

# Texas Public Health Journal

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# President's Message

## Bobby Schmidt, MEd

Public health today faces many challenges. We are being plagued by deliberate threats – bioterrorism, the unleashing of infectious agents into populations, etc. Chronic disease now poses increasing challenges to an understaffed and overworked public health workforce. High-risk behaviors rob our children of healthy futures.

Heart disease, cancer, diabetes, Alzheimer's disease and other chronic conditions now account for 70 percent of all deaths in the United States each year and for one-third of the years of potential life lost. This tragedy is compounded by the fact that these deaths are largely preventable.

Automobile injuries, homicide, and suicide account for 60 percent of deaths among youth. Five million of today's school children will die prematurely from tobacco use. Twenty-six percent of teens are overweight and at increased risk of high blood pressure, stroke and diabetes. And one million teen age girls will become pregnant in the United States this year – the highest rate for any developed country.

Texas is shadowing these national statistics. We must retool, reshape and rebuild our public health infrastructure. We must improve preparedness to bioterrorism, develop public health training centers, improve response to emerging infectious disease and develop a comprehensive food safety program if we are to have a positive impact on the public health infrastructure.

We must assure structural soundness across the board and require a more comprehensive, sustainable effort from state and local governments, as well as the private sector. This must be built on an ethic of accountability and commitment to measure not only health outcomes but also the performance and contributions of public health's infrastructure.

(Comments taken from: Public Health's Infrastructure – A Status Report by the Department of Health and Human Services, Centers for Disease Control and Prevention)

We in public health have a very unique profession. We are the only profession that touches all aspects of all Texans lives everyday. Think about it – from the water and milk we drink, to the air we breathe, to the immunizations we receive, to the food we consume, to a birth or death certificate, to preventing epidemics and protecting against environmental hazards, to assuring quality and accessibility of health services – public health is there. Think about it – we are doctors, nurses, epidemiologists, sanitarians, lab technicians, dental providers. Think about it – we are educators, policy makers, and we monitor health status in our communities. But we can be much more – we need to be much more.

During this next year, I will call on some of you to assist me and the TPHA leadership to take our organization – your organization – to a higher level. We will need you to help us mentor our young colleagues to become the public health professionals of the future. We will need you to encourage those around us to take our public health message to those that need to hear it. We will need you to take the necessary steps to partner with other public health workers and organizations to assure that prevention prevails and disease falls to the side. But mostly we will need you to be an active participant in your Texas Public Health Association.

I am proud to be the 2011 – 2012 President of the Texas Public Health Association. I am humbled by your confidence but I am energized by what lies ahead.

I now challenge you to double the size of our organization by getting at least one member to join TPHA over the next year.

Please join us in Arlington, Texas at the Arlington Sheraton Hotel, March 21 – 23, 2012 for the Texas Public Health Association's - 88th Annual Education Conference.

**From the Editor:** The summer issue, 2011 of the Texas Public Health Journal features 2 columns from our poison control expert to help you stay informed and stay healthy during the busy summer season. Think this summer has been exceptional so far? Our librarian and history buff compares it to the past. Along with a unique mix of Texas focused public health research, this

issue brings you part 1 of a 2 part series on Public Health Accreditation. The authors have done a fantastic job of providing a detailed background of the program. Part 2, coming in the Fall 2011 issue, will spell out the implications of becoming accredited. This is a very important topic in the public health field now and we thank the authors for choosing our journal to publish it in. We wrap up this issue with highlights from our successful Texas Public Health Association annual conference held in Houston, Texas in April and co-hosted by the Houston Department of Health and Human Services. We thank all who helped to make this event educational, informative and provide a venue for public health researchers to share their important work with their colleagues. Have a safe, healthy summer y'all!

## Commissioner's Comments

### The Faces of Disasters

David L. Lakey, M.D.

Commissioner, Texas Department  
of State Health Services



You've seen the stats. Texas has more presidentially declared disasters than any other state in the nation by a 2-to-1 margin. Since last fall, wildfires in Texas have scorched an area roughly larger than Delaware and Rhode Island combined. Over the years, there have been billions of dollars in property damage. Yet with all of these statistics, it's easy to forget that each disaster has a human face.

Together we have seen the devastation on the faces of those who survived a disaster as they try to make sense of a situation that sometimes cannot be explained. While the toll of these disasters is often measured in dollars, it's important to remember that it's our families, our friends, and our neighbors who may have been touched by a disaster. The faces are real. Hundreds of lives lost. Thousands of people deeply affected. Lives can be spared and much of the physical and emotional harm can be prevented or at least lessened. Many of the individuals and communities bearing the brunt of disasters did not have an emergency plan in place. Research tells us that people don't think a disaster will happen to them. Maybe folks thought that making a plan was something they would or could get to later. Possibly, they thought that they were 100 percent prepared, but in reality, they were not.

We cannot underestimate the impact a disaster can have on the people of our state. The costs can be staggering in terms of human lives and dollars spent trying to recover. Preparation and behavior change are the keys.

Information and tools to help individuals and communities make disaster plans are readily available. Along with other federal and local initiatives, DSHS has been building a trove of preparation resources through our *Ready or Not? Make a Plan* campaign since 2007. Many government and volunteer

organizations have invested a great deal to help communities make or improve disaster plans, and along the way they have had a positive impact by preparing Texans for disasters. The work has yielded immeasurable results and we gratefully recognize those who make this work their life's calling.

Often, the challenge is to convince people that disasters do happen – and that it could happen to them. It's hard for people to relate to a brochure or website that tells them to make a plan, to be prepared. They need help to connect on a visceral level to a potential disaster; otherwise it's just words on a brochure, a website or a PowerPoint presentation. We believe a tool to help is now available.

The Texas Department of State Health Services recently released *Surviving Disaster: How Texans Prepare*, an original documentary series that features Texans telling extraordinary stories of survival and sharing the lessons they've learned. The series was produced by the Texas Department of State Health Services in partnership with the Texas Division of Emergency Management and is available at [www.TexasPrepares.org](http://www.TexasPrepares.org).

The series puts a human face on disasters, reinforces how to prepare and shows the impact a disaster can have on a community.

The six eight-minute stories, produced in English and Spanish, include:

- Surviving Hurricanes: Grab It and Go
- A Community Rebuilds: Recovering From Wildfires
- Back to Business: Planning for Disasters
- Ready for Anything: Preparing for the Next Flood
- Winds of Destruction: A County's Lessons
- Facing Disasters: A Plan for Work and Home

DSHS has screened the videos in several communities across the state. We are putting the documentaries into the hands of people in Texas so they will watch them, make a disaster plan, show the videos to others and share them electronically.

The protagonists in the videos share the impact that disasters had on them. You can see a couple on Bolivar Island recall taking a "last picture" of their house as they evacuated ahead of Hurricane Ike. Watch a Montague County resident talk about a wildfire that in a matter of minutes destroyed the dream home he'd worked on for more than 23 years. A Maverick County resident retells the story of seeing a washing machine and a horse fly by during a tornado.

There are lessons to be learned through these stories. Along with advice from DSHS subject-matter experts, the survivors tell us what they've done to be better prepared for the next disaster. The videos show two businesses execute their disaster plans after having survived earlier disasters. Subjects show us how they now have a grab and go kit and plans to prepare their important documents, medications and supplies in the event of another emergency.

Public health and disaster behavioral health personnel are very involved in responding to a disaster. We also can be involved in helping people make a plan. I encourage you to use these videos to reach out to people in your communities whose job

duties involve disaster preparedness. Show them the videos and partner with them to screen them for others in your community. I also believe that key community influencers such as faith-based organizations, civic groups and businesses can be approached to use the videos to build public awareness around preparing for disasters. A prepared community is a strong community.

All of the videos, a booklet providing tips for setting up a screening, a post-screening discussion guide and other helpful resources can be downloaded from the [TexasPrepares.org](http://TexasPrepares.org) site. We've seen the faces of disaster. Now they can help others prepare. Our mission is to improve the health and well-being in Texas and we will continue our work to reduce the number of lives affected by disasters.

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# Texas Public Health Association

Affiliate of the American Public Health Association

**Welcome to the Texas Public Health Association**

The Texas Public Health Association (TPHA) is a non-profit, state-wide association of public health professionals dedicated to public health in Texas. TPHA was organized in 1923 and is an affiliate of the American Public Health Association.

Our motto is **"Health is Every BODY's Business"**

Make Public Health **YOUR** Business and [Join Today!](#)

**Vision Statement**

A safe and healthy Texas

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# A Review of the Public Health Agency Accreditation Literature: Part 1

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## ABSTRACT

The journey toward public health agency accreditation in the United States began with the 1988 Institute of Medicine (IOM) Study for The Future of Public Health. In 2010, the Public Health Accreditation Board (PHAB) completed the beta test on the voluntary national public health accreditation program. Part I summarizes the history of the development of the public health accreditation process in the United States. Part II examines public health agency accreditation pros and cons and reviews the quantitative and qualitative research and quality improvement data to answer the questions: "To what extent does voluntary public health accreditation improve quality, outcomes, and service operations?" and "Can the public health accreditation standards apply equally to both large urban and small rural local health departments?" The authors determined the literature provided some degree of quantitative, qualitative and quality improvement evidence that accreditation can improve quality, outcomes, and service operations. However, there was limited evidence that small local health departments will be able to meet the same accreditation standards as large urban health departments without some accommodations.

**Key terms:** public health accreditation

## *History of the Public Health Agency Accreditation Process in the US*

Public health agency accreditation in the United States began with the 1988 Institute of Medicine (IOM) Study for *The Future of Public Health*.<sup>1</sup> The report prompted the search for a definition of public health. In response, in 1994, a Steering Committee made up of United States public health service agencies (Table 1) and other public health organization representatives developed and published the 10 Essential Public Health Services.<sup>1-2</sup> (See Table 2)

Between 1998-2002, the Center for Disease Control and Prevention (CDC) funded and partnered with seven national public health organizations to develop the National Public Health Performance Standards Program (NPHPSP).<sup>3</sup> The organizations included the American Public Health Association (APHA), Association of State and Territorial Health Officials (ASTHO), National Association of County and City Health Officials (NACCHO), National Association of Local Boards of Health (NALBH), National Network of Public Health Institutes (NNPHI), and the Public Health Foundation (PHF). The project delineated public health standards for local and state public health systems and local governing bodies and created three assessment tools to evaluate the public health system. The State Public Health System Performance Assessment tool has been used in 19 states. The Local Public Health System Performance Assessment tool has been used in more than 500

jurisdictions. The Local Governance Performance Assessment tool has been used for more than 200 Boards of Health.<sup>3</sup>

In 2002, the IOM report, *Future of the Public's Health in the 21st Century* recommended creating a national committee to review possible advantages of public health accreditation and to decide how the system should operate.<sup>4,5</sup> Between 2002-2005, NACCHO created the Operational Definition of a Functional Local Health Department (LHD) matching the functional standards to the 10 Essential Services of Public Health (listed in Table 2).<sup>1,6</sup> The definition and standards describe the primary responsibilities of LHDs.

In 2004, public health stakeholder organizations decided to study local and state public health department accreditation options.<sup>4</sup> Between June 2005 and December 2006 the Robert Wood Johnson Foundation (RWJF) and CDC funded the *Exploring Public Health Accreditation Project*. The project's charge included determining if and how a voluntary national accreditation program effects state, local, territorial, and tribal public health department's quality and performance, and creating a potential accreditation model.<sup>4</sup> This landmark report defined the public health accreditation program parameters and determined accreditation was both feasible and advantageous.<sup>7-8</sup> The Exploring Public Health Accreditation Steering Committee made up of representatives from public health agencies and organizations identified the following reasons for recommending accreditation: 1) to improve quality, accountability, and credibility of public health departments; 2) "at least 18 states" currently conduct "performance and capacity assessment and improvement efforts;"<sup>7</sup> 3) the state programs demonstrate support for a voluntary accreditation program; 4) accreditation will promote consistency in public health agencies' performance; and 5) will assist with defining what public health does and what the public should expect.<sup>7</sup> In May 2007, PHAB incorporated as a not-for-profit organization.<sup>4</sup>

Beginning in September 2009, PHAB recruited 19 LHDs, eight state health departments and three Tribal health departments to participate in the accreditation beta test. The populations served by the LHDs varied from 5,664 to 3.1 million. PHAB completed the beta test of the accreditation tools and documents in October 2010. To gain additional information PHAB used the Think Tank method to partner with appropriate entities in special circumstances. For example, the Public Health Accreditation Council of Texas (PHACT) held three Think Tank meetings in June, July, and August 2010. The more than 50 contributors represented 25 small, medium, and large LHDs, the state health department, and other public health organizations. The participants identified challenges to the accreditation process and provided recommendations for improvement to the accreditation standards and the process.<sup>9</sup> Revisions to the PHAB accreditation standards, measures, documentation guidance, scoring/weighting, and other relevant tools are in progress and PHAB expects to launch the voluntary national public health accreditation program in fall of 2011.

The Multi-State Learning Collaborative (MLC) funded by the RWJF and the CDC and formed in 2005 is a parallel project

to the *Exploring Public Health Accreditation* project.<sup>10</sup> The MLC project's initial goal was to link the five states (Illinois, Missouri, North Carolina, Michigan, and Washington) "that had made considerable progress in improving their infrastructure through either state-based accreditation programs or accreditation-like processes"<sup>10</sup> and to share their lessons learned with colleagues and national public health partners. The MLC participants provided the Exploring Accreditation Steering Committee with examples of public health agency accreditation processes. The MLC project role included informing the Steering Committee and influencing the 2006 *Final Recommendations for a Voluntary National Accreditation Program for State and Local Health Departments* report.<sup>10</sup>

In the MLC's second phase, the participants increased to 10 states (adding Florida, Kansas, Minnesota, New Hampshire, and Ohio) and the efforts concentrated on quality improvement (QI) approaches in public health, specifically how to improve the participant's accreditation and assessment programs. The project included QI training and sharing QI tools, methods, and practices. This phase demonstrated how QI augments accreditation and assessment programs. The third phase of the MLC project implemented in 2008 expanded participants to 16 states (adding Indiana, Iowa, Montana, Oklahoma, New Jersey, Wisconsin, and South Carolina). The project's goal is to create a culture of QI, build QI into the public health agency's infrastructure, and lay the groundwork for national public health accreditation. The MLC participants created multi-health department teams to address specific public health problems by developing public health capacity and processes and improving outcomes using QI methods. For example, one health outcome target area is to "reduce the incidence of vaccine preventable disease"<sup>10</sup> and one capacity process target area is "assure competent workforce."<sup>10</sup>

In summary, public health agency accreditation started 23 years ago with the 1988 IOM Study for *The Future of Public Health*.<sup>1</sup> Many public health leaders, agencies, and organizations played important roles in the development of public health agency accreditation. The journey's milestones includ-

ed the development of the 10 Essential Public Health Services, the NPHSP, NACCHO's Operational Definition of a Functional LHD, the RWJF and CDC funded *Exploring Public Health Accreditation Project*, the PHAB's accreditation Beta Test, and the RWJF and CDC's funded Multi-State Learning Collaborative (MLC). PHAB is in the process of evaluating the state, LHD, and Tribal health department accreditation standards and plans to launch the voluntary national public health accreditation program in fall of 2011.

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**Table 1: Members of the Public Health Steering Committee**

American Public Health Association (APHA),  
 Association of Schools of Public Health,  
 Association of State and Territorial Health Officials (ASTHO),  
 Environmental Council of the States,  
 National Association of County and City Health Officials (NACCHO),  
 National Association of State Alcohol and Drug Abuse Directors,  
 National Association of State Mental Health Program Directors,  
 Public Health Foundation,  
 U.S. Public Health Service  
 (Agency for Health Care Policy and Research, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Services, National Institutes of Health, Office of the Assistant Secretary for Health, and Substance Abuse and Mental Health Services Administration).

**Table 2: 10 Essential Public Health Services**

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

# Peanut Butter Recall Calls Received by Texas Poison Centers

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## ABSTRACT

**Background:** On February 14, 2007, the Food and Drug Administration issued an alert warning to consumers not to eat certain jars of peanut butter because of possible Salmonella contamination, and the peanut butter was recalled. This investigation tested whether the Texas poison center system call volume was affected by this recall.

**Methods:** Cases were all peanut butter recall calls received by Texas poison centers from February 14 through June 30, 2007. The pattern of calls was examined with respect to the date of the calls and location from which the calls originated.

**Results:** A total of 988 such calls were received. Twelve calls were received the day of the recall. Most calls (499) were received on February 15, accounting for 50.5% of all peanut butter recall calls. The next highest number of calls was received on February 16 (179), followed by February 17 (65). Calls continued to be received through April (12), May (5), and June (3). Most of the calls came from counties in the eastern part of Texas.

**Conclusion:** Texas poison centers began to receive calls relating to the peanut butter recall shortly after the recall was announced. Most of the calls were received on the day after the announcement and declined over following days but continued for a relatively long period of time.

## INTRODUCTION

In November 2006, the Centers for Disease Control and Prevention (CDC) and state health departments noticed an increase in reported cases of Salmonella serotype Tennessee. The cases were not clustered geographically. The outbreak was ultimately linked to Peter Pan and Great Value peanut butter manufactured in the same ConAgra Foods plant in Georgia.<sup>1</sup>

On February 14, 2007, the US Food and Drug Administration (FDA) issued an alert warning to consumers not to eat certain jars of these brands of peanut butter.<sup>2</sup> ConAgra Foods recalled the products.<sup>1</sup> The FDA warning and company recall were quickly reported in the media.<sup>3,4</sup> Cases were reported from many of the states, including sixteen in Texas as of March 7, 2007.<sup>1,5</sup> This was the first reported foodborne illness outbreak linked to peanut butter in the US.<sup>1</sup>

Poison centers in the US receive calls relating to a variety of substances, including food poisoning.<sup>6-10</sup> These calls may involve requests for assistance in the management of suspected or confirmed food poisoning as well as for general information on food poisonings. According to the annual report of the American Association of Poison Control Centers (AAPCC), adverse reactions to food products and food poisoning accounted for 30,489 (1.2%) of the 2,491,049 exposures reported by US poison centers in 2008.<sup>11</sup>

Poison centers may play an important role in major foodborne outbreaks. Poison centers may assist in the identification of food poisoning cases. Poison centers also may serve as an information source for the public if they have questions about the outbreak. The objective of this investigation was to describe peanut butter recall calls received by Texas poison centers in an effort to demonstrate the pattern of calls a poison center might receive during such an outbreak.

## METHODS

The Texas Poison Center Network (TPCN) consists of the six poison centers that together service the entire state, a population of over 20 million. The six poison centers use the same Toxicall software and database to collect information on all of the handled calls.

The TPCN has in place a mechanism by which calls relating to a particular event can be flagged for subsequent convenient identification and analysis. This mechanism has been used in the past for events such as Hurricane Katrina and Hurricane Rita. On February 14, 2007, when TPCN staff realized that the poison centers were receiving a number of calls relating to the peanut butter recall, it was decided to flag these calls. The poison centers reviewed those calls received on February 14, 2007, prior to putting the flag in place in order to identify those earlier calls that also needed to be flagged.

Cases for this investigation were all peanut butter recall calls received by the TPCN from February 14 through June 30, 2007. The end date was chosen because monitoring of the TPCN database over time suggested that few, if any, peanut butter recall calls would be received after that date. The distribution of calls was determined for the date the call was received. The total number of calls (peanut butter calls and all other calls) received by the TPCN each day during the first month of this time period was calculated and compared with the total calls received each day from a similar time period in 2006. Since Texas poison centers may receive calls from other states, the pattern of states from which the peanut butter recall calls originated was evaluated. For peanut butter recall calls originating in Texas, the distribution of calls by county and Public Health Region from which the call originated was determined. It was not possible to distinguish calls that actually represented persons sickened by the tainted peanut butter from calls where a person had eaten untainted peanut butter or simply requested information on the topic.

No attempt was made to perform analyses of statistical significance. The Texas Department of State Health Services institutional review board considers this investigation exempt from review.

## RESULTS

The TPCN received a total of 988 calls relating to the peanut butter recall during the period of February 14 through June 30, 2007. Figure 1 presents the distribution of these calls by date for the first month of the time period. The TPCN began receiving calls the day of the recall. The peak number of calls was received on the following day, February 15, 2007, when 50.5% of all peanut butter recall calls were received. The

number of calls quickly declined on subsequent days although calls continued to be received for months after the initial recall notice (e.g., 12 in April 2007, 5 in May 2007, 3 in June 2007). A total of 928 (93.9%) of the calls had been received during the period of February 14 through February 27, 2007, the first two weeks after the recall.

When the total number of calls (peanut butter recall calls and all other calls) received by the TPCN during February 14 through March 14, 2007, was examined (Figure 2), the total number of calls received on February 15, 2007, was 27.0-76.1% higher than the total calls on any other day during this time period. Peanut butter recall calls accounted for 499 (35.5%) of the 1,405 total calls received by the TPCN on February 15, 2007.

Poison center call volume can be cyclic. For example, calls vary over the week, being fewer around the weekend. Thus it could be that the high number of calls received on February 15, 2007, was part of a cycle. However, when the total number of calls was compared to a similar time period during 2006 (Figure 2), the number of calls received on February 15, 2007, was 32.8% higher than the 1,058 calls received on February 16, 2006. For all other dates during the two time periods, the call volume did not differ by more than 16.0%.

Fifteen (1.5%) of the peanut butter recall calls originated from outside of Texas: Arizona (1), Arkansas (1), California (2), Florida (2), Georgia (1), Missouri (2), New Mexico (4), New York (1), and Oklahoma (1). Of the 973 calls that originated in Texas, the county was unknown for six (0.6%). Figure 3 shows the counties from which the remaining 967 peanut butter recall calls originated. Although calls originated from all over Texas, the calls seemed to be concentrated in the eastern part of the state. When the peanut butter recall call rate per 10,000 population was calculated for the eleven Public Health Regions using Census 2000 data as a denominator (Figure 4), it was found that the rate varied by Public Health Region. The rates were higher in northern and extreme western Texas.

## DISCUSSION

This investigation described the pattern of calls reported to Texas poison centers regarding the recall on February 14, 2007, of peanut butter possibly contaminated with *Salmonella* serotype Tennessee, an event that received extensive media coverage. Poison centers may play an important role in public health events such as mass chemical exposures, natural disasters such as hurricanes and earthquakes, hazardous materials emergencies, and power outages.<sup>6-8,12-19</sup> However, there is little information on the type of calls poison centers might receive with respect to major foodborne outbreaks such as this one.

There are several limitations to this investigation that should be considered. This study could not distinguish between confirmed and suspected poisoning with *Salmonella* serotype Tennessee from tainted peanut butter and information requests. Nor could a detailed evaluation of the callers except for the location where the call originated be performed.

The TPCN began to receive calls relating to the peanut butter recall shortly after the recall was announced and covered by

the media. As an already active system, the TPCN was able to respond to these calls promptly. Moreover, since the TPCN already had a procedure for flagging calls related to special events, analyses of calls relating to this event could conveniently be performed.

Most calls were received in the first days immediately after the recall, although a dwindling number of calls continued to be received for a number of days after the initial warning and recall. This pattern has been observed in Texas for other events such as the anthrax scare in 2001 and a chlorine gas release in 2004.<sup>20,21</sup> Such a call pattern might be anticipated since public concern over such an event would be expected to be highest immediately after an event then decline as time passes. Similar events in the future might be expected to exhibit an analogous pattern. This might be useful for poison center planning and allocation of resources for such events.

The peanut butter recall resulted in a major increase in total call volume on the day after the recall. Accordingly, it is important for poison centers to attempt to have a way to increase their ability to handle calls in the event of a public health event. The telecommunications system of the TPCN permits calls originating in the area covered by one of its poison centers to be answered by any of the other poison centers. Intended to decrease the time callers would have to wait before receiving assistance, this telecommunications system is part of the TPCN's normal operation. Thus, if a public health event occurs in one part of Texas that might result in a rapid increase in calls to a given poison center so that its staff are overwhelmed, nothing needs to be done by the TPCN to allow calls to spill over from the one poison center to others of the TPCN. An extreme example of the utility of this telecommunications systems occurred in September 2005 when Hurricane Rita forced the closure of the Southeast Texas Poison Center based in Galveston. While it was closed, any calls that would normally have been received by this poison center were handled by the other five poison centers of the TPCN.

Other methods for allowing poison center calls to be answered in the event of public health events are to allow poison center staff to handle calls from home or other locations or have a system for transferring calls to poison centers in another state.<sup>22-25</sup>

More peanut butter recall calls were received from counties in eastern Texas, and higher call rates occurred in northern and west Texas, in spite of the fact that the recall received national (and presumably statewide) attention. The reason for this geographic variation in peanut butter recall calls is unclear. It could reflect differences in the tendency to contact the TPCN, demography, local media coverage of the recall, tendency to pay attention to the media, or peanut butter consumption. Such regional differences might need to be considered when poison centers responds to similar events in the future.

In conclusion, this study indicates that poison centers will probably become involved in public health events such as food-borne outbreaks, and this involvement may start shortly after the event. As a result, it would be useful for poison

centers to be prepared for such events. Moreover, it might be useful for public health organizations to provide support to poison centers during these events and to coordinate with the poison centers to ensure that commonly agreed upon information is provided to the public about the event.

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Figure 1. Peanut butter recall calls received by the Texas Poison Center Network during February 14-March 14, 2007, by date.

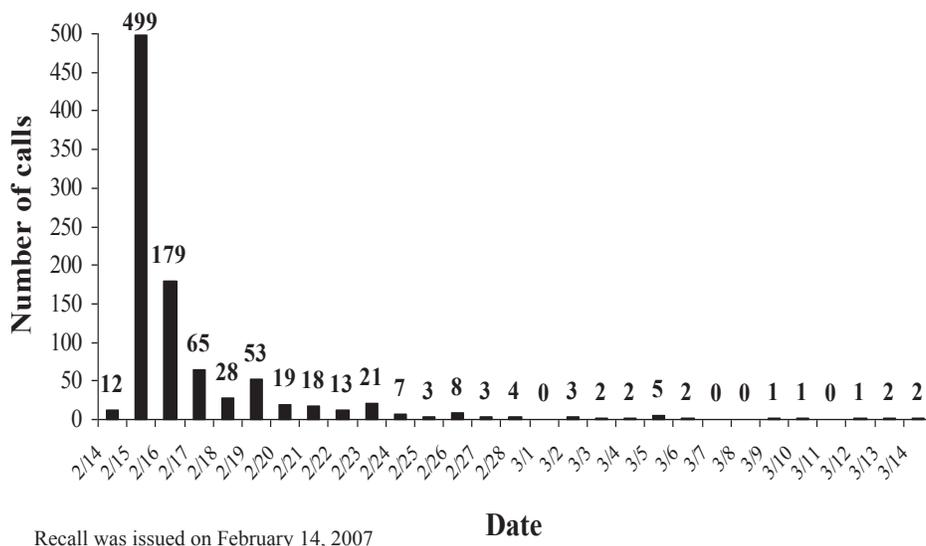


Figure 2. Total calls received by the Texas Poison Center Network during February 14-March 14, 2007, by date

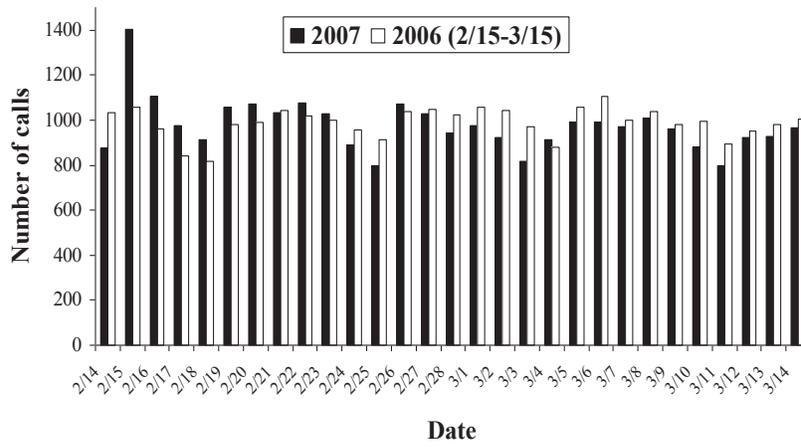


Figure 3. Peanut butter recall calls received by the Texas Poison Center Network during February 14-June 30, 2007, by county of call origin

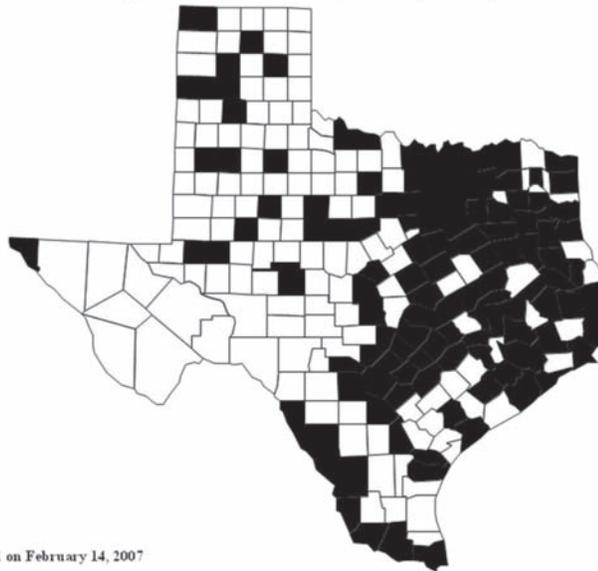
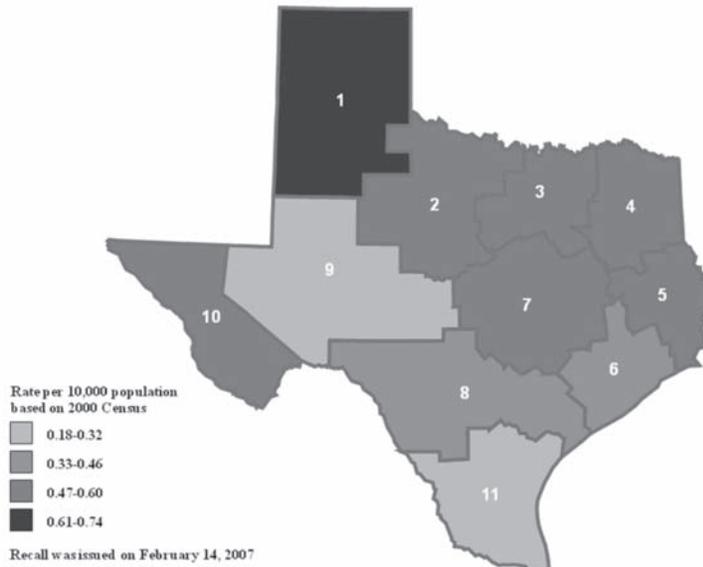


Figure 4. Rate of peanut butter recall calls received by the Texas Poison Center Network during February 14-June 30, 2007, by Public Health Region



# Novel Activity Reduces Nursing Home Depression

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## ABSTRACT

As a result of medical advances and improved self-care, people are living longer. For many, advanced age is accompanied by reduction in mental and ambulatory capabilities creating a need for medical care and/or assistance to perform everyday activities. For the older, old (> 85 years), the fastest growing elder population segment, this often means living in a long-term care facility. Women and special populations comprise more than 70% of nursing home residents, and 40% of the nation's nursing homes are found in rural areas.

The transition to a long-term care facility is a significant life event. Although sadness and depression are not a normal characteristic of aging, up to 50% of nursing home residents have some degree of depression. Depression increases medical costs, may lessen life span, and severely undermines quality of life for nursing home residents. Interventions that provide mental stimulation, help overcome loneliness, foster social interaction and social support, aid functional capabilities, and improve perception of care, are needed to combat the disorder. Among rural nursing homes budgets and services are often limited. In an effort to address these issues, we initiated a pilot study of a low-cost intervention that blended active music therapy and modified dance therapy. Nineteen elders from senior facilities in two mid-size Central Texas towns were studied. All nursing facility residents were wheelchair user females who ranged in age from 73 years to 98 years. The intervention consisted of twice a week, 45-60 minute activity sessions for a period of 8 weeks. Pre-and post-study instruments were used to assess cognitive status, depression symptoms, and functional abilities. Independent samples t-tests determined depression symptoms declined significantly ( $p = 0.0031$ ), with mild improvements in mental status and functional abilities.

## INTRODUCTION

As a result of medical advances and improved self-care, people are living longer. By 2050 the federal government forecasts that there will be 86.7 million individuals aged 65 or older -- encompassing 20.6 percent of the total population.<sup>1</sup> For many, advanced age is accompanied by reduction in mental and ambulatory capabilities, creating a need for medical care and/or assistance to perform everyday activities. This need is even more pronounced among the older, old (>85 years). This cohort is one of the fastest growing elderly population segments, and represents a majority in many long term care facilities.<sup>2</sup> Indeed, an inability to safely ambulate and some level of confusion is often the admitting factor to a long-term care facility. Demographically, more than 70% of nursing home

residents are women and special populations, and more than 40% of nursing homes are found in rural areas.<sup>3-4</sup>

The transition to a long-term care facility is a significant life event which can leave individuals in an unfamiliar state of dependency on others. The relocation is a complex adjustment for individuals that may exacerbate a variety of physical and mental disabilities. Depression is a common condition among long-term care residents and is associated with chronic disease, social isolation, loneliness, lack of social support and perceived inadequacy of care.<sup>5</sup> The prevalence of depression among nursing home residents may range from 6 percent to nearly 50 percent depending on the degree of severity.<sup>5-7</sup> Symptoms of depression often accompany chronic illness such as diabetes, heart disease, cancer and Parkinson's. Unfortunately, the depressive symptoms may be undertreated as they are viewed as co-morbid to the health condition.<sup>8</sup> Research suggests depression is associated with inferior outcomes for cardiovascular conditions, diabetes and rehabilitation programs; individuals with depression are more likely to experience falls; and, although debatable, depression is generally linked to increased mortality among seniors.<sup>9-11</sup>

Reducing depression and generally improving quality of life among long-term care (LTC) residents is a topic of interest for consumers, providers, public officials, and policy advocates.<sup>12</sup> However, due to resource limitations, staffing shortages and a lack of true direction toward reforming long-term care, improved quality of life for LTC residents remains a difficult challenge. In this study, we evaluated an innovative, non-pharmacological, low-cost activity to provide cognitive and physical stimulation, enhance mood, and relieve depressive symptoms among LTC residents. The approach incorporated elements of music therapy, dance therapy and reminiscence focused music sessions to engage nursing home residents.

## METHODS

This pilot study assessed a new activity to promote health and improve quality of life among residents of two central Texas long-term care facilities. Study format included a pre-post study analysis of mental status, functional abilities and depression. Participation in the study was voluntary with membership representing the residential population of the respective facilities. Inclusion criteria included the ability to follow simple commands and a score of greater than 5 on the Mini-Mental State Examination. The study was approved by the Texas State University Institutional Review Board. Study participants were wheel-user females with average age of 86 years. Intervention consisted of biweekly 45-60 minute activity sessions for a period of 8 weeks. Nineteen residents began the study and two dropped.

Nurses and social workers performed pre-post study residential assessments. Tools included The Mini-Mental State Exam and The Cornell Scale for Depression in Dementia. Weekly reports used to update the Minimum Data Set (MDS 2.0) were reviewed to assess the degree of assistance needed to perform key indicators for activities of daily living (ADLs) -- bed mobility, transfers, eating and toilet use.

Selection of analytical techniques was influenced by a small population sample, homogeneity among the participants and the absence of predictor variables. Accordingly, t-tests were used to determine if the intervention was associated with an improvement in cognitive skills, enhancement of ADLs, or reduction in depression. Analysis determined the improvement in depression scores was statistically significant ( $p=0.0031$ ). Hence, the five subscales of depression were examined to determine which factor(s) may have influenced improvement in scores. Subscales include Mood (anxiety, sadness, reactions to pleasant events, irritability), Physical signs (appetite, weight, energy levels), Cyclic functions (mood variation, awakening at night, earlier awakening), Behavior disturbances (agitation, slow-movements, physical complaints, loss of interest) and Ideational disturbances (suicidal, poor self-esteem, pessimism, mood-congruent delusions). Scores for these scales were statistically analyzed with descriptive statistics and t-tests.

### **Intervention**

A certified dance instructor experienced in working with residents of long-term care settings led the modified dance intervention. Wheelchair users were positioned in close proximity circling the “dance floor”. During the session, participants are taken to the center of the dance circle to receive individual attention and instruction. Individual instruction for the wheelchair users took the form of the instructor twirling the wheelchair while promenading around the interior perimeter of the circle keeping time with the music. Wheelchair residents received a colorful scarf at the beginning of the intervention and were encouraged to actively wave and twirl the scarf during the session. Residents were also encouraged to tap their feet and wave their scarf to the best of their ability. Musical selection was deemed an important component of the intervention with offerings designed to match periods during which the elder lived during younger and middle age. Musical tone and structure were also closely considered with sessions beginning with upbeat tempos followed by a few ballads or “minor notes” and ending with “major” note music.

### **RESULTS**

Seventeen residents completed the study. The Mini-Mental State Exam suggested all residents participating in the study displayed cognitive impairment at the beginning of the intervention. Post-study analysis determined improvements or declines in mental status and ADLs were not statistically different from the beginning of the study. Seven of 17 participants (41%) displayed significant depressive symptoms prior to the study; Six percent of residents displayed depressive symptoms after the intervention. An independent-samples t-test revealed a significant difference in depression scores pre-study ( $M=7.0000$ ,  $S.D.=3.5200$ ) and post-study ( $M=3.8200$ ,  $S.D.=2.1000$ ) conditions;  $t(32)=3.1988$ ,  $p=0.0031$ . Figure 1 provides a descriptive summary of pre and post study assessment.

Independent-sample t-tests of the depression inventory subscales indicate significant improvements in mood, cyclic functions, and physical signs. The subscale associated with behavioral disturbance presented improvements but not quite

statistically significant findings. Scores for ideational disturbances were not improved. Statistics depicting subscales analysis are found in Table 1 with a descriptive display presented in Figure 2.

### **DISCUSSION**

The America Dance Therapy Association has defined Dance Movement Therapy (DMT) as the “use of movement as a process which furthers physical and emotional integration of an individual”.<sup>13</sup> Dance Movement Therapy (DMT) has been reported to be an effective non-pharmacological treatment for improving cognition and behavior among individuals with dementia.<sup>14</sup> According to researchers, psychosocial experiences and expressing feelings and emotions are evoked with DMT as the activity involves interrelation group sessions which allow participants to communicate and share their emotions with others.<sup>15</sup> A review of social dance among community dwelling and ambulatory long-term care residing seniors suggest the activity provides psychosocial benefits.<sup>15-19</sup>

This study targeted a unique population consisting of wheelchair using older nursing home residents. Forty-one percent of the nursing home residents were depressed prior to study initiation. Subsequent to the study, only 6% of the population presented depression. Analysis of depression subscales reveals meaningful improvements in four of the 5 scales including Mood, Behavioral Disturbances, Physical Signs and Cyclic Functions. Very significant improvements in Mood suggest the intervention relieved sadness, anxiety, irritability and improved reaction to pleasant events. Extreme improvement in Physical Signs and Cyclic Functions corresponds with reduced mood variations, and improved appetite, sleep and increased energy. The scale for Behavioral Disturbances was improved although not statistically significant, a finding that agrees with nursing staff reports of increased interest with life in general, but not a reduction in physical complaints. The one scale that did not demonstrate improvement was ideational disturbances.

A detailed literature review failed to discover comparable health promotion interventions for wheelchair user nursing home residents. As such, this intervention is a promising new activity to reduce depression, enhance social skills and improve personal dignity among older, non-ambulatory nursing home residents. The activity may be particularly useful in rural settings where music and dancing are a major part of a woman’s social life.

Study limitations include the possibility of selection bias as the study sample was a small, non-randomized convenience sample recruited by the facility and investigators. Additionally, although mental status and ability to perform ADL’s remained stable, the absence of change in ADLs may reflect a bias resulting from using a tool for both quality assessment and for Medicare/Medicaid reimbursement.<sup>20</sup> Generalizability of the results from the two nursing homes studied is also a limitation although the study was designed as a pilot to demonstrate outcomes within the facilities studied.

Future studies to include a larger sample of elders derived

from multiple nursing homes will provide an opportunity to determine if the benefits found in this pilot could apply to different nursing home environments both in terms of residents and nursing home personnel. Additional research in the practical methodology of the intervention could include assessment of the importance of the selection and sequencing of music; the method by which the instructor interacts with the participants; the twirling of a participant while they wave a scarf; and the effects of having a community of participants encircle the isolated resident while the resident receives instruction.

Implications from this study suggest a new method to relieve depression in wheelchair user nursing home residents. This activity is a low-cost means to improve the life experience of elders. Program benefits that coincide with a reduction in depression symptoms included a reduced feeling of isolation. For one resident, a change in care plan was necessary after her "social awakening," a behavioral change the nursing staff credited to this program. The group environment allows elders an opportunity to verbally and nonverbally communicate with peers reducing social isolation and loneliness. Strong improvements for anxiety, sadness, reaction to unpleasant events and irritability were demonstrated and participants displayed better appetites, energy levels and sleep cycles.

A modified dance/music therapeutic activity stabilizes cognitive and functional abilities, enhances social skills, and elevates personal dignity for long-term care residents. Importantly, the intervention can mitigate residential depression and give new meaning to nursing home life changing the perception of a nursing home from a place to go to die, to a place to go to live.

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The Spring Issue of the *Texas Public Health Journal* featured National Public Health Week activities from around Texas that you, TPHA members, submitted to us. All are included in a special section of the July 2011 edition of APHA's *The Nation's Health*.

## The NATION'S HEALTH

The official newspaper of the American Public Health Association | [www.thenationsoh.org](http://www.thenationsoh.org)

July 2011



A student from the University of Maine School of Nursing shows a resident at an adult rehabilitation facility how to safely exercise during National Public Health Week.

Communities address injury prevention  
**National Public Health Week 2011 celebrated nationwide**

FROM EVERY CORNER of the nation, health advocates came together in April to celebrate National Public Health Week. At community events, campus forums and town halls, the theme "Safety is No Accident: Live Injury-Free" took center stage.



A Florida International University student supports pedestrian safety.

Organized by APHA, the 2011 celebration of National Public Health Week brought health departments, organizers, students and community leaders together to spread the word that injuries are

preventable. Many states have begun developing a health insurance exchange, and millions in federal funds have been distributed to assist states with the process. Progress varies widely from state to state, with some states well in the early planning stages, others having already created legislative frameworks and others simply relating to

the nation's better oral health care is attributed to the decision in the 1940s to begin adding fluoride to public drinking water systems, according to the American Dental Association. Fluoridation reduces tooth decay in all age groups by 20 percent to 50 percent, according to the CDC.

Each of the credits for

Reform progressing  
**State health insurance exchanges taking shape nationwide**

AS WORK moves forward to implement the nation's historic health reform law, many of the details will be left to the states. At the top of the list is creating state-based health insurance exchanges—a general process and one that can mean the difference between success and the status quo.

Almost every state has begun developing a health insurance exchange, and millions in federal funds have been distributed to assist states with the process. Progress varies widely from state to state, with some states well in the early planning stages, others having already created legislative frameworks and others simply relating to

SEE EXCHANGES, Page 10

Misinformation endangers oral health  
**Health advocates fighting myths about fluoridation with science**

DENTAL ADVANCES over the past six decades mean that many Americans do not remember a time when tooth decay and disease was a major national public health problem.

Each of the credits for



Photo by Paul McClellan, courtesy of Fluoride News Service  
Kurt Thompson, a registered dental hygienist, applies fluoride to the teeth of a patient in 2007. Water fluoridation and preventive dental care have improved the oral health of Americans.

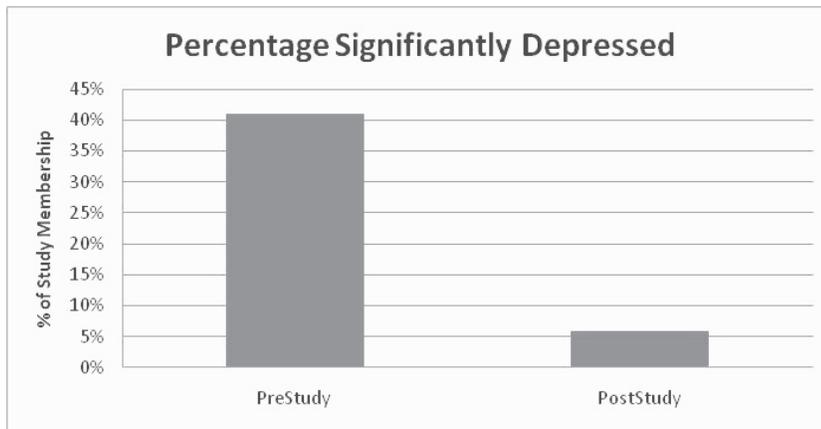
Infections cost millions, and lives  
**New measures, legislation aimed at antibiotic resistance**

RICKY LANTINI was a 21-year-old college football player—strong as an ox, his mother says. But he was helpless against methicillin-resistant *Staphylococcus aureus*, also known as MRSA, which killed him in just a few days in 2005.

The doctors in Lantini's case could not save him because the MRSA he contracted was resistant to all the antibiotics he was given, according to Theresa Drew, Lantini's mother.

SEE ANTI-BIOTICS, Page 12

**Figure 1. Summary Change in Depression Scores (n=17)**

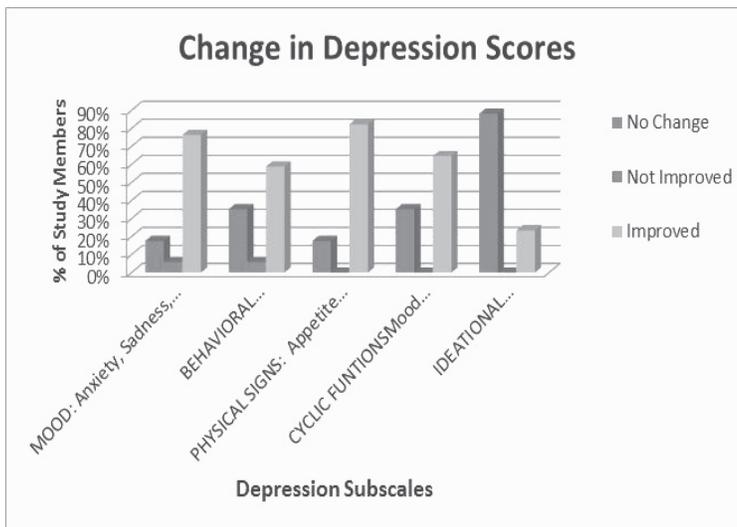


**Table 1. Depression Sub-Scale Scores of the Cornell Scale for Depression in Dementia**

Sub-Scale	Pre-Study Mean	Pre-Study Standard Deviation	Post-Study Mean	Post-Study Standard Deviation	T(32)	p
Mood	2.8824	1.3639	1.5882	0.8703	3.2981	0.0024*
Behavioral Disturbance	1.7059	1.0467	1.1176	0.7812	1.8572	0.0725
Cyclic Fluctuations	1.0000	1.0000	0.0000	0.0000	4.1231	0.0002**
Physical Signs	1.1176	0.8575	0.0000	0.0000	5.3738	<.001**
Ideational Disturbances	0.2941	0.9852	0.0000	0.0000	1.2308	0.2274

\* statistically significant 0.05  
 \*\* statistically significant 0.001

**Figure 2. Summary Change in Components Depression Scores (n=17)**



# Not Everything Behaves in Moderation: Drought and Flood in Texas

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Librarian

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Remember the old adage, “everything in moderation?” Unfortunately water does not behave in moderation. This spring it has been especially striking to watch the imbalance between record-breaking floods along the Mississippi and the extreme drought in Texas. Is this an unusual pattern and why should it matter to public health professionals?

The pictures of the flood along the Mississippi this spring have been very dramatic. Meanwhile we look at the droopy trees outside our windows or walk on our crunchy grass and we comment on how bad the drought is here in South, East, or Central Texas. And we wish we could channel some of that raging Mississippi water over here to Texas. But when we look back at the historical record, it is obvious that Texas has always had extreme cycles of drought, usually followed by devastating floods.

“Midnight conferences, armed patrols, and legal battles’ for water would become more and more frequent between now and the time the state’s acute water problem is solved.”<sup>1</sup> Is this a headline from yesterday’s newspaper? Actually it is a quote from State Sanitary Engineer V.M. Ehlers spoken in March 1957 at a conference in College Station. He noted that every county in the state had been declared a drought disaster area by federal decree and then predicted, based on studies at MIT, that soon sea water would be desalinated and used in drought-stricken areas at a cost of 6 cents per 1000 gallons. If only that MIT prediction had come true!

Two geographers studied tree-rings of old-growth post oaks to create an index of drought in northern and southern Texas from 1698 to 1980 and also compared this data to fifty years of meteorological observation (1931-1980). According to their data, some of the most severe droughts were experienced in both north and south Texas in 1790, 1805, 1855, 1887, 1917, 1925, 1956, and 1971. Wettest years in both regions include 1718, 1719, 1740, 1833, 1867, 1869, 1919, and 1924. They do conclude that the multiyear drought of the 1950s was the most severe continuous drought episode of the time period they studied.<sup>2</sup> It will be interesting to compare the current decade with these historical findings.

We do know that drought is common enough in Texas throughout the years that there is a book of humor referring solely to droughts, “When the catfish had ticks: Texas drought humor,” written in 1997.<sup>3</sup> But of course the lack of water is not really humorous and has serious implications for the public’s health. Drought brings a greater risk of wildfires;<sup>4</sup> seems to have an influence on the recent spread of West Nile Virus;<sup>5</sup> may increase the risk of leptospirosis for swimmers;<sup>6</sup> and appears to increase the natural occurrence of anthrax infections in animals.<sup>7</sup>

What about those frequent times when water comes too quickly and leads to floods? Floods were and are still common throughout Texas. For example, “The rains came and came and came, and it looked for awhile as if raging river torrents and low-land lakes were going to stay forever in drought stricken Texas.” This quote comes from the Texas Health Bulletin of June 1957, where once again drought was followed by flood.<sup>8</sup> That year flooding was extreme even in Central Texas where a series of highland lakes had been built in the 1940s to try to control periods of heavy rainfall. Statistics show that from 1959 through 2008, flash floods killed more people in Texas than anywhere else in the nation.<sup>9</sup>

An interesting account of disaster recovery and preparation efforts comes from the Biennial Report of the Texas State Dept. of Health. It discusses how public health nurses assisted after floods in San Saba and Hidalgo counties and with the Rio Grande. A manual was written, “Introduction to Nursing Preparedness for Health and Emergency Medical Service.” Classes were taught on nursing preparedness, and cooperative training efforts were made at Red Cross disaster preparedness conferences. All of this took place in 1954!<sup>10</sup>

Of course floods have serious public health consequences. Direct consequences include fatalities from flash floods, injuries from debris, chemical contamination, and hypothermia. Disruption of health and other human services also may occur. Indirect consequences include the spread of infectious diseases, malnutrition, poverty-related diseases and displaced populations.<sup>11</sup> Mental health consequences of floods are obvious but there are even mental health consequences of drought. Elmer Kelton wrote in Texas Monthly that for “the rest of his life, [his] father always expected the next depression and the next drought to start today, or tomorrow at the latest.” As we have seen, both drought and floods are common occurrences in Texas. Like the nurses in 1954 and like the DSHS Commissioner writes today, we need to feel empathy for all the people affected by current disasters and definitely start preparing for the next one. We cannot control the weather but we can control our degree of preparedness.

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## Summer Poison Control Alerts Secondary Effects of Public Health Emergencies: Example of West Nile Virus and DEET

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Public health emergencies may result in potential health problems beyond the primary focus of the event. For example, the recent H1N1 influenza outbreak resulted in an increase in potentially adverse exposures to alcohol-based disinfectants or hand sanitizers, antiviral medications, and influenza vaccines reported to poison centers.<sup>1–3</sup> Another example might involve West Nile virus and N,N-diethyl-m-toluamide (DEET).

West Nile virus is transmitted by mosquitoes and can infect birds, humans, horses, and other mammals. Approximately 80% of people infected with West Nile virus will not show any disease symptoms. However, a small proportion of infected individuals develop febrile symptoms such as headache, myalgia, and arthralgia, gastrointestinal problems, and a transient rash. Moreover, less than 1% develop neuroinvasive disease involving encephalitis, meningitis, or acute flaccid paralysis. Deaths have been reported due to West Nile virus infection.<sup>4</sup>

West Nile virus was first detected in the United States in New York City in 1999.<sup>5</sup> It subsequently spread south and west across the country, transported by migrating birds. West Nile virus was first found in Texas in Harris County in a bird that was collected on June 10, 2002.<sup>6</sup>

West Nile virus is a nationally reportable disease.<sup>4</sup> In Texas, cases are reported to the Department of State Health Services (DSHS). More information on West Nile virus and reporting of cases can be found on the DSHS website (<http://www.dshs.state.tx.us/idcu/disease/arboviral/westNile/>).

Among the measures for reducing risk of West Nile virus infection is use of insect repellants, such as those containing DEET.<sup>7</sup> Information advocating use of insect repellants and DEET is provided on the websites of the Centers for Disease Control and Prevention or CDC (<http://www.cdc.gov/ncidod/dvbid/westnile/qa/prevention.htm>) and DSHS (<http://www.dshs.state.tx.us/idcu/disease/arboviral/westNile/information/general/wnFactBrochure.pdf>).

DEET is a major component of most topically applied consumer insect repellants. It has been sold commercially in the United States for almost 50 years. DEET is the most effective repellent for mosquitoes.<sup>8</sup> Potentially adverse clinical effects have been reported with a portion of DEET exposures, particularly if the product is not used properly. The particular symptoms depend on the route of the exposure. The most frequently reported adverse clinical effects are ocular (ocular irritation, lacrimation), gastrointestinal (oral irritation, vomiting, nausea), dermal (dermal irritation, erythema or flush, rash, edema), neurological (dizziness, headache, drowsiness, seizures, muscle weakness or rigidity, tremor, slurred speech, peripheral neuropathy), respiratory (coughing, dyspnea, bronchospasm, respiratory depression), and cardiovascular (chest pain, tachycardia, hypertension, hypotension).<sup>9,10</sup>

Table 1 presents the annual number of West Nile neuroinvasive disease and potentially adverse DEET exposures reported in Texas. The total number of DEET exposures reported to Texas poison centers and the proportion that resulted in serious outcomes remained relatively steady during 1998–2001. However, in 2002, when West Nile virus was first reported in Texas, the total number of DEET exposures increased by 68% and the proportion resulting in serious outcomes more than doubled. While the total number of DEET exposures tended to decline after 2004, it never reached pre-West Nile virus levels, nor did the proportion of DEET exposures resulting serious outcomes. Although a definitive link cannot be established, this would suggest that West Nile virus was possibly at least partially responsible for a sustained increase in DEET exposures reported to Texas poison centers.

Thus, whenever a public health emergency occurs, public health authorities and healthcare providers might need to prepare for health problems beyond the primary focus of the emergency.

**Table 1. Annual West Nile neuroinvasive disease (WNND) and N,N-diethyl-m-toluamide (DEET) exposures in Texas, 1998–2009**

Year	WNND		DEET exposures <sup>3</sup>	
	no. <sup>1</sup>	Incidence per 100,000 <sup>2</sup>	All exposures	Serious exposures <sup>4</sup> no. (% total)
1998			339	5 (1.5%)
1999			332	7 (2.1%)
2000			268	7 (2.6%)
2001			387	9 (2.3%)
2002	202	0.9	651	31 (4.8%)
2003	439	2.0	766	26 (3.4%)
2004	119	0.5	1,007	42 (4.2%)
2005	128	0.6	848	25 (2.9%)
2006	233	1.0	759	41 (5.4%)
2007	170	0.7	786	42 (5.3%)
2008	38	0.2	565	26 (4.6%)
2009	93	NA	485	22 (4.5%)

<sup>1</sup>Reported to Texas Department of State Health Services (<http://www.dshs.state.tx.us/idcu/disease/arboviral/westNile/statistics/annual/>)

<sup>2</sup>From Lindsey NP, Staples JE, Lehman JA, Fischer M; Centers for Disease Control and Prevention (CDC). 2010. Surveillance for human West Nile virus disease - United States, 1999–2008. *MMWR Surveill Summ* 59(SS-2):1–17.

<sup>3</sup>Exposures reported to the Texas Poison Center Network

<sup>4</sup>Serious = moderate effects (pronounced, prolonged symptoms), major effects (symptoms that are life-threatening or cause significant disability or disfigurement), or death

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## Potential Impact of Coral Snake Antivenin Shortage

Coral snakes are one of the four types of venomous snakes native to the US. There are three species of coral snake in the United States. *Micrurus fulvius*, the eastern coral snake, occurs in North Carolina, South Carolina, Georgia, Florida, Alabama, Mississippi, and eastern Louisiana. *Micrurus tener*, the Texas coral snake, inhabits western Louisiana, Arkansas, and Texas. *Micruroides euryxanthus*, the Arizona coral snake, is found in Arizona and New Mexico.<sup>1,2</sup> Coral snakes account for a small proportion of snake bites in the US. Of the 8,306 venomous and nonvenomous snake bites reported to Texas poison centers during 2000-2010, 290 (3.5%) involved coral snakes.

Although coral snakes produce less venom than pit vipers, their venom is considered to be the most potent snake venom in the US except for that of the Mojave rattlesnake (*Crotalus scutulatus*).<sup>3</sup> Coral snake venom primarily acts as a neurotoxin and may cause such symptoms as localized swelling, paresthesia (numbness of the skin), nausea, vomiting, euphoria, lethargy, excessive salivation, seizures, and motor weakness or paralysis that may include complete respiratory paralysis. Symptoms may manifest between one to seven hours after envenomation but may be delayed as long as eighteen hours. The symptoms may progress rapidly.<sup>2</sup> In spite of the potential for serious symptoms, coral snake bites rarely result in death. The first reported fatality due to a coral snake envenomation in over forty years was reported in 2009.<sup>4</sup>

One of the primary treatments used in the United States for a confirmed coral snake bite of either *Micrurus* species is the administration of coral snake antivenin. In 1967, the US Food and Drug Administration (FDA) approved Wyeth® Antivenin

(*M. fulvius*) (Equine Origin) North American Coral Snake Antivenin (Wyeth Laboratories, Inc. Marietta, Pennsylvania) for use in the treatment of *Micrurus* bites.<sup>2</sup> This is the only coral snake antivenin approved by the FDA. Wyeth, now owned by Pfizer, Inc., discontinued making the antivenin in 2003 because of closure of its manufacturing plant. At that time, the FDA requested that a five-year supply of the antivenin be made.<sup>5</sup> Subsequently, the FDA extended the expiration date, and all existing supplies were set to expire on October 31, 2010.<sup>5,6</sup> Therefore, supplies of the antivenin are decreasing. More information about the status of coral snake antivenin is available on the Florida Poison Information Center-Tampa website (<http://www.poisoncentertampa.org/antivenin/faq.aspx>).

This potential shortage of coral snake antivenin is important because a study found that the proportion of coral snake bites managed by US poison centers that were moderately severe increased during 1983-2007. The study's authors stated that "If no antivenin replaces this FDA-approved antivenin, we hypothesize that rates of moderate, major, and fatal medical outcomes will increase."<sup>1</sup>

Of the coral snake bites reported to Texas poison centers during 2000-2010, 243 were followed to a known final medical outcome, that is, the full course of the symptoms and treatments involved in the envenomation were known. Antivenin was used in 139 (57.2%) of these cases, and serious outcomes (moderate or major effects) were reported in 85 (35.0%). No deaths were reported among any of the cases. Of the 79 cases reported during the first five years of the time period (2000-2004), 55 (69.6%) were treated with antivenin and 27 (34.2%) resulted in serious outcomes. Of the 164 cases reported during the second six years of the time period (2005-2010), 84 (51.2%) were treated with antivenin and 58 (35.4%) resulted in serious outcomes. Although the use of antivenin decreased over time, the severity of the outcomes remained unchanged.

Other factors may need to be considered when evaluating the importance of coral snake antivenin when treating envenomations, particularly in Texas. There are indications that the bites of *M. tener*, the Texas coral snake, are generally less serious than the bites of *M. fulvius*, the eastern coral snake.<sup>7</sup> Moreover, a previous study using Texas poison center data from 2000-2005 found that a higher proportion of coral snake bite patients who received antivenin had serious outcomes than those who did not receive antivenin.<sup>8</sup> Among the coral snake bites reported to Texas poison centers during 2000-2010, 60 (43.2%) of the 139 cases where antivenin was used had serious outcomes while 25 (24.0%) of the 104 cases where antivenin was not used had serious outcomes. It might be that antivenin is more likely to be used with those bites that were already exhibiting serious effects or were expected to be serious. If a bite was not expected to be serious, then the antivenin might not be used. The coral snake antivenin's product instructions warn that the antivenin should not be administered prophylactically to asymptomatic patients.<sup>2</sup> Thus, if a patient remains asymptomatic, and thus is classified as a non-serious outcome, they might not be given antivenin.

Furthermore, adverse reactions to coral snake antivenin may occur.<sup>8,9</sup> People sensitive to the antivenin may develop anaphylaxis.<sup>2</sup> Such reactions might increase the severity of the patient outcome.

Thus, coral snake antivenin has been a component in the management of the majority of coral snake bites in Texas in the past. Although data suggest that many coral snake envenomations may be managed without antivenin without an increased risk of serious adverse outcome, this might not apply to all such envenomations. If stocks of coral snake antivenin in the US disappear entirely, healthcare providers and public health agencies might want to monitor any changes in the outcome of coral snake bites.

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## Texas Public Health Training Center

The training center continues to provide in depth training to the public health professionals of Texas. Please visit their website at <http://www.txphtrainingcenter.org/>

## TPHA News and Information

### New TPHA Officer and Governing Council Members

Congratulations to our newly elected officer and governing council members. James Swan, PhD, was elected to the position of 2<sup>nd</sup> Vice President. As 2<sup>nd</sup> Vice President, Dr. Swan will oversee and be responsible for the Association's membership and will be an ex-officio member of the membership committee.

Three members were elected to three-year governing council positions. These members, Marcia Becker, MPH, Michael Hill, MPH, MPA, FACHE and Jennifer Smith, MSHP began their terms immediately following the TPHA annual conference.

Raouf Arafat, MD, MPH was appointed to fill a one year position on Governing Council. Vacancies occurring on the Executive Board were filled by Linda Kaufman, MSN, RN, CS, Melissa Oden, DHed, LMSW-IPR, MPH, CHES and Ben G. Raimer, MD.

We look forward to working with each of our newly elected members.

### 2011 Resolutions

TPHA members voted to approve the following standard resolutions.

*Standard Resolution A:* Since the 2010 Annual Meeting of the Texas Public Health Association, the deaths of several of our members have occurred. In respect to the memory of these departed associates, the membership of the Association herein stands in silent tribute to the deceased members, and their deaths will be noted in the official records of the Association.

#### *John Murphy-Vital Statistics Section*

#### *Reid Martin-Environmental and Consumer Health Section*

As the office is notified of deaths of our members we will add those names to the list of deceased members.

*Standard Resolution B:* The membership of the Texas Public Health Association, highly aware of the time and effort to plan and arrange for the 2011 Annual Educational Conference, wishes to express its gratitude to the Program Planning Committee, chaired by Adriana Babiak-Vazquez, MA, MPH, Stephen L. Williams, Director, Houston Department of Health and Human Services and Staff of the Houston Department of Health and Human Services.

The Texas Public Health Association wishes to express its thanks to all our Exhibitors and Sponsors for their most generous and gracious support and contributions to the annual meeting.

Members also voted to approve 4 resolutions on Cancer Prevention and Detection; Get Texas Moving and Eating Healthy; Vaccinations are Safe, Effective and Important; and Texas Should Be Smoke Free. Full text of the final resolutions can be found on the TPHA website at [www.texaspha.org](http://www.texaspha.org)

### **TPHA Annual Conference**

The Texas Public Health Association held its 87th Annual Education Conference April 13-15 in Houston, Texas with 300 participants, speakers and exhibitors. We had 5 paper presenters, 24 poster displays and 2 educational materials presentations, not to mention a “Who’s Who” list of presenters!

### **Public Health Presentations Competition**

TPHA once again hosted an extremely successful Public Health Presentations Competition during the AEC. Winners of the competition were:

**University of Texas Community Outreach Program: Changing Lives Changing Communities**, presented by Christine Arcari, PhD, MPH, Assistant Professor, UTMB

**The Association between Poverty and the New HIV Diagnoses in Houston/Harris County: 2008-2009**, presented by Katherine Ngo, MPH, Houston Department of Health and Human Services

**Pre-School and School Health Surveillance Guidance Kit**, Dean Lampman, MBA, Regional Surveillance Coordinator, Tarrant County Public Health

Winning Members’ Choice Category

**Comparative Effectiveness Research on Cancer in Texas (CERCIT): Development of a Statewide Data Resource**, Catherine D. Cooksley, DrPH

The **Student Travel Scholarship** was awarded to **Ushang Desai, MBBS, MPH**, Graduate Student, School of Rural Public Health, Texas A & M University Health Science Center. Mr. Desai presented a poster titled **Chart Audit**: Documentation of preventive screening tests by primary care physicians. The travel scholarship includes reimbursement of up to \$400 for expenses to attend the annual conference.

**A heartfelt thank you to all of our exhibitors and sponsors. Our conference would not be the same without your support:**

Cancer Prevention and Research Institute of Texas (CPRIT)  
Care Improvement Plus  
ETR Associates  
GlaxoSmithKline  
National Library of Medicine  
Netsmart  
O'Brien's Response Management  
Texas A&M HSC School of Rural Public Health  
Texas A&M University  
Texas Association of Local Health Officials  
Texas Chiropractic College  
Texas Department of State Health Services-TVFC  
Texas Department of State Health Services- The Behavioral Risk Factor Surveillance System and Youth Risk Behavior Surveillance System  
Texas Department of State Health Services- Youth Risk Behavior Survey (YRBS), Behavioral Risk Factor Surveillance System (BRFSS)  
Texas Public Health Training Center, University of Texas School of Public Health (**sponsor of pre-conference work-TPHA Journal**)

### **shop on Human Trafficking)**

The University of Texas School of Public Health (**Sponsor of Public Health Presentations**)  
University of Texas Medical Branch at Galveston (**sponsor of pre-conference CERCIT workshop**)  
US Army Health Care Team  
US Food and Drug Administration

### **Thank you to our pre-conference sponsors:**

Texas Public Health Training Center, University of Texas School of Public Health (sponsor of pre-conference workshop on Human Trafficking)  
The University of Texas School of Public Health (Sponsor of Public Health Presentations)  
University of Texas Medical Branch at Galveston (sponsor of pre-conference CERCIT workshop)

We had a record number of attendees come early to participate in these outstanding pre-conference sessions. Thank you to the planners and presenters!

### **Winning Paper Category Entry**

**Title/Author(s): University of Texas Community Outreach Program: Changing Lives Changing Communities**, Smith KL<sup>1</sup>, Reiningger B<sup>2</sup>, Arcari CM<sup>1</sup>, Gay J<sup>2</sup>, Mitchell-Bennett L<sup>2</sup>, Siller J<sup>3</sup>, Martinez M<sup>4</sup> and Peters P<sup>5</sup>

<sup>1</sup> University of Texas Medical Branch – Galveston

<sup>2</sup> University of Texas – Houston, School of Public Health, Regional Campus Brownsville

<sup>3</sup> Catholic Charities of Corpus Christi

<sup>4</sup> Mercy Ministries of Laredo

<sup>5</sup> Proyecto Juan Diego, Cameron County

**Objective:** University of Texas Community Outreach (UTCO) is a community-based diabetes prevention and control program which utilizes Community Health Workers (CHWs) to facilitate healthy lifestyles.

**Methods:** CHWs in four south Texas counties deliver education, nutrition, and physical activity promotion for the community and disease self-management classes for diabetics.

**Results:** In year one, 26 CHWs guided 2,043 events comprising of 738 general diabetes education classes, 817 fitness activities, 313 nutrition classes, and 170 self-management classes. In a sample of 25 diabetics in a self-management class, HbA1c decreased 9.7% between baseline and 3-month follow-up (9.2% vs. 8.3%, p<0.01). Among 137 adults participating in a 6-week weight loss challenge, 89% lost weight, on average 7.3 lbs. Participants (n=1,008) who reported at least one contact with a CHW were 4.2 (95% CI 2.0-8.8) times more likely to meet physical activity guidelines of 150 minutes or more of weekly physical activity compared to participants who did not interact with a CHW controlling for age, gender, BMI and diabetic status.

**Conclusions:** Initial results indicate a positive impact of the use of CHW outreach on diabetes prevention and control. A randomized intervention trial and a cohort study to evaluate the effectiveness of CHW outreach are ongoing.

## Winning Poster Entry

**Title/Author(s):** **The Association between Poverty and the New HIV Diagnoses in Houston/Harris County: 2008-2009**, Katherine Ngo, MPH, Biru Yang, MPH, PhD, Monica Slentz, BS, Lu-Yu Hwang, MD, M. Aaron Sayegh, PhD, MPH, Debo Awosika-Olumo, MD, MS, MPH, Houston Department of Health & Human Services

**Background:** In 2010, Houston Department of Health and Human Services (HDHHS) researchers initiated a project to enhance the HIV surveillance data collected across its jurisdictions. The project involves the geocoding and linking of HIV diagnoses information to social determinants of health (SDH) data.

**Methods:** Researchers geocoded, to the census tract level, the residential addresses of people newly diagnosed with HIV during 2008 and 2009. SDH variables from the 2000 U.S. Census were utilized in the analyses. These variables included the percentages of linguistically isolated households, residential instability, education level, unemployment, and poverty for each tract. Correlation analysis detected significant associations between the SDH variables and the number of new HIV diagnoses in a census tract.

**Results:** Of the 754 census tracts, 525 contained at least one residential address of a person newly diagnosed with HIV. Bivariate analyses detected significant linear associations between residential instability, unemployment, the percent of persons living in poverty and the number of people newly diagnosed with HIV. Of the significant associations, the greatest magnitude is poverty and the number of people newly diagnosed with HIV ( $r = 0.278$ ,  $p < 0.0001$ ).

**Conclusions:** These results indicate a significant linear relationship between poverty and the number people newly diagnosed with HIV in a census tract. Future analysis is required to determine if this association represents successful outreach or a service gap.

## Winning Educational Materials

**Title/Author(s):** Pre-School and School Health Surveillance Guidance Kit, Dean Lampman, MBA, Regional Surveillance Coordinator, Tarrant County Public Health; Tabatha Offutt-Powell, MPH, Doctoral Student, University of North Texas Health Science Center School of Public Health

**Abstract:** The Tarrant County Advanced Practice Center (APC) has met a public health community need for comprehensive guidance materials reflecting lessons learned in developing pre-school and school health surveillance systems, which can be a valuable complement to other data sources public health uses to monitor and respond appropriately to community health patterns. The APC's Preschool and School Health Surveillance Guidance Kit, now available at no cost from NACCHO, is a ground-breaking, practical "how to" resource public health agencies can use to implement their own advanced school and pre-school health data surveillance programs. The kit covers all aspects of the approach taken in Tarrant County (Fort Worth, TX) to collaborate with schools

(and local childcare facilities) in developing a mutually beneficial system. The result is a unique, Web-based portal for information exchange that's now generating thousands of health reports annually and was deemed a promising practice for pandemic influenza preparedness by CIDRAP. The Tarrant County system uses an affordable, open source platform; it has proven useful for tracking both seasonal and H1N1 influenza as well as MRSA cases. The Guidance Kit also includes four case studies describing how several other health departments have built similar systems.

## Members' Choice Winner

**Title/Author(s):** **Comparative Effectiveness Research on Cancer in Texas (CERCIT): Development of a Statewide Data Resource**, Catherine D. Cooksley, Dong Zhang, Karl Eschbach, Melanie Williams, James S. Goodwin for the CERCIT Investigators

**Target Audience:** nurses, physicians, epidemiologists, public health educators, administrators, policy makers

**Need for Project:** Addresses the 4th goal of the 2005 Texas Cancer Plan: "Enhance Existing Cancer Data Systems to Fully Support the Needs of the Texas Healthcare Professionals, Policymakers, Planners, Researchers, and the General Public".

**Relevance to Public Health:** Development of this data source will facilitate the utilization of "Quality Data to Support Outcome-driven Cancer Control Planning and Evaluation" (also from the 4th goal of 2005 Texas Cancer Plan).

**Introduction:** Public-use files of government insurance claims and commercial insurance data have been used to assess general health care delivery for years. Claims-cancer linked data, for example, Surveillance Epidemiology End Results (SEER) linked Medicare data, have been used extensively in studies specific to cancer care. Such linked data for all Texas cancer patients is not yet available. Comparative effectiveness and outcomes research in Texas cancer patients is thereby limited. The CERCIT data resource will support those studies through an extensive collection of claims data.

**Aims & Methods:** The "resource" will include several datasets built around Texas Cancer Registry (TCR) data. The TCR will supervise linkage to claims data sources, Medicare and Medicaid (public-use government). Unlinked data from each claims source will provide study populations for comparison and prevention/ screening studies. The TCR and government claims files are routinely stripped of all identifying information prior to being released for research purposes and will be the same for this data resource. Supplemental provider characteristics and contextual files of population-based measures including socioeconomic status will be linked to each of the datasets.

**Results & Conclusions:** In fiscal year 2008, the Kaiser Family Foundation reported that 17.5 million (69%) Texans had either employer, individual, Medicare or Medicaid insurance coverage. Using Kaiser's estimates, the "resource" will include claims data for roughly 6 million Texans. This presentation will detail how the CERCIT consortium of investigators

from the University of Texas Medical Branch (UTMB), University of Texas M.D. Anderson Cancer Center, Rice University, Baylor University, University of Texas Health Science Center, School of Public Health and the Texas Cancer Registry will use this statewide data resource to study cancer and related care in Texas; train the next generation of comparative effectiveness researchers and provide the Texas public with cancer research results and information.

### Texas Public Health Association Presents Awards at the 2011 Annual Education Conference

The Texas Public Health Association presented its awards during the President's Reception and Awards Ceremony held Thursday, April 14, 2011 at the Marriott Hotel. Congratulations to all the recipients!

During the annual conference President Adriana Babiak-Vazquez, MPH recognized the efforts of those members and supporters who work behind the scenes and/or on the front lines to make TPHA a better organization for all.

Certificates of appreciation were presented to the following TPHA members and volunteers who have worked on behalf of TPHA throughout the year and include: governing council and/or executive board service, committee work, journal editing and typesetting, program planning for the AEC, local arrangements, continuing education committee, representing TPHA on partner committees and boards, representing TPHA at a national level with APHA, serving as parliamentarian at business meetings, and more.

Roger Barker	Linda Kaufman
Jean Brender	Salma Khuwaja
Patricia Diana Brooks	David Lakey
Linda Chambers	Hardy Loe
Jamyia Clark	Elizabeth Macaluso
Catherine Cooksley	Gloria McNeil
Nancy Crider	Carolyn Medina
Carol Davis	Sharon Melville
Robert L. Drummond	Melissa S. Oden
Charla Edwards	Jane Osmond
Linda Elting	Neil Pascoe
Rita Espinoza	Veronica Primeaux
Panthea Evans	Ben G. Raimer
Deborah Flaniken	Kaye Reynolds
Carol Galeener	Terry Ricks
Alexandra Garcia	Michael Robertson
Shawn Gibbs	Bobby Schmidt
Jessica Gullion	Aisha Siddiqui
Tom Hatfield	Sandra Strickland
Charissa Haun	James Swan
John R. Herbold	Cathy Troisi
Linda Hook	The University of Texas
Herbert Jamieson	School of Public Health
Richard Jiminez	The American Public
Bobby Jones	Health Association

Several Houston Department of Health & Human Services staff were recognized individually and our appreciation extends to all employees of the health department for their commitment to the success of the annual conference.

Stephen L. Williams	Frank Levy
Raouf Arafat	Adeolu Moronkeji
Marcia Wolverton	Hafeez Rehman
Deborah Banerjee	Janan Sackllah
Angelica Choice	Shona Sen
Ethelbert Davis	Kirstin Short
John Fleming	Chetan Sriram
Amanda Kubala	Vernesia Voltz

The **Jessie A Yoas Memorial Legislative Advocacy Award** honors a member who had a passion for legislative advocacy. The 2011 award was presented to TPHA President Elect Bobby Schmidt. Bobby represents TPHA on the Texas Public Health Coalition and actively monitored public health legislation throughout the regular 82nd Texas Legislative Session. He worked with Senator Jane Nelson's staff to sponsor the Senate Resolution 3 recognizing the Texas Public Health Association "for its many years of service to the legislature and the citizens of Texas".

The **Outstanding Service Award** is given to the person or persons who excelled in their service to TPHA. The 2011 award was presented to Terri Pali and Patricia Diana Brooks.

*During her presentation, TPHA President Adriana Babiak-Vazquez states, "Terri Pali is not only our Executive Director but she's also a member and many times, we forget that. Terri is most deserved of this year's Outstanding Service Award as she was instrumental in assisting me launch several innovations to assure a successful annual educational conference, including several fundraising, in-house entertainment and networking ideas. In addition to her positive "can do" spirit, she is extremely knowledgeable about the association and was always willing to share her knowledge with me, in my work for the association. Success in an organization such as ours is never the work of one person. It takes key collaborative partnerships and support and, I'm sure all will agree that Terri Pali should be the recipient of our first Outstanding Service Award.*

*Our second Outstanding Service Award recipient is Patricia Diana Brooks, Immediate Past President of TPHA. I can't begin to say how much work Diana does for the association. She happily agrees to help out anytime anyone in TPHA asks and always has one idea or another to share that will bring more members, more monies, more educational opportunities for TPHA. She is extremely generous with her time and monies. I am very appreciative of those things she brings. Her greatest asset to the association is her ability to just be there for you- any of you- when you need her the most. Her service is of leadership through service and the strength of her convictions that helped me get through many a day, as I'm sure she has helped many throughout our membership. Thank you Diana and congratulations!*

The **President's Award** was presented to the Houston Department of Health and Human Services under the leadership of Stephen L. Williams, M.Ed, MPA, Director and Raouf Ararat, MD, MPH, Associate Director, for going above and beyond in their role as the host health department for the Texas Public Health Association's 87th Annual Education Conference. See his comments below:

*It is with great pleasure that we accept this President's award on behalf of Houston Department of Health and Human Services (HDHHS). HDHHS was privileged to partner with the Texas Public Health Association and serve as the host city for its 87th Annual Education Conference. Our Department has been invested in the community's health for many years therefore we welcomed the opportunity to showcase all the work and efforts of Texas public health agencies.*

*The current public health infrastructure of our society consists of a variety of agencies and professional disciplines and in order to achieve excellence in our public health goals of improving the well-being of communities, collaboration with fellow public health entities is key. In our current environment of economic constraint, it is necessary to use the commitment we have to the success of public health practice as an impetus to network with fellow colleagues in hopes that resources and experiences be shared and possibly pooled to increase collaboration throughout Texas.*

*History has shown that in order to succeed, we can't work independently but must collaborate in well designed partnerships to achieve positive results. The manner in which diverse public health systems function as a whole determines our success in addressing new public health challenges. Forming partnerships with reputable public health entities such as the TPHA, to construct events and conferences is extremely significant and mutually beneficial. Conferences such as this showcase multiple perspectives on different public health issues, advance our present knowledge and strengthen the public health infrastructure of Texas.*

*Again, we would like to thank the Texas Public Health Association for recognizing the Houston Department of Health and Human Services. It is with great honor that we accept this award and to commemorate it, we will continue to strive to ensure the health and safety of the community by staying committed to delivering quality public health services.*

The **Past President's Award** was presented to Patricia Diana Brooks who served as our president 2009-2010. Diana continues to serve TPHA as chair of the membership committee.

The **Thinking Progressively for Health Award (TPHA)** was presented to Scott R. Lillibridge, MD, Texas A&M Health Science Center-SRPH. President Adriana Babiak-Vazquez presented the award to Dr. Lillibridge and stated, "*It is one of my greatest pleasures as President of TPHA to be able to give several association awards. One of those I am so happy to be presenting is this next award, the "Thinking Progressively for Health" Award to Dr. Scott Lillibridge.*

*Dr. Lillibridge has spent his career helping others through his tenure as assistant secretary of the health and human services and through the medical preparedness and response work at both the national and international levels. He is a legend in our times. When thinking of all his work and projects he has been instrumental in developing, centers he has founded and chaired and countless communities he and his group have helped through emergencies in far-reaching places of this world, what stands out is that he does things innovatively. It is never enough for him to do what others may have done. No, he leads his teams in thinking outside of the proverbial box by challenging for things to be done better, faster, more economical.*

The **TPHA Legislative Excellence Awards** were presented to The Honorable Rodney Ellis and The Honorable Sylvester Turner

**Senator Rodney Ellis** was elected to the Texas Senate in 1990. During his tenure, he has earned praise as a leader on economic development, education, civil rights, responsible environmental policy, tax cuts for the middle class, criminal justice, and workforce development issues.

Senator Ellis in the 82<sup>nd</sup> Legislative Session: Chair – Government Organization; Member – Committee of the Whole Senate, Criminal Justice, Open Government (Select), State Affairs, Transportation & Homeland Security. He sponsored SB355 - Relating to the elimination of smoking in certain workplaces and public places; providing penalties.

Senator Ellis has passed over 500 pieces of legislation. One of his most notable accomplishments includes passage of the TEXAS Grant program, which has disbursed almost \$1.8 billion in tuition and fees to over 207,000 students. The program continues to educate students for the improvement of the Texas workforce.

Most recently, Senator Ellis passed an amendment to create a green jobs development and training program to help Texans prepare for employment in the burgeoning green technology industry and to usher the state of Texas into an environmentally responsible and secure future.

Senator Ellis is the proud founder of the Texas Legislative Internship Program (TLIP). Since TLIP's inception, it has become the largest legislative internship program in the state, giving almost 400 young people the opportunity to make a difference in Texas politics and public policy.

Before his election to the Texas Senate, Senator Ellis served three terms as a member of the Houston City Council and as chief of staff to the late U.S. Congressman Mickey Leland. He holds a bachelor's degree from Texas Southern University, a master's degree from the Lyndon B. Johnson School of Public Affairs, and a law degree from the University of Texas School of Law. Ellis also studied at Xavier University of New Orleans and the London School of Economics.

Rodney Ellis is married to Licia Green-Ellis and has four children.

**Representative Sylvester Turner** was raised in Acres Homes and attended the University of Houston and Harvard Law School before founding The Law Office of Barnes and Turner in 1983. He has served as a seminar lecturer for the University of Houston Law School and South Texas College of Law, and as an adjunct professor for the Thurgood Marshall School of Law.

Representative Turner in the 82<sup>nd</sup> Legislative Session: Vice-Chair – Appropriations; Member – State Affairs

Rep. Turner was elected to the Texas House of Representatives in 1988 and has since earned the respect of his colleagues from every corner of the state and across the political spectrum. In the last legislative session, he authored and passed the bill which added 127,000 previously uninsured children to the Texas Children's Health Insurance Program (CHIP). He was awarded the 2007 Child Advocacy Award by the Texas Pediatric Society and the Presidential Award of Merit from the Texas Association of Family Physicians for his role in protecting the health of Texas children.

In 2003, Rep. Turner was awarded the Helen Farabee Community Leadership Award by the Houston Mental Health Association. He has twice been honored by the Texas Classroom Teachers as a Legislative Star for leading the fight for students and educators. He was named one of "The Best of the 77th Legislature" by Hispanic Journal for his work on education and consumer rights. For his efforts to ensure open and accessible government, Turner was awarded the "Star of Texas Award" by Common Cause of Texas and the "Open Government Award" by the Texas Daily Newspaper Association. Rep. Turner was also named one of the Ten Best Legislators of the "75th" and the "80th" Legislative Sessions by Texas Monthly Magazine.

In addition, Rep. Turner has received three prestigious awards for his monumental work as a champion for the Children's Health Insurance Program and Medicaid. These awards include the "2007 Texas Hospital Advocacy Tribute Award" by the Texas Hospital Association, the "Friends of Medicine Award" by the Texas Medical Association, and the "Champion for Children" Award by the Amerigroup Foundation. Rep. Turner has also been honored with the "2007 Park Advocate Award" from the Greater Houston Partnership which is symbolic of his lifetime commitment of positively transforming neighborhoods and communities.

Rep. Turner has also been honored by the Epilepsy Foundation of Southeast Texas for his work in securing funding for specialty clinics that serve low-income adult Texans with seizure disorders. Rep. Turner has also received the Legislative Award from the Texas Police Chiefs Association and the Legislative Excellence Award from the Children's Advocacy Centers of Texas.

He is also currently a member of Brookhollow Baptist Church. Rep. Turner is the proud father of Ashley Paige Turner, a graduate student at Texas Woman's University in Houston.

The **James E. Peavy Memorial Award** is the Association's highest accolade. It is presented annually to a public health worker in Texas who has made significant contributions to the advancement of public health knowledge or practice, or who has demonstrated a genuine concern for the health needs of society. This year's recipient, Dr. Eduardo Sanchez, embodies all of those characteristics.

Dr. Eduardo J. Sanchez, MD, MPH, FAAFP, has already had a distinguished career in public health despite his relative youth. He has been dedicated to the underserved in his clinical practice in Austin and his rise to leadership in public health was meteoric. He served as the Austin/Travis County Health and Human Services Chief medical officer and subsequently both as Commissioner of Texas Department of Health and the Texas Department of State Health Services where he oversaw the consolidation of four state agencies. After leaving those posts with a distinguished record, he became the director to the Institute for Health Policy of the UT School of Public Health in Houston. In all of these roles, he also played major leadership roles in NAACHO, TACHO, TAPHP, ASTHO, the Institute of Medicine and CDC task force and studies. His interest ranges broadly from childhood obesity to HIV/AIDS, disparities, family planning and disaster preparedness.

Dr. Sanchez is a prolific writer, speaker and policy maker. While now in the private sector as CMO at Blue Cross Blue Shield of Texas, he contributes to public health continually through various professional associations. He is well deserving of the James E. Peavy Award.

**Congratulations to all of our award recipients!**

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## **Congratulations to the Texas Council on Cardiovascular Disease and Stroke Awards Recipients of 2010**

CVD and stroke are leading causes of death in Texas. Increases in the rates of physical inactivity, poor dietary choices, diabetes, high blood cholesterol and obesity, as well as the continued high prevalence of hypertension and the use of tobacco contribute to this disease each year. Community-based programs are often our first line of defense, helping to inform, educate, and provide resources and assistance to the people of Texas in addressing the reduction of these major risk factors. To that end, the Texas Council on Cardiovascular Disease and Stroke, in conjunction with the CVD & Stroke Program of the Texas Department of State Health Services, is pleased to announce the recipients of this year's Texas Cardiovascular Health Promotion Awards. This award is designed to recognize outstanding cardiovascular health promotion programs in Texas, especially those using evidence-based practices.

### **2010 TX CVD Council Awards for Program Excellence The Outstanding Program Award is presented to:**

#### **The East Texas Stroke Initiative, Memorial Health System East Texas-Lufkin, Texas**

A partnership between Memorial Health System East Texas (MHSET) and The Methodist Hospital (TMH) Houston, Texas. The East Texas Stroke Initiative was made possible by a 3 year 5.8 million dollar grant funded by the TLL Temple Foundation. Now in its second year, the program has accomplished four of five goals: Joint Commission Primary Stroke Center Certification with no recommendations for improvement; the establishment of widespread Community Education for Stroke Prevention Strategies, Signs & Symptoms and Medical Urgency; an 11.5 percent increase in t-PA administration rate to qualified candidates with an ischemic stroke; and decreasing the length of stay overall for stroke patients to one day.

The fifth goal is to reduce regional stroke mortality rates reduced from 197 out of 100,000 people to 150 within 5 years. The Texas Council on CVD and Stroke applauds the ambition of the East Texas Stroke Initiative, and has no doubt it will achieve its goal.

#### ***The Honorable Mention Awards are presented to the following:***

#### **Angelina County Public Health Coalition – Stroke Education**

All of East Texas is located in the Stroke Belt - the region in the southeastern United States recognized by public health authorities for having an unusually high incidence of stroke and other forms of cardiovascular disease. Angelina County is located in Public Health Region 5; statistics show that this area of Texas is significantly above the state average in Mortality

from Stroke, Heart Disease, and Cardiovascular Disease.

Working in conjunction with a large local medical community and a newly opened CVD/Stroke Center located at Memorial Health System of East Texas in partnership with The Methodist Hospital in Houston, the Angelina County Public Health Coalition created a pilot project with funding from the Texas Department of State Health Services to create an educational campaign to reduce mortality and morbidity in regards to stroke. In ten months, the Angelina County & Cities Health District reached out to 91 businesses, churches, civic groups, and healthcare entities -- with a total of 2,700 direct contacts in the community. Radio and television-based media engagement has been outstanding, reaching every corner of Angelina County with information regarding the signs and symptoms of stroke, calling 911, knowing your blood pressure, blood sugar, weight, and how to decrease your risk from stroke.

#### **Denton County Diversified Cardiovascular Health Initiative**

Working within the SMART objectives (Specific, Measurable, Achievable, Relevant, and Time Bound) from the Texas Plan to reduce CVD and stroke of 2008, the community-driven Denton County Healthy Communities Coalition focused on three major components to the Denton County Diversified Health Initiative:

- The Third annual Denton County "Take the First Step" 5 K/1 Mile Fun Run/Walk, which attracted more than 700 participants (up from 300 the previous year), and reached out to 1,000 people and businesses in a single day.
- The Denton County Cardiovascular Health Summit held on August 26, 2010 which brought hundreds of professionals together to address The role of CVD in the community, the creation of a toolkit for participants, identifying resources to address CVD risk factors in the community and finding three ways that Public Health could partner with the community to address CVD risk factors.
- The creation of the Denton County Healthy Communities Coalition. Comprised of public health officials, school representatives, health care providers, fitness organizations, and many others, the mission statement of the coalition is "**To improve the health of Denton County residents through disease prevention and health promotion**".

#### **Eddy Scurlock Stroke Outreach Program – The Methodist Hospital, Houston**

In 2005 as a result of the region's high stroke prevalence, The Methodist Hospital took a community focused approach towards stroke care. Community stroke education was executed through a comprehensive stroke outreach program which targeted at-risk populations, EMS and other first responders, healthcare professionals, community hospitals, schools, and large employers.

The Program reached 11,000 people last year in the following ways:

- A community stroke awareness walk- The Strides 4 Stroke Walk at Rice Stadium, now in its 5th year, attracting 4,000 participants.
- 2 full-time Stroke Outreach Program Coordinators charged with providing stroke education throughout metropolitan Houston and south central Texas.

- Collaboration for stroke education with area community hospitals developing their own stroke programs.
- Collaboration for community education and awareness with city, county, and state based organizations.

We know that there are many excellent cardiovascular health promotion programs in Texas. Thank you for your work in making your communities healthier!

### Public Health Poetry Corner

At this year's TPHA Annual Education Conference, we added a cultural twist to the reception for the exhibits and posters opening. We invited attendees to read their public health related poems. Please visit our website at [www.texaspha.org](http://www.texaspha.org) and read their complete works.

#### **Barbara Carle**

- Mother's Lament
- What I Want for Christmas
- New Outlook

#### **Kay L. Cox**

- Deductible not Met
- I am...*with homage to Anne Waldman, "Fast speaking woman: changes and essays"*

#### **Anya Ezhevskaya**

- Mother
- What Infants Dream Of

#### **Katherine Sanger**

- Tin Foil Hats
- To make bad things happen to good people

#### **Luis Vazquez**

- Thoughts of Her Un-bandaged Reflection-Inspired by the quilt "It's a different world" by Elaine Olsen
- Numbers

#### **Adriana Babiak-Vazquez**

- Watercolor (Also in Spanish Acuarela)
- Bland



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Join the Texas Public Health Association and make a difference! Join us in our work to promote and protect the health of the people of Texas. Add your voice and strength to ours to better the public's health.

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Texas Public Health Association, P.O. Box 201540, Austin, Texas 78720-1540, Phone (512)336-2520 Fax (512)336-0533, E-mail: Txpha@aol.com or visit our website at [www.texaspha.org](http://www.texaspha.org). **Please return this completed application with your dues payment to the address below.** Contact the TPHA office if you have any questions about this application for membership. All members receive the TPHA Journal, reduced registration fees, continuing education and eligibility to join the Texas Department of Health Credit Union.

Your dues entitle you to a primary membership in one TPHA Section (see the list of sections). Non-voting secondary memberships in additional sections cost \$5.00 each per year. Please indicate which section(s) you wish to affiliate with. Your membership dues are good for one year from the date on the application.

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<i>Email is required for you to receive your electronic copy of the TPHA Journal All students receive the Texas Public Health Journal in electronic format.</i>		
Sponsor: (Signature of TPHA member) <i>OPTIONAL</i> :		

**Section Codes - Indicate in one of the boxes below the primary section you wish to affiliate with.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Administration – AD   | <input type="checkbox"/> Environmental -ECH             | <input type="checkbox"/> Vital Statistics - VS  |
| <input type="checkbox"/> Aging & Public Health-<br>APH (new section)                 | <input type="checkbox"/> Epidemiology - EPI             | <input type="checkbox"/> Unaffiliated - UN  |
| <input type="checkbox"/> Community Health<br>Workforce Workers-CHWW<br>(new section) | <input type="checkbox"/> Health Education – HE          | If you wish to affiliate<br>with a non-voting<br>secondary membership,<br>enter code(s) here. <div style="border: 1px solid black; width: 40px; height: 40px; margin: 5px auto;"></div> |
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1962 Lewis Dodson*	1981 <i>Robert E. Monroe</i>	2000 <i>Nancy Adair</i>
1963 L. P. Walter, MD*	1982 <i>William T. Ballard*</i>	2001 <i>Dale Dingley, MPH</i>
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1970 W. Howard Bryant*	1986 <i>Helen S. Hill*</i>	2008 <i>Catherine D. Cooksley, DrPH</i>
1970 David F. Smallhorst*	1986 <i>Henry Williams, RS*</i>	2009 <i>Hardy Loe, M.D.</i>
1971 Joseph N. Murphy, Jr.*	1987 <i>Frances (Jimmie) Scott*</i>	2010 <i>John R. Herbold, DVM, PhD</i>
1972 Lola Bell*	1987 <i>Sue Barfoot, RN</i>	<i>*deceased</i>
1972 B. G. Loveless*	1988 <i>Jo Dimock, RN, BSN, ME</i>	

## TPHA Life Members

*Ron Anderson, MD*  
*Minnie Bailey, PhD*  
*Ned V. Brookes, PE*  
*Oran S. Buckner, Jr., PE, RS*  
*Burl Cockrell, RS*

*Exa Fay Hooten*  
*Robert MacLean, MD*  
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*Laurance N. Nickey, MD*

*David R. Smith, MD*  
*Kerfoot P. Walker, Jr., MD*