eroglu, Marketing Specialist – CDC
Wendy Blumenthal, Data Manager – CDC
Luke Naeher, Epidemiologist –
Battelle Contractors
Becky Hart, Epidemiologist – Battelle Contractors
Richard Moyer, Program Manager – CDC
Annemarie Wasley, Epidemiologist – CDC
Stephanie Benjamin, Epidemiologist – CDC
Qaiser Muhktar, Epidemiologist – CDC

In addition, CSTE's Executive Committee has undergone some changes, with Becky Meriwether, President-Elect, moving from the Louisiana Office of Public Health to Tulane University.

All of the changes and refocusing of CSTE have moved the organization to a different level. This year we were responsible for several firsts including

- "Live" testimony at a committee hearing in which we defended our recommendations for budget appropriations for public health programs,
- An hour-and-a-half presentation at the CDC Senior Staff meeting, where Dr. Anderson presented the "old" CSTE and the "new" CSTE to our partners, and
- Adding the CDC Public Health Prevention Specialists, as a group, to the CSTE annual meeting, where they will use our conference as a training event.

Next year promises to be even more rewarding, challenging and dynamic for CSTE members and staff. We have submitted our application for funds and expect exciting projects — that need member leadership — in public health law, bioterrorism, epidemiologic assessment, hospital infection and medical errors, injury prevention and control, surveillance, West Nile Virus, MCH capacity building, chronic disease indicators, food safety, HIV, training and others. Each project we undertake will have a CSTE member as its designated lead and will be staffed by CSTE to help bring our members and partners to consensus, draft products, and assure that we meet our obligations to deliver products that the states will find helpful.

Our new organizational structure offers many opportunities for member leadership. You can read more about the structure that we've proposed beginning on page 4 of this newsletter. We hope for your continued participation and interest in the organization as you watch us grow.

Donna Knutson

Donna Knutson
Executive Director

# Synopsis of Current and Proposed CSTE Organizational Structure

A critical issue for CSTE has been managing the flow of information and coordinating or tracking communication. In other words, whom do you call within the organization for what types of issues/requests, and how are these handled and then disseminated to the remainder of the membership? The confusion exists partly because we have not had a single point of contact system. During the annual meeting we will spell out how we propose to rectify these communication/participation problems. The proposed organizational structure contains numerous opportunities for leadership among CSTE members.

## Executive Committee (10 members)

Elected by general membership, serve three-year terms

- **Officers** – President, President-Elect, Vice President, Secretary-Treasurer
- **Three Specialty Area members** – Infectious Disease, Chronic/MCH/Oral health, Environmental/Occupational/Injury
  **Three "at-Large" members**

## Proposed additional Executive Committee member duties

Specialty Members expected to serve as Executive Committee liaisons to a Standing Committee or to serve as a Standing Committee chair/co-chair: Infectious disease, Chronic/MCH/Oral health, Environmental/Occupational/Injury.

2. Surveillance, Cross-cutting Committees will also have an Executive Committee liaison or be led by an Executive Committee member, but it may be appropriate that another senior CSTE member serve as chair.

## Current Executive Committee member assignments and proposed assignments

**President –** Executive Committee chair, ASTHO liaison, APHA liaison
**Proposed** – Appoint committee chairs, appoint lead and co-lead consultants with the concurrence of the Executive Committee

**President-Elect –** Annual Meeting Planning Committee chair, NACCHO liaison

**Vice-President –** ASTHO liaison, NPHIC liaison, APHL liaisor

**Secretary-Treasurer –** Assure financial status reports, track position statements
**Proposed** – Current Secretary-Treasurer John Middaugh to serve as the initial Cross-cutting Committee chair

**Infectious Disease Executive Committee position –** NASPV liaison
**Proposed** – Incumbent Executive Committee member Susan Jenkins to serve as initial Infectious Disease Committee chair

**Chronic Disease/Oral Health/MCH Executive Committee position** – ASTCDPD liaison, AMCHP liaison, ASTDD liaison
**Proposed** – Incumbent Executive Committee member Richard Hopkins to serve as initial Chronic Disease/Oral Health/MCH Committee chair

**Environmental/Occupational/Injury Executive Committee position** – liaison with ATSDR, NCEH
**Proposed** – Incumbent Executive Committee member (term ends 6/2000) Bruce Brackin to serve as initial chair/vice-chair

**At-large Executive Committee positions** – Duties as assigned
**Proposed –**

- Incumbent Executive Committee member Gianfranco Pezzino – NAPHSIS liaison, initial Surveillance Committee chair
- Incumbent Executive Committee member Matt Cartter – initial Infectious Disease Committee vice-chair
- Vacant at-large Executive Committee position – liaison to committee of choice

Proposed – 5 Standing Committees

- **Infectious Disease**
- **Chronic/MCH/Oral health**
  **Environmental/Occupational/Injury**
  **Surveillance**
- **Cross-cutting**

**Initial organizing committee leadership as noted above. Initial committee membership made up of 1999-2000 appointed consultant leads and co-leads of related topic areas. President, with Executive Committee approval, appoints area lead and co-lead consultants for two-year terms. Terms can be renewed. At the annual meeting and throughout the year, members will be queried as to their interest in being consultants and participating on subcommittees or teams.**

Standing Committee Tasks

1. Work on position statements, resolutions
2. Participate in planning and reporting conference calls
3. Provide an "agenda" for CSTE policy
4. Organize annual meeting breakout sessions
5. Appoint a liaison to the Surveillance and Cross-cutting Committees
6. May develop topic "teams" to include other interested CSTE members and other public health professionals to help define specific agendas
   May represent CSTE during consultations with other agencies, or appoint member of "team" as designee
8. Assist CSTE staff with direction regarding funded projects
9. Responsible for reporting activities and results of consultations to Committee; Committee Chair and Executive Committee liaison reports to the National Office staff and the Executive Committee

Teams (optional at Committee's discretion)

Currently some consultants have organized specific interest member groups and have begun holding regular teleconferences or maintaining contact with the groups via e-mail. If a parent committee finds sufficient activity in an area, they may want to designate a team and team members. Teams offer broader membership participation.

## Infectious Disease Committee – Proposed Teams/Subcommittees

**HIV/AIDS**
Chair: Guthrie Birkhead
Charge:

1. Provide communication to CDC and others regarding direction of HIV/AIDS programs on quarterly basis
2. Provide guidance to CSTE staff in developing "Guidelines for the Use of Public Health Data"

**Influenza Planning**
Chair: Kathleen Gensheimer
Charge:

1. Provide communication to CDC and others regarding direction of influenza planning at state and federal level
2. Provide states seed-money to develop influenza plans
3. Provide technical assistance to states developing plans

**Food Safety**
Chair: Jesse Greenblatt
Charge:

1. Assess state food safety systems, present capacity and methods of building capacity in the future
2. Develop a network to continue to provide state-based comments and input in food safety area with other agencies

**Hospital Infections and Medical Errors**
Chair: Alfred Demaria
Charge: Create a set of consensus indicators to provide template for consistent surveillance for hospital infections and medical errors at the state level

# Chronic Disease/Oral Health/MCH Committee

**Proposed organizing Chair: Richard Hopkins**
**Vice-Chair:**

**Current Lead and Co-lead Consultants and Areas most likely to fit with this committee:**

| | |
|---|---|
| Katrina Hedberg ..... | .Cancer, NAACCR, Nutrition, BRFSS |
| Philip Huang ..... | .Cardiovascular, Cross-cutting, Diabetes, Tobacco |
| Mathew Reeves ..... | .Cardiovascular |
| Ron Voorhees ..... | .Cross-cutting, Nutrition, ASTDHPHE, Surveillance |
| Sarah Patrick ..... | .Diabetes |
| Joann Lindenmayer | .Genetics, ASTDCDP |
| Peter Rumm ..... | .Genetics |
| Cristobal Cintron .... | .MCH |
| Donna Rickert ..... | .MCH |
| Chris Maylahn ..... | .Oral Health |
| Becky Meriwether .. | .Oral Health, Surveillance |
| Bob Rolfs ..... | .BRFSS |
| Ursula Bauer ..... | .Tobacco |

**Chronic Disease Indicators**
Chair: Richard Hopkins
Charge:

1. Continue to develop "A" list of indicators
2. Develop "B" list of indicators
3. Provide data volume to states and others

**MCH Capacity**
Chair: Donna Rickert
Charge:

1. Continue to develop MCH capacity in states
2. Provide forum for CSTE and partners to develop competencies, training, and epidemiologic capacity for state health departments

**Genetics**
Chair: Joanne Lindenmayer
Charge:

1. Assess training needs in genetics epidemiology in state health departments
2. Develop mentorship program
3 Identify core elements of successful state genetics programs

**Chronic Epidemiologists to states**
Chair: Paul Siegel
Charge:

1. Provide funds to states to hire chronic disease epidemiologists
2. Assess training needs of chronic disease epidemiologists
3. Develop mentorship program
4. Identify barriers to practicing chronic disease epidemiology at state, local, territorial and tribal levels

## Environmental/Occupational/Injury Committee

**Chair:**
**Proposed organizing Vice-Chair: Bruce Brackin**

**Current Lead and Co-lead Consultants and Areas most likely to fit with this committee:**

| | |
|---|---|
| Henry Anderson | .Environmental Health |
| John Middaugh | .Environmental Health |
| Dennis Perrotta .. | .Asthma |
| Mat Reeves ..... | .Asthma |
| Mel Kohn ..... | .Injury Control, STIPDA, Surveillance |
| Carl Spurlock .... | .Injury Control, Surveillance |
| Richard Hoffman | .Lead/Other heavy metal |
| Bela Matyas ..... | .Lead/Other heavy metal |
| Tish Davis ..... | .Occupational Health |
| Ken Rosenman .. | .Occupational Health |
| Carmen Deseda | .Surveillance |
| Jim Miller ..... | .Water contamination |
| Mack Sewell ..... | .Water contamination |

## Environmental/Occupational/Injury Committee – Proposed Teams/Subcommittees

**Occupational Health**
Chair: Letitia Davis
Charge:

1. Provide member input to NIOSH and other agencies
2. Develop a plan for increasing the capacity of occupational health epidemiology within state public health departments
3. Develop a set of occupational health indicators for use at state and local levels
4. Participate in developing training activities in occupational health
5. Provide a training event for SENSOR/ABLES grantees

**Environmental Health**
Chair: Henry Anderson
Charge:

1. Provide a forum to develop environmental health indicators
2. Provide environmental health epidemiologists to states
3. Provide training to epidemiologists to expand their capacity in environmental health

**Injury Prevention and Control**
Chair: Mel Kohn
Charge:

1. Work with STIPDA to refine Injury Indicators
2. Publish document with indicators and data for states with STIPDA

# Surveillance Committee

### Proposed Chair: Gianfranco Pezzino

### Co-Chair:

**Current Lead and Co-lead Consultants and Areas most likely to fit with this committee:**

| | |
|---|---|
| Larry Hanrahan .... | .Informatics |
| Becky Meriwether | .Chronic diseases |
| Ron Voorhees ..... | .Chronic diseases |
| Guthrie Birkhead | .Infectious disease |
| Jerry Gibson ..... | .Infectious disease |
| Richard Hoffman | .Confidentiality |
| John Middaugh .. | .Confidentiality |
| Mel Kohn ..... | .Injury, Environmental |
| Carl Spurlock ..... | .Injury |
| Carmen Deseda | .Environmental |

## Surveillance Committee – Proposed Teams/Subcommittee

**Electronic Disease Surveillance Systems**
Chair: Gianfranco Pezzino
Charge:

1. Provide forum for states to explore electronic disease surveillance systems through assessment, planning and implementation of systems
2. Provide education to CSTE members and local/state/federal/legislative decision makers regarding NEDSS-type systems
3. Produce "Lessons Learned" to help states understand the decision trees and issues to be explored when setting up systems
4. Modify the "Data Release Policy" that CDC and CSTE agreed to in 1994.

# Cross-cutting Committee
## Proposed Chair: John Middaugh
## Co-Chair:

**Current Lead and Co-lead Consultants and Areas most likely to fit with this committee:**

| | |
|---|---|
| Mack Sewell | Border/International Health, Public Health Advocacy |
| Steve Wiersma .... | Border/International Health |
| Dennis Perrotta .... | Bioterrorism |
| Patty Quinlisk ..... | Bioterrorism, EIS/PMR |
| Suzanne Jenkins .. | EIS/PMR Programs |
| Betty Jung ..... | HP 2010 |
| Steve Macdonald | HP 2010 |
| Matt Boulton ..... | Public Health Advocacy |
| Donald Goodwin | Public Health Prevention Services |
| Jesse Greenblatt | Public Health Prevention Services |
| Becky Meriwether | Public Health Training |
| Mat Reeves ..... | Public Health Training |
| Tim Aldrich ..... | Women's Health |
| Donna Rickert ..... | Women's Health |
| Guthrie Birkhead | Public Health Law, IRB |

## Cross-cutting Committee – Proposed Teams/Subcommittees

**Epidemiology Capacity Assessment**
Chair: Steven C. Macdonald
Charge:

1. Revise "Epi Assessment Tool" for use at state and territorial level
2. Create system to respond to HP 2010 data requests to measure epidemiologic capacity at state health department level

**Bioterrorism**
Chair: Dennis Perrotta
Charge:

1. Provide communication to CDC and others regarding direction of bioterrorism programs on quarterly basis
2. Provide forum to develop case definitions for diseases and conditions related to a bio- or chemical attack
3. Provide information regarding response plans, electronic surveillance and early warning systems to other members of CSTE

**Public Health Law**
Chair: John Middaugh
Charge:

1. Provide communication to CDC and others regarding state public health powers surveillance, research, privacy and confidentiality
2. Assemble the list of Nationally Notifiable Diseases, link to diseases and conditions reportable at the state level, and the actual statute language for other states to use as a resource
3. Develop "Guidelines for the Use of Public Health Data"

# CSTE Profile: David Fleming, Past President

Dr. David Fleming is leaving the Oregon Health Division this month, where he has been the State Epidemiologist since 1992, to accept the position of Deputy Director for Science and Public Health at CDC.

Dr. Fleming has traveled to Atlanta from Oregon so many times over the past 10-15 years that he already considered it his second home. He began his medical career as an internist, but an elective he took at CDC as a medical student turned his attention to Public Health. What appeals to him about this field is the opportunity to prevent illness as opposed to treating illness after it occurs; in addition to being a doctor of internal medicine, he also became a doctor of preventive medicine.

As a preventive medicine resident in New Mexico, Dr. Fleming learned the value of working in the state. He went to Oregon in 1986 as Deputy State Epidemiologist and a specialist in infectious disease. The fun of working at a state health department, he says, is that you must be a generalist, working on a wide range of activities. He has especially liked working in epidemiology as the field has expanded beyond infectious diseases to chronic diseases, environmental health, tobacco prevention and injury prevention, for example. He has benefited CSTE immeasurably, serving on the Executive Committee and as President-Elect, President, Vice President, and as a lead consultant in the areas of HIV/AIDS and childhood immunizations.

Dr. Fleming is passionate about preventive health, especially tobacco control and injury prevention. Over the past four years Oregon has built a strong tobacco prevention program, and the state raised the tobacco tax to generate funds dedicated to prevention. According to Dr. Fleming, studies now show that tobacco use in Oregon has dropped over 20%; youth tobacco use has decreased there for the first time in a decade.

In the role of State Epidemiologist, Dr. Fleming has had to maintain a careful balance between advocating for sound public health policies — i.e., tobacco control — and serving as a neutral party to collect unimpeachable data and inform the debate, as in the case of legalized physician-assisted suicide, which Oregon has been the only state to legalize. "You cannot let advocacy color your reporting of the information," he explains.

His vision for Public Health includes working on the front lines to define and implement best practices; making sure that we're measuring the results of programs and modifying them as necessary; linking the science of epidemiology with applied public health surveillance and applied research; and continuing to focus appropriately on infectious disease while extending resources in other areas like educating people to avoid risk behaviors and prevent injuries.

As the CDC's Deputy Director for Science and Public Health, Dr. Fleming will be the point person there for several cross-categorical programs: minority health, women's health and global health. Overall, he sees his new job at CDC as assisting the Director in making sure that the right things happen at CDC. It's easy to see why Oregon will miss David Fleming! Meanwhile, he will miss the easy access that Oregon provides to skiing and trout fishing. Now, maybe Oregon will be his second home.

WWW.CSTE.ORG

The web site is in the process of being renovated. Information that can be found on the web site includes, but is not limited to, membership application form, newsletters, position statements, Washington Reports, publications, CSTE staff information, program updates, Annual Conference updates, By-laws, drafts of the strategic plan, membership directory, board members, calendar of events, and a members only access page.
The web site can be visited at www.cste.org

**Attention Influenza Pandemic Planners**
Influenza Pandemic Planning Meeting
September 12-13, 2000
Wyndham Gardens Hotel – Atlanta, GA

The Council of State and Territorial Epidemiologists, in collaboration with the Centers for Disease Control and Prevention, is pleased to announce a one-and-a-half-day Influenza Pandemic Planning Meeting on September 12-13, 2000 in Atlanta, Georgia. The purpose of the meeting will be to review the potential consequences of the next influenza pandemic through a table top exercise, to highlight important issues involved in planning a state pandemic response, and to discuss specific pandemic planning issues requiring state and federal cooperation. States that have begun their pandemic planning process will share their experience and "lessons learned." A highlight of the meeting will be an evening of reflections from 1976 and 1997 pandemic warnings. For more information about this exciting conference, please contact the CSTE office at 770-458-3811, or visit our web site at www.cste.org.