President’s Message

Lessons from my daughter’s 8th grade English class

One night last week, my middle-school daughter came into the kitchen with a look of frustration on her face. Her latest English assignment involved writing an essay arguing a position of her choice. She wanted to write about why dance, her favorite activity, is a sport. Her intent was to push back against arguments from friends that dance is “just an art.”

As we talked about the assignment, it became clear her struggle sprang from the fact that she was looking at the choice as binary – dance was either a sport or an art form. Even though she had developed several legitimate points arguing that dance is a sport, she couldn’t quite shake the conviction that it was just as much, if not more, an artistic expression. She gradually realized the need to modify her thesis – dance is a sport AND an art.

That solution seems obvious in hindsight, but we all find ourselves in her situation from time to time. If anything, false choices like the one my daughter faced are even more common in the adult world. For example, many of us at some point have been told we must choose between being a good parent or a good worker. Or that we must align ourselves with either science or religion. Or that we must choose between protecting public health and protecting jobs.

Another false choice I’ve heard over the years is that communications is either an art or a science. Depending on who you believe, those of us in communications are either messaging wizards who draw on innate skill to conjure up the right words to evoke the right feelings at the right time, or we are technicians using Big Data to deliver carefully calibrated, evidence-based messages to a target audience.

I don’t deny the power of evidence and data, but there is an undeniably creative aspect to good communications as well. It comes down to having skills in both the science of communication and the art of communication – some may call it a soft science, others may call it empathy or humanity.

This multi-faceted nature of public health communication is highlighted when communicating about risk. The recent public unease over the outbreak of Zika virus in Central and South America shows the power...
By Brad Christensen

NPHIC Members Rank Benefits, Praise Resources

In a recent survey, NPHIC members ranked the usefulness and importance of various services, and in written responses, stated their top reasons for joining the organization.

Looking at various other membership benefits, special conference calls from the CDC or elsewhere on breaking or emerging public health issues (such as Ebola or Zika) easily topped the list. Coming in second were CDC/NPHIC conference calls on new communication applications or tools. The calls were followed, in order, by “expanding my professional network;” the resource libraries; membership directory/contact information; credentialing; awards program, and peer mentoring.

Asked to state their top reason for joining NPHIC, written comments most frequently cited education and information resources, followed closely by networking/relationship building. Others mentioned professional development/training and conferences.

Among the typical written comments were these:

“Great communication tools and near real time information — most valuable membership I have.”

“I don’t like to reinvent the wheel, so having access to others who do messaging and their resources makes my work easier.”

“Access to shared resources, advance notice of CDC/other news, and direct access...Continued on page 3
of information and emotion in our field. Both elements are accentuated when the issue at hand is a novel disease linked to a visually powerful and lasting physical impact on newborn infants. People are concerned and they need good information. They also want to know their concerns and fears are understood by those in positions of authority.

Successful risk communication about Zika, or anything else, requires a combination of evidence (science) and empathy (humanity). Omit one from your messaging and you may look clueless. Omit the other and you may look heartless. As the old saying goes, “people want to know you care before they care what you know.”

Over the years I’ve had the good fortune to meet and learn from a number of top-notch risk communication experts. Their writings and training sessions can tell you all about the importance of empathy as well as many other key principles of effective risk and crisis communication.

As for the evidence part of the equation, they’d probably tell you that you must build your messaging on a foundation of solid, accurate information. However, in a field where issues can evolve by the minute and we are bombarded with updates, e-mails and tweets, how can anyone possibly stay up to speed on all they need to know? For me, one answer is NPHIC.

NPHIC has a variety of tools you can use to stay up to speed on changing issues — monthly conference calls with CDC experts, newsletters, e-mail updates and the excellent set of resources available on the NPHIC website at www.NPHIC.org. Perhaps the most valuable aspect of NPHIC is the connections it can help you make with public health colleagues in your state and your region. These connections not only can be great sources of information (especially in times of crisis), but they can also be excellent sources of inspiration and learning.

Like all organizations, NPHIC is evolving to meet the changing demands of its members and partners. I hope you find that process helpful, and that you will take advantage of the opportunities throughout the year to join in that process. If there is anything we can do to help you, please don’t hesitate to reach out.

As a final introductory note, it is an honor to serve as the 2016 NPHIC president. Throughout my career, I have found that professional organizations like NPHIC add tremendous value to our work. They introduce us to new ideas, connect us with new colleagues and spark new friendships that make our work more powerful and rewarding. Thank you to our many active members and contributors. For those who are new to NPHIC or who have only gotten involved in a portion of our programs and activities, I encourage you to take advantage of all this organization has to offer and to find your own way to contribute to the discussion.

Michael Schommer
President
Go For The Certified Communicator In Public Health

By Kimberley Conrad Junius, CCPH

It was a year ago that I learned about the Certified Communicator in Public Health (CCPH) credential through NPHIC. I had just entered into a six-month arrangement with a job coach I hired, thinking I was mid-career, with 21 years behind me and probably about 21 years ahead of me. At minimum, I wanted to update my resume. At best, I wanted to reevaluate and reignite my passion for health communications.

I was inspired when I found out about the CCPH, which requires a resume, and thought I could use it as an incentive to spur me into action. The job analysis — which describes the five core competencies and seven skillsets of a CCPH — also caught my attention; partly because my agency had recently become accredited by the Public Health Accreditation Board (PHAB) and I knew the importance of demonstrating a competent workforce; and partly because I was curious to be evaluated by my peers.

I submitted my application and fee to NPHIC in the spring, indicating my intent to submit a portfolio in the fall. I’d heard it could take 60 hours to pull a portfolio together. I had no idea whether I’d follow through, but hoped I would; knowing I had six months. Meanwhile, my job coach helped me move from paralysis to action, and together we created a beautiful two-page resume; and that gave me the energy and confidence I needed to update my LinkedIn profile.

For a brief moment, I thought I was “cooking with gas” - until I started thinking about gathering items for my portfolio. Not knowing where to begin, I basically let it sit all summer until early October when, with a month to the deadline, I decided to actually go for the CCPH. I lined up three excellent references and by mid-month, I began writing in earnest what would eventually be a 20-page paper.

Getting started was the hardest part. It was very satisfying to reflect on what I’d accomplished, which helped identify work samples to include in the portfolio. It probably did take 60 hours to pull the whole package together, but NPHIC was very supportive and informative throughout the process, which ended up being a reward in itself. I found out in early December that I received CCPH credential and was the first in Illinois to represent a local health department. To date, 37 people have earned the CCPH designation since 2013.

Leaders within my department — the Cook County (Ill.) Department of Public Health - were pleased. “The CCPH credential gives local health departments a framework for evaluating, improving, recognizing and demonstrating capacity to use the appropriate messages, messengers and means to promote health, prevent disease and protect the public,” said the department’s chief operating officer, Dr. Terry Mason.

The accreditation coordinator, Valerie Webb, agreed, saying: “This can come in handy during the accreditation application or renewal process, especially when demonstrating workforce competencies and the ability to inform and educate the public about public health issues and functions.”

Public information officers in Illinois have expressed interest in becoming certified. I was invited to present to fellow members of the Northern Illinois Public Health Consortium Communications Committee, comprised of PIOs from eight county LHDs in and around Chicago; and on an Illinois Department of Public Health-led call with other regional PIO groups throughout the state. I also was urged to submit abstracts to the National Association of County and City Health Officials (NACCHO) Annual Meeting in July; and the Illinois Public Health Association’s Integrated Public Health and Healthcare System Preparedness Summit in June.

I encourage all of my health communications colleagues throughout the nation to “go for the CCPH” and, if you are not already, become an NPHIC member and learn more about peer-to-peer mentoring and other opportunities to network and get involved.

[NPHIC will accept 25 CCPH applications April 1-31 on a first-come, first-served basis, so don’t delay. Portfolios will be due Aug. 31. For more information, visit https://www.nphic.org/career/credentialing or email Credentialing Manager Kris Smith, at ksmith@nphic.org.]
‘Ecosystem’ Approach Urged For Communicators

By Richard Sheehe and Gary L. Kreps

Managing public communications across a range of situations and stakeholder audiences is a lot like building a puzzle from many useful, but fragmented, pieces of insight. Especially during a crisis, it can be challenging to share relevant information with multiple audiences and maintain a consistent and trusted organizational identity amid diverse, and sometimes conflicting, priorities and principles.

Imagine, for instance, you’re hearing calls to test a very wide population for a disease that, in all scientific likelihood, won’t spread beyond a small group of individuals. From a communications standpoint, how do we balance public fears and political demands for “abundance of caution” against fiscal, scientific and organizational concerns about misallocation of resources? Emotion, medicine, politics, competing stakeholder interests and basic human nature are all at work here — and your communication strategy needs to take every perspective into account.

Connecting the Dots

Communicators hoping to untangle situations like this will benefit from fewer silos and more coordination among the many practice areas involved. Media advisers, community relations staff, subject-matter experts, scientists, emergency managers, finance, legal and regulatory colleagues can all play important roles in guiding strategy. But it’s the communicator’s job to synthesize these diverse and sometimes competing interests into a public posture that is unified, consistent and trustworthy.

In the struggle to connect the dots, we believe the most successful strategies involve filtering wisdom from multiple disciplines through a common lens focused squarely on the communications mission. In this article, we’re not advocating any one particular program or methodology, but rather a strategic mindset: Try to imagine your information landscape as a multi-disciplinary ecosystem of interrelated and sometimes interdependent dynamics that govern communications success.

Three Strategic Priorities

The accompanying graphic is one way to illustrate this kind of “Communications Ecosystem” mindset, as we’ve come to call it. Whatever your specific strategy might look like, we suggest it involve several key characteristics:

1. **Your strategy should be multi-disciplinary** — Depending on the specific situation, the communicator may be dealing with science, politics, HR, law, medicine, critical infrastructure and just about any other field you could think of. No single discipline should necessarily overshadow the others as you craft and share messages. Legal strategy dressed up as a communications plan, for instance, can come across as inhuman or robotic; a plan based solely on community expectations can lead to overpromising; a media-driven playbook may sacrifice message discipline for quotability. Understanding and respecting the insights and applicability of multiple professional disciplines — and helping your many colleagues do the same — can bring checks, balances and consistency over time and across different circumstances.

2. **Your strategy should be evidence-based** — Your approach should invite common ground between the academic and practitioner’s worlds. Real-world lessons learned and “war stories” should be backed up by accurate metrics, analysis and research findings on how specific audiences interpret, share and respond to messages. As our ecosystem graphic on page 6 suggests, data-driven evidence on cognitive, biological and social dynamics affecting how we communicate is essential to your strategy. “Evidence-based practice” has helped revitalize medicine, criminal justice, education and other disciplines, but its direct application to strategic communication remains rare. We all should work to change this!

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3. **Your strategy should be accessible to the communicator as “end user”** — Multi-disciplinary and evidence-backed insights aren’t much good if they’re out of reach for the frontline communicators who work with the public, media and other stakeholders daily. Your approach should include useful toolkits, templates and dashboards that can be put to use on short notice and in real time to keep your communication programs timely, relevant and influential.

If adopting this expansive and practical "ecosystem" view of communications sounds like a tall order, the good news is that you don’t have to start from scratch. We all owe a great debt to the CDC’s own CERC curriculum, which builds all three of the above characteristics into guidance for crisis and emergency risk situations. A great example is the CERC “Crisis Communications Lifecycle” graphic, an accessible dashboard that is backed by tons of applicable research and best practices across multiple disciplines.

Your own organization invariably will have unique communication dynamics and challenges that require a certain amount of customized strategy in crisis and non-crisis situations alike. Regardless of your particular solution, however, it helps to think through the larger communications “ecosystem” when vetting issues and engagement strategies. It’s a key step toward your own accessible framework to build continuity, align messages and stay effective and trustworthy.

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[Gary L. Kreps, Ph.D., FAAHB, is director of George Mason University’s Center for Health and Risk Communication and is a university distinguished professor in GMU’s Department of Communication. A researcher and educator who has authored more than 400 articles, books and essays, Dr. Kreps also served as founding chief of the Health Communication and Informatics Research Branch at the National Cancer Institute.]
Youth Advocates Tackle E-Cigarette Threat At Vermont Capitol

By John Silcox, CPH

During a rally at the Vermont State Capitol in February, youth advocates from the group “Our Voices Xposed” urged lawmakers to consider the hazards posed by e-cigarettes.

While they weren’t there to lobby on behalf of any particular legislation, the high school students did share information about the rising rate of e-cigarette use among their peers, and the increasingly aggressive marketing tactics the tobacco industry uses to exploit youth – from candy flavors to colorful packaging.

Just weeks after the rally, on March 10, the House Human Services Committee voted for a bill to ban electronic cigarettes in places already protected by Vermont’s Clean Indoor Air laws, along with other restrictions.

For Rhonda Williams, chronic disease prevention chief for the Vermont Department of Health VDH, it was a clear example of why youth-empowered activism is so important.

“When youth are able to tell from their experience what it is like, that just resonates in a different way for anyone, but especially local and state decision makers,” Williams says.

The VDH continues to invest in youth engagement and education around key public health issues like tobacco prevention, even as the dollars have dried up in recent years. The state, which formerly supported more than 60 youth organizations, now backs less than half that number.

But Our Voices Exposed (OVX) — and a sister group for middle schoolers called Vermont Kids Against Tobacco (VKAT) — still play an important role in the department’s chronic disease work.

“They are a tangible voice,” Williams says. “Their perspective is trusted in ways that adults, even those in public health, cannot be.”

OVX, in particular, has a history of speaking out against the dangers of smoking and the tobacco industry’s exploitation of youth. The group was formed 15 years ago, and VDH funding helps pay for adult advisors, transportation and trainings that culminate in the annual youth rally at the Capitol.

In previous years, OVX has addressed hot-button issues like smoking in cars and restrictions on point of sale. Now e-cigarettes have drawn the attention of youth leaders and tobacco-free coalitions.

Electronic cigarettes, or e-cigarettes (sometimes called vape-pens or e-hookahs), are battery-powered devices that produce an inhalable aerosol from a heated liquid containing nicotine. While e-cigarettes and other vaping devices may be less hazardous than smoking tobacco, they are not regulated by the FDA and the vapors they produce often contain unknown levels of toxins.

Public health officials also fear that e-cigarettes will lead to nicotine addiction and a gateway to conventional cigarettes for America’s youth.
The CDC found a dramatic, nine-fold increase in e-cigarette use among adolescents since 2011, and in Vermont, e-cigarette use now outpaces that of conventional cigarettes among high school students.

According to the 2015 Youth Risk Behavior Survey, 30 percent of Vermont high school students have tried e-cigarettes and 15 percent reported using in the last 30 days (compared to 11 percent for cigarettes).

VDH’s position is that e-cigarettes are unregulated, produce dangerous toxins that can damage lung and heart health, and the nicotine they supply is especially addictive to developing brains. Also, evidence is lacking to support their use as an effective quit tool when safer and more proven methods are available, such as counseling and nicotine replacement therapies.

Vermont already bans e-cigarette use at schools and day care centers and prohibits the sale to minors under 18. But some lawmakers feel there isn’t enough evidence on the health risks of vaping to justify further restrictions on their sale or use.

About 30 members of OVX participated in February’s rally to try to change minds on this issue.

From a nearby high school, they marched to the State House where students read a powerful poem, Sorry, about the impact of tobacco, followed by a keynote address from State Representative Ruqaiyah “Kiah” Morris.

During a visit with lawmakers, the youth advocates also shared their concerns about the rise in e-cigarette use among high school and middle school students.

The House committee studying the issue also took testimony from other youth advocates in writing and by phone, noting that many flavors, such as cotton candy and peanut butter, seem intended to directly appeal to young people.

The committee ended up voting 10-1 in support of a bill that would not only ban e-cigarettes where smoking is prohibited, but would require retailers to display e-cigarettes in places accessible only to sales personnel — such as behind counters or in locked displays.

Whether it is ultimately passed by the full House and Senate remains to be seen, but it is a good first step.

The Health Department’s commitment to youth engagement remains strong, even if changes are afoot. Starting next year the Vermont Department of Education will assume management of the OVX and VKAT programs with the Health Department providing the training materials and technical support.

“We see growing synergy on that front,” Williams says.
Vaccine Airdrops Battle Rabies In Texas, Alabama

By Brad Christensen

Programs involving massive airdrops of baited packets of oral rabies vaccine have taken place in several nations and in a few U.S. states as a means of controlling the disease among wildlife populations.

Among the most successful has been an annual undertaking by the Texas Department of State Health Services (TDSHS). That effort began in 1995, after a major rabies outbreak in South Texas resulted in two human deaths and thousands of post-exposure rabies treatments. It has successfully eradicated rabies among coyotes and gray foxes. Its prime target since 2014 has been skunks.

“It’s one of those things that really is a public health success story,” says TDSHS Press Officer Chris Van Deusen. “People were dying and now they’re not.”

Taking a cue from Texas, the Alabama Department of Public Health launched its program in 2014, targeting rabid raccoons in the northern part of the state. “Over the last several years, rabies has become more of a problem, as we have encroached increasingly on the wildlife populations,” says Dr. Jim McVay, director of Alabama’s Bureau Health Promotion and Chronic Disease Bureau.

Areas of Florida, Pennsylvania, Vermont and upstate New York, are among other locations that have employed airdrops of rabies vaccine in the past. Such airdrops began in Europe in 1991, involving large sections of France, Belgium and other countries to control rabies in red foxes. That effort was expanded in 1995 to focus on wild dogs in Tunisia, Turkey and parts of southern Africa.

The packets that most frequently are dropped are about the size of a fast-food ketchup packet. Each packet contains the oral vaccine Raboral V-RG within a plastic shell. The packet is dipped in fish oil and coated with fishmeal crumbs. While the packets elicit a terrible odor to humans, they ring the dinner bell to a hungry coyote. Other than mild gastrointestinal tract discomfort, the packets have been shown to be safe for ingestion by 60 animal species, including cats and dogs. To dissuade people from disturbing the packets, each Texas packet, for example, bears this printed warning: “Rabies Vaccine – Live Vaccinia Vector – Do Not Disturb.”

Since 1995, Texas has dropped more than 47 million individual doses of these “stink bombs” over more than 664,000 square miles of the state. Canine rabies cases have declined from 142 in the first year of the Texas program to zero from 2005 through the present. The grey fox program has enjoyed similar success, dropping from 244 cases in 1995 to zero, except for one bovine case, since 2009.

The Texas program annually involves approximately 250 flights by five King Air aircraft, as well as a Texas Parks and Wildlife helicopter, resulting in a total flight distance of approximately four times around the world.

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Portland Glass Firms’ Emissions Fuel Health Controversy

By Laurie Boston

If you gaze at the craftsmanship and artistic beauty of stained glass, it is hard to imagine that emissions from its production may provide serious health consequences. However, this is the challenge that Portland, Ore. is currently facing in a public outcry that erupted in February.

Seeds for the whole controversy were sown when a team from the U.S. Forest Service Pacific Northwest Research Station conducted a pilot study using moss samples to measure air contaminants, including heavy metals, within the Portland area. Results from the study identified two potentially unsafe levels of arsenic and cadmium in the air around two of Portland’s largest stained-glass manufacturers. The Oregon Department of Environmental Quality (DEQ) last October conducted air monitoring outside one of the glass manufacturing plants. Cadmium emissions were found to be 47 times higher and arsenic emissions 155 times higher than state benchmarks.

The results were disclosed publicly on Feb. 3, the same day the Portland Mercury newspaper broke a story about the toxic emissions. As residents near the glass manufacturers and others in the community expressed their rage, DEQ maintained that it was unaware of the initial moss findings until last May and acted as quickly as they could. But e-mails released under Oregon’s public records law revealed that DEQ had been informed as early as November, 2014 of partial findings. In the midst of the controversy, DEQ Director Dick Pedersen and Portland Air Quality Manager David Monro both resigned.

“Studies indicate that inhalation of inorganic arsenic can cause increased risk of lung cancer. Long-term exposure is linked to skin color changes, nerve damage, skin cancer, and lung, bladder, and liver cancer.

• Breathing high levels of cadmium can severely damage the lungs. Long-term exposure to lower levels of cadmium in the air is linked to kidney disease, lung damage, and fragile bones.

• Chronic, low-level exposure to hexavalent chromium increases the risk of lung cancer. Inhaling high levels can cause acute respiratory problems.

However, based on available cancer data, medical
researchers have yet to find evidence of an increase in cancers associated with elevated levels of cadmium and arsenic in Portland residents.

In testimony before Oregon’s House Energy and Environment Committee on Feb. 23, Oregon Health Authority (OHA) Director Lynne Saxton outlined how OHA is currently working with DEQ and the Multnomah County Health Department to take action. She identified three priority areas on which they are focusing: assessing health risks and informing the public; helping residents in the affected areas receive testing and reduce their exposure; and working with federal, state and local partners to develop risk-based health permitting rules in Portland and other Oregon communities.

“This exposure has highlighted fundamental gaps in our federal and state laws, rules and permitting processes,” she concluded. “OHS looks forward to working with state legislators, our congressional delegations, DEQ, local health departments and community members to identify appropriate solutions as soon as possible, while continuing to monitor health risks and inform the public.”

Some notable action items include using the incident command structure and establishing a joint information system with DEQ and Multnomah County Health; establishing a hotline to answer questions; covering the costs of cadmium testing for current residents living in the highest risk neighborhoods; and implementing rule-making requiring all positive urine tests for cadmium in Oregon be reported to OHA.

Additionally, a website titled “Safer Air Oregon” has been created as a joint effort by DEQ, OHA and the county “to share information about toxic metals emissions and what we’re doing to protect the public’s health.” View it here.

Currently, the Texas airdrops are focused along the Mexican border as a preventive measure for canine immigrants, and in east-central Texas, in a pilot effort to control rabies among skunks. The 2016 airdrop began on Jan. 12 and ended Jan. 31. Approximately 1 million doses were dropped along the border and 1.4 million in the skunk study area.

Alabama’s most recent airdrop occurred last October. Approximately 1 million doses were involved. Most of the packets were dropped from airplanes and helicopters, but some were distributed on foot in Huntsville and other more urban areas.

The bombardier prepares to drop his load.
That sounds a lot like college students: 10 years out from their kindergarten vaccinations and living in close quarters such as dorms, apartments, fraternities and sororities, and participating in group activities such as athletics, band, and social events. In addition, the mumps vaccine is not 100 percent effective.

“We’re dealing with a vaccine that is 88 percent effective and a contagious disease like mumps,” said Iowa State Epidemiologist Dr. Patricia Quinlisk. “This does not mean the vaccine is not working; in fact, the mumps vaccine is working as expected. Another way of looking at this is that because of the vaccine, the vast majority of people are NOT getting mumps.”

But quite a few are. At the University of Iowa, for example, around 300 cases of mumps have been reported since July of 2015. Trips home and to visit friends are likely responsible for the spread of mumps across much of the state, including a cluster of more than 40 cases at the University of Northern Iowa. All told, more than 500 cases of mumps have been reported in Iowa since July.

“While mumps can cause fever and painful, swollen glands and can cause students to miss many days of classes, there is also the...”
possibility of serious long term complications such as deafness and testicular swelling, which can result in sterility. Both of those complications have already occurred in students,” said Quinlisk. “Mumps can also rarely cause inflammation of the brain and pancreatic problems. Bottom line, this is not a disease that you want to get.”

To try and stem the outbreak at the University of Iowa, the Iowa Department of Public Health consulted with CDC, and working through the local health department and university, offered free vaccination clinics for students to receive a third dose of MMR vaccine. Since these third dose clinics were offered in November, the number of mumps cases on campus has steadily declined. Was the third dose the key to slowing the outbreak? CDC is working with public health officials in Iowa now on research to try and determine that.

For more information about the Iowa mumps outbreak, including examples of how the University of Iowa has communicated with its students, visit https://idph.iowa.gov/ehi/mumps. To learn more about the Indiana mumps outbreak, see http://www.in.gov/isdh/25450.htm.
New California Law, Disney Outbreak Boost Vaccinations

By Phyllis Bell-Davis

Children enrolling in kindergarten in California in the 2016-17 school year will be the first class impacted by the passage of SB 277 which, in essence, eliminates the exemption from immunization requirements based upon personal beliefs.

But even before taking effect, the new law appears to have had some impact, in part due to the Disneyland measles outbreak. That outbreak sickened 147 people in the U.S., including 131 in California, by the time it was declared over in April, 2015. According to a California Department of Public Health (CDPH) report, kindergarten immunization coverage increased by 2.5% to 92.9% in the 2015-16 school year.

As the new school year approaches, the importance of immunizations will be promoted in many ways, says Dr. Robert Schechter, CDPH medical officer and chief of the Immunization Branch’s Clinical and Policy Section.

In addition of to the typical back-to-school press release, CDPH will provide electronic and other communications with schools, providers and partners who are involved in immunizations. “There will also be a link to CDPH key messages at www.ShotsForSchool.org where parents, schools, local health departments, and providers can view information such as requirements for vaccinations,” adds Schechter. “We will also have frequent communication with public groups, as well as inside our organization and committee workgroups.”

Many key messages have been conveyed during Preteen Vaccine Week (PVW) in February to promote immunizations and highlight the doctor visit as an opportunity for preteens to receive vaccines.

Also during National Infant Immunization Week (NIIW) in April, key messages stress the importance of protecting infants from vaccine-preventable diseases and celebrate the achievements of immunization programs and their partners in promoting healthy communities.

Referring to the Disneyland outbreak, which spread to a dozen California counties, as well as six other states and two other countries, Schechter says it “caused a lot of discussion about the role of vaccines in preventing diseases, and with this discussion and a lot of media awareness, CDPH saw an increase over the past year in vaccinations.”

That increase to nearly 93% coverage was revealed in CDPH’s 2015-16 Kindergarten Immunization Assessment report. Full coverage meant vaccinations for DTP, Polio, MMR, and Hep B. Alameda County had the largest increase of any county in the rate of fully-immunized students (7.3%).

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Despite improvements in vaccination rates, a number of schools and communities still remain at risk, notes Schechter. “Rates nationwide and in California show a disparity in the African American population, and among adults. Other ethnic and racial groups have disparities but not as wide,” he says.

Schechter says many factors may be contributing to the low vaccination rates among African Americans; in particular, the legacy of the infamous 40-year clinical study – the Tuskegee syphilis experiment, that began in 1932. The victims of the study, all African American, included many men who died of syphilis, 40 wives who contracted the disease, and 19 children born with congenital syphilis.

“There are possible lingering concerns and suspicions about health care due to the that experiment and the decades of unequal access,” adds Schechter. “One hopeful note is that over the last 20 years, there has been increased access to vaccines and to programs like the Vaccines for Children (VFC) program that provides free vaccines up to age 18, and the Affordable Care Act in which most health plans are supposed to offer vaccinations free of charge. These types of programs have reduced economic and racial disparities, and are open to public and private health care providers, and those providing caring for indigent populations.”

“Vaccinations have very little adverse effects which are usually mild and brief, and may include soreness, redness and swelling at the injection site. Getting shots may sting a little, but it’s much better than getting sick,” said Schechter.

A listing of CDPH key messages and educational campaigns regarding childhood immunizations is here. You can also view CDPH’s 2015-2016 Kindergarten Immunization Assessment report here.
NPHIC members might have seen news reports in October with headlines like, “Nurse used same syringe on 67 people at New Jersey flu clinic.” The story about a breach in infection control at a company-sponsored flu clinic led some healthcare professionals to ask, “What if that happened in our county? How would our local health department handle it?” Health departments might need to conduct a time- and resource-intensive investigation. The CDC recently published an in-depth look at this very investigation regarding flu vaccinations delivered by a health services company to employees of a business.

Likewise, public information officers facing such an event would need to get information out in a clear, concise way.

The questions above are thought-provoking, given similar unsafe injection events followed by the national One & Only Campaign, since its inception in 2009. The campaign offers grant funding from the CDC to state health departments, for injection safety educational outreach. Its slogan is: “One Needle, One Syringe, Only One Time.”

Did you know that — according to the CDC — since 2001, more than 150,000 patients have been told they might have been exposed to bloodborne pathogens like hepatitis B virus, hepatitis C virus, or HIV because of unsafe injection practices? And those numbers represent only those cases known to CDC and state/local health departments. Given the challenges of tracing exposures back to healthcare settings, those numbers might represent the “tip of the iceberg.”

That’s why the One & Only Campaign put together its State/Local Health Department Toolkit, offering resources a health department might need, should it be called upon to investigate reuse of needles/syringes or misuse of single-dose or multi-dose vials.

The toolkit shows recent, real headlines, which dispel the notion that, “It can’t happen in my facility.” It offers scalable activities from basics like joining the One & Only Campaign and downloading/ordering One & Only materials for health education outreach, to outbreak investigation resources including templates for writing a patient notification letter and/or press release, strategies for dealing with media inquiries and assessing the impact of unsafe injection practices.

This toolkit is free and includes evidence-based resources (journal articles, clinical guidance on safe injection practices, and other information). It was created with the understanding that most health departments don’t have extra time and staff to handle outbreaks. It could be an important tool to have on the shelf should the need arise.
Southwest District Health (SWDH) and Southwest Idaho Medical Reserve Corps (MRC) are now in preparation for Idaho READYKAMP 2016 to promote citizen preparedness among local youth. The camp is designed for 6th, 7th, and 8th graders who reside in Southwest Idaho and are interested in learning how to help their families and communities become safer, stronger, and more prepared in the case of an emergency. This will be the third year for the camp, provided at no cost to participants.

“This preparedness camp empowers our youth to serve as ambassadors of preparedness for their communities with hands-on exercises, learning opportunities, and fun activities,” says Doug Doney, SWDH’s public health preparedness manager. “Our graduates are encouraged to share their newly acquired expertise with their families, schools, and communities so that all are safer and better prepared if disaster strikes.”

In late July, campers will converge on the campus of Nampa Christian High School in Nampa for this four-day, three-night camp. All activities are held at the school, except for the field trips. The campers sleep in a mobile all-hazards shelter, provided by nearby Ada County Paramedics.

Participants learn about preparedness, hazardous materials, fire safety, search and rescue, water rescue, triage, cardiopulmonary resuscitation (CPR), first aid, emergency radio communications, and terrorism.

Training modules are presented by local first responders and experienced MRC volunteers using the Federal Emergency Management Agency (FEMA) Teen Community Emergency Response Team (CERT) curriculum. The training is combined with traditional summer camp activities, such as movie nights, camp fires, marshmallow roasts, pizza parties, and field trips.

“Last year we had five returning campers from the previous year who acted as team leaders,” says Jeff Cappe, SWDH health liaison and Medical Reserve Corps coordinator. “Their contribution was significant because they were able to instill a level of trust and acceptance in the first-year campers that an adult in the same situation may not be able to accomplish. The campers were inspired by the knowledge and leadership of the team leaders.”

On the final day of camp, the campers participate in a mock disaster exercise, using the skills and knowledge gained during camp. Each participant is assigned a response role and functions under the incident command structure.

For 2015, the mock disaster scenario incorporated an explosion in the high school chemistry lab and involved the Idaho National Guard’s 101st Weapons of Mass Destruction Civil Support Team. That team is comprised of HAZMAT-certified technicians prepared to respond to chemical, biological, radiological, or nuclear incidents.

The camp culminates with a graduation and awards dinner for the campers and their families. Last year, 32 earned a diploma, a preparedness backpack, and were CPR certified.

Parents have noticed that in addition to basic response skills, their youth also gain awareness for action planning, leadership, and teamwork, adds Cappe.

The camp is made possible because of donations from community partners, cooperation with first responders, and dedicated SWDH staff and volunteers who devote many hours to the camp.
Many Resources Available For National Infant Immunization Week

National Infant Immunization Week, set for April 16-23, is an annual observance held to highlight the importance of protecting infants from vaccine-preventable diseases. During NIIW, local and state health departments, immunization partners, healthcare professionals, community leaders from across the U.S., and the CDC work together to highlight the positive impact of vaccination on the lives of infants and children and to call attention to immunization achievements.

CDC has developed materials and resources for you to use during NIIW and year-round to promote the benefits of childhood immunization. All of these materials can be downloaded free from the NIIW website, and have been developed based on research with the target audiences. Below are just a few ideas of how you can get involved:

Engaging Partners:

- CDC will be promoting educational messaging around vaccination on our social media channels, including CDC Facebook, @CDCgov and @CDCIZLearn. Continue the conversation by sharing and retweeting our messages on Facebook and Twitter.

- CDC will be announcing the recipients of the 2016 CDC Childhood Immunization Champion Award during NIIW. Leverage your state’s Champion award to generate local or regional media coverage for infant immunization issues. You may also want to host an award event to recognize the hard work and commitment of your local Champion.

Engaging Healthcare Professionals:

- CDC research shows that healthcare professionals are parents’ most trusted source of information about their child’s vaccines. Share the fact sheets in Provider Resources for Vaccine Conversations with Parents with healthcare professionals. These resources, co-developed by CDC, the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), are designed to help providers in the conversations they are already having with parents about vaccines, vaccine safety, and vaccine preventable diseases.

- Include CDC’s new drop-in newsletter article in your newsletters and other publications that reach healthcare professionals: “How to Turn NIIW into a Celebration for Your Entire Practice”.

Engaging Parents:

- Hang posters in clinics and other community settings to reach parents of young children.

- Use CDC’s PSA Pitching Guide to place radio and TV public service announcements locally.

- Publish print ads and drop in articles in your publication(s) that reach parents.

Tell other communities about the infant immunization events you are holding during NIIW! Add your events to the online activity calendar. Should you have any questions, please reach out to Jill Woodard.
Colorado Immunization Initiative Hits ‘Bulls-Eye’

By John Silcox, CCPH

Through a quality improvement process, Colorado cut by a third the time it takes for vaccine providers to connect their electronic health record systems to the state’s immunization registry.

To the lay person that might not seem that big of a deal.

But by making it faster and easier to connect to the state’s immunization information program, Colorado is making sure its residents are getting the shots they need when they need them.

“When these systems are talking, it supports clinical decisions at the point of care,” says Heather Roth, program manager for Colorado’s Immunization Information System.

For its efforts, Colorado was recognized this year with a “Bulls-Eye Award” by the Association of Immunization Managers (AIM). AIM started the awards in 2009 as a way to honor the hard work and innovation of its members, says staffer Claire Hannan.

The award recognizes state, territorial or local immunization programs for innovative strategies that “hit their mark,” achieve goals, and increase awareness by encouraging replication in other programs.

Three winners are announced each year, and for 2016, Colorado shared the award with Michigan and New York City. They were chosen over eight other nominees.

Michigan’s immunization program used the motivation of a friendly competition among colleges and universities to increase flu vaccination rates in young adults, while New York City employed social media advertising to help curb an outbreak of mumps.

Colorado’s Immunization Information System (CIIS) is a secure, web-based system that consolidates immunization records for Coloradans of all ages. More than 1,205 immunization providers currently feed into the system.

Since reporting is voluntary, it hasn’t always been easy getting providers to sign up. But when the federal Centers for Medicare and Medicaid created an incentive program in 2011 to encourage eligible providers and hospitals to adopt and use electronic health record systems, it put a strain on public health immunization programs.

For these electronic health record (EHR) systems to be able to exchange data with state immunization registries, it often requires an interface to make them interoperable, which can take upwards of nine months to design, test and validate.

Now imagine doing that for more than 75 individual EHR vendors, as Colorado did.

“When once you build an interface with one system, you’ve built an interface with one system,” Roth says.

Not only do the EHRs vary, but the quality of the training (or lack thereof) given to providers on using these systems also differs from practice to practice.

Colorado’s immunization program did not have the staff or resources to keep up with the demand, and the result was a backlog of more than 600 healthcare providers (more than 40% of them family practices), Roth says.

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This backlog was creating significant gaps in Colorado’s immunization data, resulting in some vaccination coverage rates being artificially low, she says.

Between May and December of 2015, a quality improvement (QI) team representing key players at the Department of Public Health and Environment and the Colorado Regional Health Information Organization gathered baseline data, documented problems, identified solutions and developed an implementation plan.

Through process mapping and a root-cause analysis, the QI team discovered significant inefficiencies and duplication of effort in the process for validating data.

Not all root causes could be addressed, so the team focused on things it had the power to change.

An automated self-serve testing tool was developed and enhanced training was provided to staff who were entering vaccine data into their EHRs, which sped up the testing, onboarding and validation process significantly.

At the same time, Colorado was able to hire more staff and increase its bandwidth.

Since these improvements were made, the provider waitlist has been trimmed from 637 to 390, with another 85 providers currently in the self-serve testing phase.

And there is more to this project to come.

The Department is also working on procuring a single EHR for some of the local public health agencies in the state that currently lack the capability.

[To be considered for the 2017 Bull’s-Eye Award, nominations are due by Friday, Dec. 2. Visit the AIM website at http://www.immunizationmanagers.org/?page=BullsEyeAward2013 to learn more about the submission process. - Ed.]

New Membership Information

Kathleen Andrews, Monmouth County Health Department, N.J.
Kate Awsumb, Minnesota Department of Health, Minn.
Tom Bodkin, Chattanooga-Hamilton County Health Dept., Tenn.
Amanda Brown, Southern Nevada Health District, Nev.
Bill Christian, Tennessee Department of Health, Tenn.
Melissa Frohna, The Scientific Consulting Group, Md.
Julie Graham, no affiliation listed, Wash.
Jennifer Hiestand, Zanesville-Muskingum County Hel. Dept., Ohio
Lori Imsdahl, no affiliation listed, Minn.
Kaia Johnson, Minnesota Department of Health, Minn.
Che Knight, Boston Public Health Commission, Mass.
Helen Talley-McRae, CDC – Chenega contractor, Ga.
Jayleen Richards, Solano County, Calif.
Lisa Slater, McLean County Health Department, Ill.
Scott Smith, Minnesota Department of Health, Minn.
Dana Solomon, Southeastern Idaho Public Health, Idaho
Sue Vahlberg, Valor Health, Idaho
Chelsea Williams, The Scientific Consulting Group, Md.

These folks are the newest members of NPHIC. Now is the time to invite the communicators you know to join NPHIC, too. Let’s keep NPHIC growing!
Getting Ready For Spring Cleaning

*By Phyllis Bell-Davis*

This is the time of year to open the windows, shake out the rugs and get busy with spring cleaning! This season also means stocking the home with various poisonous products that could be harmful, if not used in the recommended way, and may become very toxic, if mixed together. As you do your spring cleaning, make sure to protect your family, especially children, by keeping these potentially poisonous products locked away and out of reach.

According to the American Association of Poison Control Centers, approximately 90% of poisonings happen at home, and more than half of these poisonings affect children under the age of six. Many involve typical household cleaning products.

Some poison prevention tips to keep your children and other loved ones safe while spring cleaning include:

- Never leave children unattended when chemicals are in use.
- Never mix cleaning products as this may create toxic fumes; use only one product at a time.
- Read the label instructions before using the product.
- Store cleaning products in their original containers and not in empty food containers or bottles. Children often confuse cleaners and food items because packaging is similar.
- Remember: even though a product has a child safety cap, it is only child-resistant, not childproof!

Call the poison center **immediately** if you suspect someone has touched, breathed or swallowed a cleaning product. Calls to 1-800-222-1222 are answered 24 hours a day by Specialists in Poison Information who are specifically trained nurses or pharmacists with knowledge and access to the latest computerized, comprehensive poison assessment and management techniques. The Specialist will tell you exactly what to do and will follow-up with you by phone, if necessary, to provide further assistance.

To learn more about common household cleaning products that can pose a poisoning risk, contact your local poison center at 1-800-222-1222.
Alternative Breast Cancer Screening Methods

By Sophia Bernazzani

Although the need for breast cancer screening is well-known, having a mammogram may not be the best option for everyone. As Nursing@Simmons notes, there are various reasons why women seek alternative testing methods, and it’s important to understand how they differ. Here, we’ll provide an overview of issues women commonly face and further explore each alternative method that’s available.

Common Issues

One of the most common issues that women face is having a higher proportion of glandular breast tissue, also known as “dense breasts.” This condition can make it difficult to obtain conclusive results with traditional mammogram screening — and nearly 50 percent of women younger than 50 fall into this category. Since women with dense breasts face a higher risk of developing breast cancer, it’s important that screening results are accurate.

Other reasons that women turn to alternative screening methods include abnormal risk factors, wanting a more precise testing method, or having concerns about some aspect of the mammogram process.

Alternative Methods

Currently, there are four alternative methods for breast cancer screening — which work differently and are chosen for a variety of reasons.

- Digital mammography produces digital images of the breast to more closely examine suspicious areas. Typical candidates for this method are women who are younger than 50, have dense breasts, or who are still menstruating. The benefit lies in the ability to obtain a more precise image with lower doses of radiation. The downside relates to higher costs and limited access — since they’re not as widely available.

- Magnetic Resonance Imaging (MRI) uses magnets and radio waves combined with injected contrast material to obtain a detailed view of a specific area. This alternative may be appropriate for women who have already been diagnosed with breast cancer or to screen high-risk women. MRIs are approximately five times more expensive than mammograms, and aren’t for individuals who are claustrophobic, have specific types of metallic implants, or poor kidney function.

- Ultrasounds use sound waves to create an image. These tests are used for women with dense breasts, but also to guide needle biopsies and assess lymph nodes for potential disease. Though affordable and widely available, ultrasound results are not as accurate as those with more sophisticated testing, such as MRI. This lack of accuracy can translate to both missed diagnoses and false positives — with unnecessary and invasive testing as a result.

- Molecular Breast Imaging (MBI) is a new test that uses higher doses of radiation to illuminate areas likely to be cancerous. It is typically used to plan surgery, assess lymph nodes, and monitor therapeutic response. More accurate than other methods, it examines molecular activity, instead of just anatomy. Results are obtained quickly, and whole body testing can be performed immediately if suspicious areas are detected.

Since breast cancer is the most common type of cancer among American women, screening is essential. With the variety of alternatives available, women now have more choices to find the method that best meets their individual needs.