



*Washington State Public
Health Association*

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Winter 2005

An Affiliate of the American Public Health Association ■ Founded in 1935

Health Care Coverage Tops Citizens' Concerns

The Working For Health Coalition sponsored a statewide poll seeking Washingtonians' opinions on health care.

Rick Mockler, WSPHA Vice-President for Region 3, has been representing WSPHA on the 30+-member Working for Health Coalition for the past year. In early February, the Coalition released the results of a statewide telephone survey of 750 likely voters it commissioned Widmeyer Research and Polling of Washington, D.C. to conduct in January.

For the first time in a poll like this, respondents

said health care was the most pressing problem (27%), followed by the economy (12%) and public education (12%). People said they were especially concerned about those without health coverage and the rising cost of health insurance. And in overwhelming numbers, they said they support a viable safety net of community health centers and hospitals that provide health care to people without health insurance. 81% said it is very important to have a health care safety net, while 53% said they felt it is very appropriate to spend tax dollars to protect the safety net.

Other key findings of the survey include:

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It's Coming!...

National Public Health Week

National Public Health Week is April 4-10, 2005.

This year's theme, "Empowering Americans to Live Stronger, Longer," focuses on healthy aging. The thrust is to promote the three P's for adding healthy years to life: preventing health problems by practicing healthy living, protecting health through early detection and screening, and developing a plan to manage one's health that will promote high quality of life in later years.

Communities across the state are planning a number of exciting public health events, including a public health walk in each WSPHA region. Contact your regional vice president to see what is being planned in your area and how you and your agency or organization can be involved.

Let's make this the biggest and best **National Public Health Week** ever in Washington State by educating Washingtonians about the importance and great work of public health!

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President's Corner

BY JEFF MERO



Public Health Workforce, Taxes, and Drugs

An aging workforce, budget cuts and the inability to compete financially with the private sector to recruit qualified health professionals are some of the factors stressing state and local public health care systems. The situation is so serious that two U.S. senators plan legislation creating a loan repayment and scholarship program to entice epidemiologists, nurses, laboratory scientists and other health professionals to work in state, city and county health departments.

"We consider [recruiting] to be the number one problem facing public health officials," says George Hardy Jr., executive director of the D.C.-based Association of State and Territorial Health Officials (ASTHO). "This is an incredibly huge problem." Hardy's organization conducted a survey in 2003 that spotlights the problem for a profession that is all but forgotten except during times of national emergencies and disasters. The most startling news from the survey of 37 state health departments is that the average age of the public health employee is 46.6 years old, and some states have vacancy rates of up to 20 percent.

"We are going to lose a lot of years of experience," says Richard Raymond, Nebraska's senior public health official and ASTHO president. "The new health care workers coming in are not going to have that experience and risk making mistakes that could have been avoided."

The need for a skilled public health workforce is intensified as federal authorities rely on local officials to help with homeland security duties such as identifying disease outbreaks and educating the public on avoiding exposure to diseases. Raymond suggests public health departments need to reinforce their recruitment process by educating high school students about careers in public health, as well as increasing pay to attract qualified indi-

viduals. "We can be our own worst enemies or best recruiters," he says.

The federal legislation would help recruit a new generation of workers. The bill, sponsored by Sen. Chuck Hagel, R-Neb., and Senate Minority Whip Richard Durbin, D-Ill., would authorize \$35 million per year for scholarships and another \$195 million to help graduates repay their loans in exchange for agreeing to work in the public health sector. They offered a similar bill last year, but Congress did not act on it.

" A survey of 37 state health departments has startling news: the average age of the public health employee is 46.6 years old, and some states have vacancy rates of up to 20%."

New Tax to Fund Public Health?

The State Department of Health would decide how to distribute more than \$90 million per year to support local public health services and subsidize hospital emergency room care if Sen. Mary Margaret Haugen, D-Camano Island, has her way. Sen. Haugen is the prime sponsor of Senate Bill 5700, introduced on February 2. The bill would establish a 20 cents per thousand dollar assessed value tax on all taxable property in the state beginning in 2006. Preliminary estimates suggest the tax would raise \$130 million a year, with about \$37 million for public health hospital districts and the remaining \$93 million for DOH to distribute "solely for the purpose of

Continued on next page

Statewide Poll (cont'd.)

- ◆ A large majority said they support actions the state legislature could take to provide health insurance for children, working families and poorer residents who have none. Such actions include eliminating Medicaid administrative barriers and premiums, ensuring all kids are covered by 2010, and increasing funding for safety net community health centers.
- ◆ Most believe that employers have a responsibility to provide health insurance to their employees and feel that when companies don't, it increases costs for everyone. 95% said it is important for larger employers to provide affordable basic health insurance.
- ◆ 79% supported the Legislature requiring the same level of health insurance for mental illnesses that people get for physical health problems, even if insurance premiums were increased slightly. They believe cutting expenditures for mental health care increases health care costs.

Dr. Bob Crittenden, chair of the Working for

For the first time, respondents said health care was the most pressing problem (27%), followed by the economy (12%) and public education (12%).

Health Coalition, said the poll results show how pervasive the concern people have about having health insurance is. "Health care costs and the real potential we all have of losing coverage affects everyone, whether you currently have insurance or not," he said.

The primary goal of the Working for Health Coalition is to increase public knowledge of the health care safety net and the public programs that support it (www.workingforhealth.org). Other members include AAP, WA Chapter; Assoc. of WA Public Hospital Districts; Children's Alliance; CHOICE Regional Health Network; Children's Hospital; Group Health; Harborview; Healthy Mothers, Healthy Babies; League of Women Voters; Seattle & King County Public Health; SEIU Local 775; SEIU Local 1199 NW; SEIU WA State Council; United Food & Commercial Workers; WA Academy of Family Physicians; Citizen Action; WEA; WSALPHO; WSNA; WSMA; WA PTA; WSHA; WA Dental Service Foundation; WA Rural Health Association; and others.



President's Corner (cont'd.)

maintaining and improving local public health services and subsidizing emergency room care." As of this writing the bill hasn't been scheduled for a hearing, but lawmakers are facing a \$2+ billion shortfall this session. And recent estimates suggest local public health jurisdictions need more than \$400 million in new money to meet their basic obligations.

More on Our Drug Resolution

On January 20 the Board of Trustees of the King County Bar Association (KCBA) unanimously approved a resolution on State Regulation and Control of Psychoactive Substances, culminating three years of research and debate (the full report of the KCBA's drug control project can be found at www.kcba.org/druglaw/index.html). Like the resolution adopted by a divided membership at the WSPHA Annual Business meeting in October, the resolu-

tion calls upon the state legislature to establish a consultative body "composed of experts in pharmacology, education, medicine, public health, law and law enforcement, as well as public officials and civic leaders, including delegates from the leadership of each caucus in the House and Senate, to provide specific recommendations for legislation to establish regulatory systems and structures for the State of Washington to control psychoactive substances that are currently produced and distributed exclusively through illegal markets..."

Similar endorsements have come from Physicians for Social Responsibility, the Church Council of Greater Seattle and the League of Women Voters of Seattle. As many as a dozen other statewide organizations are expected to endorse the report before a March 3rd press conference.





Announcing the Northwest Medical Informatics Symposium

April 13 – 15, 2005

Spokane, Washington

The Historic Davenport Hotel

www.nmis2005.org

- ◆ Approximately 90% of the country's 30 billion health care transactions every year are conducted via mail, phone or fax.
- ◆ An estimated 18% of medical errors are due to inadequate availability of patient records.
- ◆ Estimates are that the country would save almost \$34 billion per year in health care costs through the full implementation of electronic healthcare information exchange.

The U.S. health care system is seeing a dramatic increase in the use of health information technology. Health care administrators and national and state policy makers believe information technology is one answer to the skyrocketing costs of medical care. Dramatic changes will be seen in the health care system in the next ten years.

The advent of electronic medical records and health information exchange systems creates unprecedented opportunities for public health to access high quality, comprehensive health data for surveillance and assessment. Public health officials need to understand the changes that are occurring in health care, and need to be a part of planning for regional health information exchange organizations.

The Northwest Medical Informatics Symposium will bring together national experts to provide an overview of the policy and information technology issues facing the health care system. Representatives of regional health information technology projects will highlight their accomplishments and describe the health information opportunities already developing in the region.

A special session Wednesday afternoon, April 13, will focus on the interface between public health and health care. Featured speakers are:

- ◆ John Loonsk, MD – Director of Informatics for the Centers for Disease Control and Prevention
- ◆ David A. Ross, ScD – Director of the Public Health Informatics Institute
- ◆ Lawrence Hanrahan, PhD – Senior Epidemiologist for the Wisconsin Division of Public Health and Principal Investigator of the Wisconsin Public Health Information Network
- ◆ Jac Davies, MPH – Director of Program Development, Inland Northwest Health Services

Speakers will describe the impact that the increased use of information technology in health care can have on public health, and identify ways for state and local public health officials to take advantage of the current momentum in the health care industry.

Join us in Spokane for this unique opportunity to begin bridging the gap between public health and health care. More information and registration is available at www.nmis2005.org.



Summer Institute for Public Health Practice Public Health Emergency Preparedness Seattle, WA — August 22-26, 2005

Mark your calendar for summer in Seattle! The Summer Institute for Public Health Practice will be held the week of **August 22-26, 2005** at the University of Washington, Seattle. It is sponsored by the Northwest Center for Public Health Practice in the School of Public Health and Community Medicine.

Public Health Emergency Preparedness is the theme of this year's week-long institute, which is designed to provide public health practitioners with intensive, practical, case-based training in support of bioterrorism and emergency public health preparedness.

Participants will be able to select among tentative training modules in epidemiologic methods,

management, leadership, emergency mental health, public health law, informatics, working with first responders and geographic information systems (GIS). Each morning, a nationally prominent leader will address all Institute attendees on a key, cross-cutting aspect of preparedness (e.g., crisis communications). We believe this training in disease surveillance, outbreak investigation, inter-agency cooperation, communication, law, executive leadership and graphical display of data will build competencies that are directly applicable to many aspects of general public health practice.

For more information, contact pautler@u.washington.edu or check the web site at: <http://www.nwcphp.org/niphpl/>.

The Washington State Public Health Association newsletter



is published quarterly by the Washington State Public Health Association. We welcome contributions to the news-

letter on public health research issues, programs in public health, or upcoming events of interest. Material submitted for publication is printed at the discretion of the Newsletter Committee. Notices of events should include the date, place, time, name and telephone number of the contact person or organization. Articles should be sent to Richard Kauffman, Editor.

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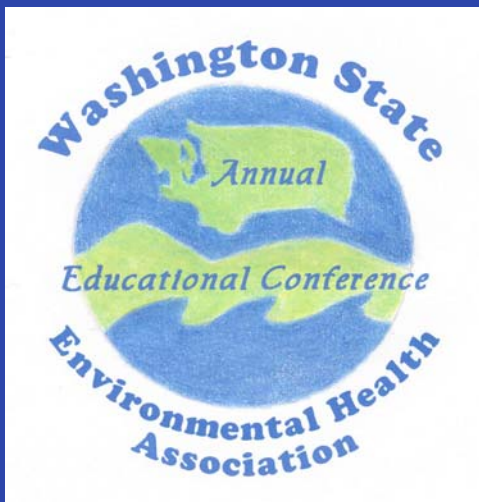
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**SAVE THE
DATE!**

MAY 4-6

www.wseha.org

**Washington State
Environmental Health
Association 60th Annual
Educational Conference**

**May 4-6
Red Lion at the Park
Spokane, Washington**

*The theme for this year's conference is:
"Environmental Health: Role in
Emergency Preparedness and Response"*

This year's conference will also feature full-day legal and on-site classes on Wednesday.

Opening Keynote: *"Crisis Dynamics: Actions, Movement, and Results in Critical Events" from Robert Howard, Ph.D., E.MBS, MPH; former Strategic Communications Director for the National Center for Infectious Disease at CDC.*

A detailed conference program will be available on the website the first week of March. For further information, please check the website at www.wseha.org and click on AEC 2005 or contact Kathy Kimsey at (425) 334-3358.

Attention Nurses!

Many nurses working in public health around the state have been lamenting the lack of a specific "gathering place" for nurses in public health. Lament no more! --there is a movement afoot now to investigate the feasibility of creating a Public Health Nursing Section in WSPHA. It is envisioned that this Section would provide an opportunity for WSPHA members to gather, organize, educate, and network specifically with nursing colleagues in the association, as well as with a broader network of public health association members and other nurses. A PHN Section could provide a voice for public health nursing in Washington State as

well. The proposed Section has the potential to bring together public health nurses from universities, health departments, and community settings through virtual and/or physical means. The WSPHA Board has endorsed the potential development of this complement to the Association...but it can't happen without you! If you are interested in a leadership opportunity and being an integral part of helping to create a Public Health Nursing Section of WSPHA, please contact Board member Betty Bekemeier at bettybek@u.washington.edu



*Should
WSPHA
create a
public
health
nursing
section?*

Welcome New Members!

Sara Barker, MPH Candidate, University of Washington
 Rebecca Boucher, BSN, Registered Nurse, University of Washington
 Nona Govella, RN, Student, University of Washington
 Cherish Hart, MA, State Program Director, March of Dimes
 Mary Hughes, MS, PhD Candidate, University of Washington
 Victoria Hughes, BS, DO, Student, University of Washington
 Robin Read Ochoa, BA, Graduate Student, University of Washington
 P. Max Severeid, Student, University of Washington
 Carrie Sopher, BSW, MPH Candidate, University of Washington

The Doctor Is In

News and Views from William O. Robertson, MD



One More Time – Are Cell Phones A Health Risk?



The safety of cell-phone use has hit the fan again in Europe. According to the Wall Street Journal (January 13, 2005), the Chair of Britain's National Radiological Protection Board announced that making cell phones available to children ages 3-8 was "unjustified." To be noted, however, is that he later admitted he had no concrete proof whatsoever that there was actual evidence of any damage to anyone's health – he was simply espousing the "precautionary principle". It turned out that the Board had published a report the day before simply reiterating its finding of five years before that it could find no concrete evidence of any damage caused by cell phone use. But consumer groups worldwide panicked, especially since so many studies of the topic have been sponsored by the wireless industry. Once again the question: "Can such research be trusted?" For one, I'm convinced it can.

Now It's Iron-Fortified Salt!



For more than 60 years, public health workers have been enthusiastic promoters of the use of oral iron medication for pregnant women in particular in an effort to minimize the likelihood of either her or her baby developing iron deficiency anemia. When ferrous sulfate, a common iron salt, was added to prepared infant formulas in the late 1950's, the incidence of such infantile anemia in non-breastfed infants fell from 35% to less than 2% here in the US. Unfortunately, such anemia continues to be a problem in underdeveloped nations, regardless of the mode of feeding. Science News has reported on studies from North Africa that show adding iron to table salt, just as we do with iodine here, has reduced the incidence of iron deficiency anemia from 30% to less than 5% in Morocco where breastfeeding predominates and adding iron to infant formula would be a waste of time. Apparently, adding iron to table salt is cheaper than supplementary medication for pregnant women, and compliance is less of a problem. Of course, the long term implications of using table salt as the vehicle for getting iron into mothers and their babies has yet to be determined, but extrapolating from the use of salt as the vehicle for iodine here, it ought to pose no long term problems.

DDT: The Dose, NOT the Chemical, Makes the Poison!

As noted in the Journal of Toxicology-Clinical Toxicology

(2004 42:299), in Turkey a father and his teen-aged son mistakenly mistook DDT powder for wheat flour when preparing some fish for dinner. Both developed acute organochlorine poisoning with convulsions, had to be intubated and ventilated and went on to develop renal shutdown necessitating hemodialysis. But both were able to be discharged from hospital in less than two weeks without any sequelae whatsoever. A review of the literature confirmed numerous suicidal and a few accidental poisonings from very large doses of DDT in humans but no human consequences from any environmental exposures. Yes, Rachel Carson's "Silent Spring" notwithstanding, detailing claims about DDT's danger to falcons, eagles, condors, etc, but even today, questions about association with human consequences still remain. I mention the above because worldwide, malaria remains such a menace and its control is susceptible to DDT and last year, the West Nile Virus scare raised the question of resurrecting DDT for possible use here in the US. Remember that the biggest problem with DDT is its persistence in the environment, not its human or mammalian toxicity. And now we have some bugs to destroy it in the dirt.



Prescription Drug vs. Over-The-Counter



The British Medical Journal (2004:329:182-3) recently ran a provocative editorial entitled "Which Drugs Should Be Available Over-the-Counter?" asking the reader to think about a) diagnostic considerations; b) possible adverse effects; c) costs to the manufacturer as well as to the individual patient; d) timeliness – how quickly can I get it? and e) will it be subsidized by insurance? Just this last month, the FDA had some of its panels address that very issue when it again wrestled with the "morning-after pill" and several different anti-cholesterol drugs. In all candor, do you think the decision was or will be based on "evidence-based double-blind control trials," or on political considerations which somehow escaped mention by our European colleagues? Anybody want to make a bet?

Complementary Alternative Medicine

As noted in the Winter edition of the American Chemical Society's educational newsletter directed at potential student members, in 1993, researchers at Beth-Israel Harvard surveyed some 1500 randomly selected Americans about

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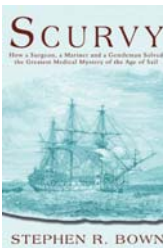
The Doctor Is In (continued from previous page)

complementary alternative medicine (CAM). They concluded that at least one in three used CAM. A newer study by NIH's National Center for Complementary and Alternative Medicine replicated many of the questions, finding that 36% of Americans used CAM in 2002, with some 5% depending on yoga to improve their health. But "prayer by the respondent for his/her own health" was endorsed by some 43% of the respondents, with 24% counting on others for prayer. Natural products, herbal meds and enzymes were mentioned by 19%, deep breathing exercises by 12%, meditation by 8%, chiropractic by 8%, and massage by 5%. The respondents listed the top ten conditions for which they sought treatment with back pain #1 at 17%, followed by head colds, neck pain, joint pain, arthritis, anxiety/depression, upset stomach, headache recurring pain, and insomnia. You may or may not be a believer in CAM but you have to admit that many, many patients certainly seem to be. And, can you accept that if it helps, more power to them, so long as if it doesn't help, they consider other options.



What Scurvy Can Still Teach Us

Had you realized that a simple dietary deficiency syndrome, scurvy (too little ascorbic acid or Vitamin C), has been responsible for more sailors' deaths than all the other known occupational hazards of seafaring, including storms, shipwrecks, sea battles, sinkings miles from shore and so on. When Vasco de Gama first sailed around the tip of South America, 100 of the 160 members of his crew died from scurvy. In 1601, a British sea captain, James Lancaster, demonstrated that giving lemon juice to one of his ship's crew members prevented the disease. It took another almost 150 years before a British Navy physician, James Lind, who knew of Lancaster's finding, replicated his study with a "controlled trial" consisting of eight groups of two sailors in each group (not quite an optimal sample size!) and pinpointed the value of citrus fruits. Even then it took another almost 50 years before that "technological innovation" was applied throughout the British Navy, and 70 years more before it was espoused by the British Merchant Marine. For some hints about just what may have contributed to the delay, including some insight into Lind's most unusual professional behavior that really didn't help the diffusion process, get a copy of Stephen Brown's "Scurvy" published by St. Martin's Press. There are lessons to be learned for each and every one of us. It seems that chance played a big role in scurvy prevention being adopted before Nelson's victory at Trafalgar, clearly seeing the presence of severe scurvy among many French sailors as pivotal in the outcome of the battle that spelled the end of Napoleon.



The Cost of Lead "Clean-Up" in Seattle's Schools

Been reading about the budget shortfall at the state level recently --\$1.8 billion or so? And the anticipated shortage of some \$22.5 million just this year for Seattle schools? Some would say that educational needs are at an all time high, and yet Seattle is planning to close some schools and to lay off teachers because of funding shortfalls, not simply because of falling enrollments. A bill has been introduced into the State Senate that seeks some \$10 million more for the purchase of bottled water to tide the Seattle schools over as they undertake to solve their drinking fountain problem. Wouldn't it be prudent to get at least some data that the blood lead levels of the kids in the schools have actually been impacted by this whole fiasco? According to DOH's lead monitoring program, they've not seen even a blip in the levels of the school-age kids who have been tested, but they are really not an ideally representative sample. I would simply reiterate what I've said and written before: I really don't care how much lead is in the water – or in the dirt on Vashon Island or in eastern Washington – so long as it fails to gain access to our plants (vegetables), to our animals or to us humans. Absent absorption by any of the three groups, I really wouldn't care if lead constituted half the weight of the dirt! Remember: Seattle's kids had a mean level of 33 micrograms/dL in the '60's and 22 in the '70's which fell to just under 1 – 1! -- in 2003, with none of the decline being attributed to lowering lead levels in our drinking water. Is a scientific word to the wise sufficient, or does politics still trump science?



Ever-Present Flame Retardants

As noted by the American Academy of Pediatrics' Committee on Environmental Health (for January 2005), polybrominated biphenyl ether flame retardants have been placed in many products for at least a quarter of a century, more than 200,000 metric tons each year at the very least. They are persistent in the environment and, thus, are ubiquitous there, just as are their first cousins, the polychlorinated biphenyls (PCB's). The bottom line remains: is there any health effect of the dramatic increases found in blood, tissue and breast milk? The answer is just about as clear as the question about so many different drug studies of the day, such as whether SSRI's really help or hurt adolescents. Better and still larger studies are being called for, with samples being somewhat larger than those which proved sufficient to uncover the treatment of scurvy as noted elsewhere in this column. In the meantime, worry more about those aliens from outer space. They are less likely to give you ulcers – even if you have H. pylori on board.



Dr. Robertson is Medical director of the Washington Poison Center and a Professor of Pediatrics at the UW School of Medicine.



Getting the Lead Out of Our Children

By Steven G. Gilbert, PhD, DABT

How can it be that some are still debating the issue of keeping lead out of children?

There is overwhelming evidence demonstrating the neurobehavioral effects of lead on children at even very low levels of exposure. The Agency for Toxic Substance Disease Registry (ATSDR) has refused to set a minimum risk level (MRL) and the Environmental Protection Agency has refused to establish a reference dose (RfD) because some of the “health effects associated with exposure to lead occur at blood levels as low as to be essentially without a threshold” (IRIS 1999).

The Centers for Disease Control and Prevention (CDC) states: “Because no threshold for adverse health effects in young children has been demonstrated, public health interventions should focus on eliminating all lead exposures in children. Lead concentrations in drinking water should be below the EPA action level of 15 ppb.” (MMWR 2004).

The CDC estimates that 434,000 U.S. children aged 1-5 years have blood lead levels greater than its recommended level of 10 micrograms per deciliter of blood (<http://www.cdc.gov/nceh/lead/faq/about.htm>). The number of children in Washington State with elevated blood lead levels is unknown because there has been no systematic study.

We know that low levels of lead exposure are harmful to developing brains. We should be working to ensure that our children are not exposed to lead. School boards should make the needed capital investments in schools to guarantee that no child is exposed to elevated lead from drinking water. This is not difficult and we know what to do. Lead in the dust of homes remains an issue because of lead based paint in and around homes as well as lead from old smelters. More-

over, the soil in homes, parks, schools and childcare centers many miles from old smelters remains contaminated with lead.

Acknowledging the health effects of lead and moving to protect our children from lead exposure, Shoreline and Seattle School Districts have adopted the most progressive lead “action limit” for school drinking water in the country, 10 parts per billion (ppb). The current California Public Health Goal for lead in drinking water is 2 ppb, and the EPA’s maximum contaminant level goal for lead is 0 ppb.

The debate about lead we should be having is whether to lower the current CDC action level for children’s blood leads from 10 mcg/dL to 2 mcg/dL. It is well known that there is no safety factor built into the CDC action level. If lead was known to cause cancer in 1 out of 1000 children with blood lead levels at 10 mcg/dL, we would not be having this discussion. But for some reason, the persistent and irreversible damage to children’s intellectual abilities does not receive the same level of concern.

Compelling reasons for lowering CDC’s blood lead action level are:

- ◆ Children have a right to develop in an environment that allows them to reach their full potential;
- ◆ We adults have an ethical responsibility to pro-

“The debate about lead we should be having is whether to lower the current CDC action level for children’s blood leads from 10 mcg/dL to 2 mcg/dL. It is well known that there is no safety factor built into the CDC action level.”

Lead

Continued from previous page

vide a healthy and safe environment for our children;

- ◆ There is sufficient scientific evidence that children suffer from cognitive deficits when exposed to lead that results in blood lead levels less than 10 mcg/dL;
- ◆ Lead toxicity appears to be irreversible and persistent;
- ◆ We know how to reduce lead exposure and should be doing it; and
- ◆ No child should have an elevated blood lead level. We should determine why he or she does and take appropriate measures to reduce or eliminate the exposure.
- ◆ Reducing lead exposure helps a child's siblings and future children living in the area by reducing their exposure as well.

- ◆ A lower blood lead action level reflects current results from human and animal research.
- ◆ A lower blood lead action level would provide a more accurate guide to pediatricians and other health care professionals, whereas the current action level of 10 mcg/dL gives health care providers and others the ability to argue against taking appropriate measures to reduce childhood lead exposure (for example, lead in the water of some Seattle schools).
- ◆ Lead is a recognized carcinogen as well as a reproductive toxicant.
- ◆ Lead exposure in children costs the US \$43.4 billion per year.
- ◆ Lead exposure is a problem for children around the world. The US CDC should be a leader in setting the highest standards.

Recommended revision to CDC current blood lead action level:

BLL (µg/dL)	Actions	Time frame for beginning intervention
<2	No action	
2-5	Provide caregiver lead education. Provide follow-up testing. Refer child for social services to investigate possible sources of lead exposure.	Within 30 days
5-10	Above actions, plus: If BLLs persist (i.e., 2 venous BLLs in this range at least 3 months apart) or increase, proceed according to actions for BLLs 10-20.	Within 2 weeks
10-20	Above actions, plus: Provide coordination of care (case management). Provide clinical evaluation and care. Provide environmental investigation and control current lead hazards.	Within 1 week
20-70	Above actions.	Within 24 hours
70 or higher	Above actions, plus hospitalize child for chelation therapy immediately.	Within 24 hours

Steven G. Gilbert, PhD, DABT, is the Director of the Institute of Neurotoxicology and Neurological Disorders in Seattle, and author of "A Small Dose of Toxicology." More information is available at www.asmalldoseof.org

Assessment in Action:

New Partnership Improves Community Health Assessment Practice

In 2002, Assessment in Action was formed, a partnership between the Washington State Department of Health and local health jurisdictions (LHJs) to plan statewide improvements to the practice of community health assessment (CHA). Supported by a 5-year cooperative agreement with the Centers for Disease Control, the partnership is working to strengthen assessment capacity at the local level and enhance VISTA, the primary software tool used for assessment by LHJs.

Increasing the skills and abilities of the local public health workforce to do community health assessment is a major focus of Assessment in Action. AssessNow, a web-based information clearinghouse, and CHAMP, an assessment mentorship program, are two recently implemented projects to help meet this goal.

AssessNow is a web-based learning resource and information clearinghouse for public health staff working in community health assessment in Washington State. It was developed in partnership with the University of Washington's Northwest Center for Public Health Practice and provides community health assessment practitioners

with information, tools, resources, and a forum for dialogue.

The first phase of AssessNow was launched in October 2004 and includes:

- ◆ Publications—published community health assessment reports from DOH, LHJs and their community partners.
- ◆ Data Sources—descriptions and links to local, state, and national sources of data for community health assessment.



AssessNow

www.AssessNow.info

AssessNow is a web-based learning resource and information clearinghouse for public health staff working in community health assessment in Washington State.

- ◆ Assessment Toolkit—information, tools, and learning resources on the practice of community health assessment.

The second phase is under development and expected to be complete by Fall 2005. It will include a password-protected section where public

health staff will be able to access a technical assistance staff directory for assessment; templates and work samples; model approaches to assessment practice; peer mentoring program materials; and training materials.

Community Health Assessment Mentorship Program (CHAMP)

CHAMP is a 12-month peer-to-peer mentorship program, matching experienced in-

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Healthy Schools Launches New Website

A Healthy Schools in Washington website has been developed for school personnel and officials to connect to resources that will help them improve nutrition and physical activity opportunities for students.

www.healthyschoolswa.org

SB 5436, which became law last year and was largely based on WSPHA's 2002 policy resolution calling on school officials to partner with public health to improve the nutrition and physical activity environment in schools, requires Washington school districts to adopt nutrition and physical fitness policies by August 2005. On the website, visitors can find a new page dedicated to resources for complying with SB 5436, including names of individuals

who have agreed to be contacted as resources, listed by school district; a list of existing or potential funding sources; and ideas about healthy vending without loss of revenue. New resources will be continuously added.

The website was created through a partnership of the Children's Alliance, the Department of Health, the State Board of Health, Office of the Superintendent of Public Instruction, Washington State School Directors Association, and the UW Center for Public Health Nutrition, with review and input by WSPHA. The website can be accessed at <http://www.healthyschoolswa.org>

– Ruth Abad, Dept. of Health



ASSESSMENT

Continued from previous page

dividuals with those wishing to gain experience in specific community health assessment competency areas. CHAMP was created for both new and veteran community health assessment staff interested in increasing their CHA competency. It assists local health officials interested in building CHA capacity in their agencies.

Recruitment for mentors and mentees began in October 2004, with announcements about CHAMP posted on AssessNow

and WA-ASSESS, a listserv that provides a forum for exchanging ideas and information about community health assessment. Recruitment was done at the Joint Conference on Health in Wenatchee and at a statewide CHA meeting in late October. Every effort was made to match mentors' strengths with mentees' unique needs in the pairing process.

Five mentorship pairs have been matched this first year. Each pair will focus on a project chosen by the mentee that builds the mentee's knowledge, skills and abilities in specific

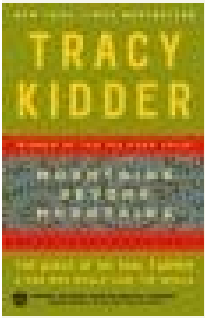
CHA competency areas. Examples of proposed projects include analyzing local Behavioral Risk Factor Surveillance System (BRFSS) data, a mapping project, and program evaluation. Mentorship activities began with mentorship training in January 2005.

More information about Assessment in Action can be found at www.doh.wa.gov/EHSPHL/AIA.



Mountains Beyond Mountains

by Tracy Kidder



Reading this book gives one the definite feeling of having discovered our very own American version of Mother Theresa, except this time the crusader is driven by convictions that closely match our own in public health. Subtitled *The Quest of Dr. Paul Farmer, A Man Who Would Cure the World*, it is the story of one physician, trained in medical anthropology and public health, determined to relieve the suffering of poor people through fairly simply applied medical and public health measures. It is masterfully written by award-winning writer and documentarian Tracy Kidder, chronicling the life and work of Farmer in the impoverished community of Cange, Haiti, during and after the reign of Baby Doc Duvalier. Originally published in 2003, the book was re-issued in paperback six months ago with a reader's guide to assist those interested in using the book in discussion groups. The title of the book derives from the Haitian proverb "Beyond mountains there are mountains," a reference to the unending trials of the poor, whose lives are the primary context of this affecting book.

That Kidder chose to write the book in first person turns out to be a good thing for readers, contributing to its impression as a hard-to-put-down page-turner. It's a technique that allows an author to insert himself in his story as one in the cast of characters, so that Kidder's own unique powers of observation and analysis, as well as his relationship with his subject, are part of the telling. It no doubt also allowed the inclusion of the many interesting facts and stories in the book about Farmer's personal life, relationships, and beliefs. The journey from being raised in a trailer to college to medical school to eventually finding his life's purpose in Haiti are satisfyingly detailed by a story-

teller appropriately circumspect though clearly awed by his subject.

In addition to toiling with endless energy among his patients in Cange, Farmer found time to start a non-profit organization, Partners in Health, to raise the money he needed to build a rudimentary medical complex and buy medicines and supplies. Once yearly, he returns to Harvard to see patients, train medical students, visit his donors, tie up loose ends on any pending publications, and make occasional speeches about his work in Haiti, especially in the field of infectious diseases. His crusade to find a cure for drug resistant tuberculosis led to clashes with the World Health Organization, academic experts, and privileged liberals over how resources are allocated and how the health needs and rights of the poor in poor countries are viewed. Delving deep into Farmer's beliefs and motives challenges a reader's own self-concept as a caring person of compassion for the less fortunate. Kidder puts it best in his first chapter: The world is full of miserable places. One way of living comfortably is to not think about them, or when you do, to send money.

A prolific author of books and journal articles, in 1999 Paul Farmer wrote in "Pathologies of Power: Rethinking Health and Human Rights (*American Journal of Public Health* 89(10):1489-96)" that "We have a long way to go in the struggle for health and human rights... We need to listen to the sick and abused and to those most likely to have their rights violated... Claims that we live in an era of limited resources fail to mention that these resources happen to be less limited now than ever before in human history."

Paul Farmer chooses every day to do more than send money when he thinks of all the miserable places in the world. For the public health workers among us who are here mostly for the great satisfaction of understanding how what we do advances social justice, *Mountains Beyond Mountains* gives us the hero of our profession who does all that he does simply because it's the right thing to do.

– Karen Valenzuela

Winter Reading



New Dietary Guidelines Announced

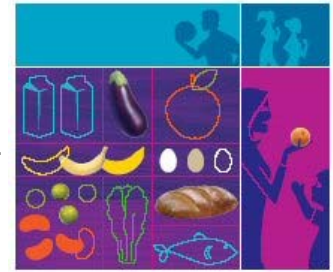
In January, the Department of Health & Human Services and the Department of Agriculture announced the release of the Dietary Guidelines for Americans 2005, the federal government's science-based advice to promote health and reduce risk of chronic diseases through nutrition and physical activity.

The sixth edition of Dietary Guidelines for Americans places stronger emphasis on reducing calorie consumption and increasing physical activity. This joint project of the Departments of Health and Human Services and Agriculture is the latest of the five-year reviews required by federal law. It is the basis of federal food programs and nutrition education programs and supports the nutrition and physical fitness pillars of President Bush's HealthierUS Initiative.

Eating a healthy balance of nutritious foods continues as a central point in the Dietary Guidelines, but balancing nutrients is not enough for health. Total calories also count, especially as more Americans are gaining weight. Because almost two-thirds of Americans are overweight or obese, and more than half get too little physical activity, the 2005 Dietary Guidelines place a stronger emphasis

on calorie control and physical activity.

The Dietary Guidelines provide health education experts, such as doctors and nutritionists, with a compilation of the latest science-based recommendations. Consumer-friendly materials such as brochures and Web sites will assist the general public in understanding the scientific language of the 2005 Dietary Guidelines and the key points that they can apply in their lives. To highlight those points, a consumer-oriented brochure accompanies the 2005 Dietary Guidelines. USDA's Food Guidance System also will serve as a tool to educate consumers on the Dietary Guidelines for Americans. The Food Guidance System, currently called the Food Guide Pyramid, is undergoing revision and will be released in the spring of 2005. The 2005 Dietary Guidelines and consumer brochure are available at www.healthierus.gov/dietaryguidelines.



Dietary Guidelines for Americans 2005

SAMHSA Announces New Suicide Hotline

The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) today announced the launch of the **National Suicide Prevention Lifeline 1-800-273-TALK**. The national hotline is part of the National Suicide Prevention Initiative (NSPI)—a collaborative effort led by SAMHSA that incorporates the best practices and research findings in suicide prevention and intervention with the goal of reducing the incidence of suicide nationwide. In addition to the national hotline, a new website is being launched www.suicidepreventionlifeline.org.

In the United States, suicide currently is the 11th leading cause of death among all age groups, accounting for approximately 30,000 deaths annually. More than 100 crisis centers

in 39 states currently participate in the National Suicide Prevention Lifeline. SAMHSA is committed to working with state and local organizations, such as the Mental Health Association of New York City, the National Association of State Mental Health Program Directors, and community crisis centers, to expand the availability of suicide prevention and intervention services.

The National Suicide Prevention Lifeline is funded by a 3-year \$6.6 million grant from SAMHSA's Center for Mental Health Services, which has been awarded to the Mental Health Association of New York City and its partners—the National Association of State Mental Health Program Directors, Columbia University and Rutgers University. The National Suicide Prevention Lifeline is a network of local crisis centers located in com-

munities across the country that are committed to suicide prevention. Callers to the hotline will receive suicide prevention counseling from trained staff at the closest certified crisis center in the network. A nation-wide public education campaign to raise awareness about suicide and the national hotline is under development.



Improving Health the Only Way We Can

By Federico Cruz, MD

Director, Tacoma-Pierce County Health Department

We live in a puzzling time. On the one hand we possess the most sophisticated technology in the world on which to build our health care system. The best trained doctors and the finest hospital and clinic facilities that can be found anywhere on this planet are in the U.S. We possess powerful drugs and medical equipment that people 30 years ago could only dream about.

Yet as a community made up of real people, we keep getting more and more unhealthy. Something is not right.

We spend \$1.4 trillion on health care in the U.S. each year, more than anywhere else in the world. You would expect, then, that we should be the healthiest people on the planet. You would be wrong. We rank 37th --between Costa Rica and Slovenia! This is part of the deception that starts with thinking that a health care system focused on illness and disease will keep us healthy. It doesn't work that way. Health more likely comes to those who live a healthy life style, not to those with a Blue Cross/Blue Shield card in their wallet.

It may sound crazy but it is important to ask: "Is the demand for health insurance at the root of our health care crisis?" While health care coverage certainly is important so that people will go to the doctor when they are sick, and to prevent catastrophic illness from devastating a family's finances, the real root of our problem goes much deeper. Somehow we have to move away from a system we engage with only when we are sick.

Fostering A Wellness System, Not an Illness System

A good health care system assists a person to maintain health. But it only works if we make healthy choices that make health possible. In our own state of Washington we have a system of care that spends billions treating disease, yet fails to deliver better health.

It is unfair to expect our health care system to gamely diagnose and treat heart- and cancer-related illnesses, when we know that the main precursors — diabetes and high blood pressure — are conditions that often come from poor diet, lack of exercise, smoking and/or excessive drinking. We need to focus on the root causes of these diseases. This means a wellness approach, and this requires a different way of doing business.

There is a great debate across our country on how to fix this mess. On one side are the advocates of a "healthcare-for-all" system. On the other side are the advocates of a free market approach. As in many things the answers are never one or the other but a mix.

Where Do We Want to Go?

The first step is simple: Tell the truth. An illness care system will never get us where we want to go. We have to ask, "Where do we want to go?" and then define it. We want a healthier community with fewer people getting disabled by chronic diseases. We want fewer people sickening and dying at an early age. We

"We have a system of care that spends billions treating disease, yet fails to deliver better health."

— Continued on next page

Continued from previous page

want fewer obese children who present to school unready to learn.

Can we achieve this? The answer is a straightforward “yes” if we invest in wellness instead of illness. We spend so much of our health care dollars on taking care of people after they are sick. More of these precious resources need to be invested in PREVENTION.

Every dollar spent on the front end to keep people healthy means five or six dollars do not need to be spent on the back end as people get chronically sick. We know this works but we do not do it.

Everyone I ask always agrees with me that prevention works and we should do more of it. Elected officials tend to agree on the power of prevention. But when it comes to investing in it, there is a strange paralysis. Prevention approaches just don't have the

drama of emergency cures, daring surgeries, dramatic chemotherapies that pull people back from the brink of death. But the intent of our public health dollars is not to invest in drama but in better health. Prevention may not have a huge industry behind it, it may not employ tens of thousands of people, but it works. The driver for how we spend our scarce tax dollars must be “put your money where it will do the most good.”

So how do we transition to a prevention model while still serving those in need?

Build the new system around a startling fact: 25% of all our health care budget pays for the treatment of illnesses that are totally preventable.

Prevention is Key

We know how to do prevention. It just takes commitment and dedicated resources. The message is clear: Change directions in how we spend our health care dollars. Can we realistically spend less money on health care when we see the huge increases each year in health

Opinion

care spending that seem to be outside our control? If fewer sick people need these costly tests and treatments, YES. It's just that simple!

There is also an unpleasant truth here that no one wants to talk about, but let me say it anyway. We have to decrease the dollars we pay for sick care. This is ethical and will work (no long lines of people dumped out of care), but only if we shift a significant part of these sick care dollars to local communities to do prevention campaigns. Decreasing the number of diabetics, the

number of obese people, and the number of people with high blood pressure means many fewer people with chronic diseases. This translates into fewer doctor visits, fewer ER visits,

fewer lab tests, and fewer prescriptions.

We have an opportunity to improve the health of our state without bankrupting either the individual citizen or the government. Even with an investment of massive amounts of new tax dollars, our current system does not lead us to health. It would just provide more and more care for the sick without a cure. It is time for us to embrace an approach that can achieve much more. We want less disease and death in our communities. We want to live longer without a crushing burden of chronic disease. This is doable with existing dollars on the table in our present budget. It just takes doing health care differently.

We can set ourselves the previously unthinkable goals of spending less money on health care and having healthier communities in our state.

It just takes prevention.

“The intent of our public health dollars is not to invest in drama but in better health. Prevention may not have a huge industry behind it, it may not employ tens of thousands of people, but it works.”

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