

Wayne Staggs To Retire After 39 Years of Service

By Pam Pontones, MA
State Epidemiologist



Wayne Staggs, long-time epidemiologist at the Indiana State Department of Health (ISDH), will retire on September 30, 2010. A reception will be held in his honor on September 30 from 1:00-3:00 at ISDH in Rice Auditorium.

After graduating in 1968 with a bachelor's degree in botany from Butler University, Wayne began his public health career in 1970 in the Marion County Health Department's Housing Section, assessing alleys and other areas for rodent infestation and trash violations that posed a potential public health threat. In 1971, Wayne joined the ISDH Food Division, beginning in the Retail Food Section and then moving to the Training Section. He conducted presentations for local health departments and individual trainings for inspectors. In 1983, Governor Robert Orr appointed Wayne to a four-year term on the Board of Registration for Professional Sanitarians, which officially registered environmentalists. Registration required a minimum number of years of experience in the field and successful completion of a written exam.

Following short stints in the ISDH Local Health Services and Grants and Special Projects programs, he joined the ISDH Immunization Program in 1985, and earned his master's degree in education from Butler in 1975. While a member of the Immunization Program for 21 years, Wayne conducted assessment and epidemiology activities, and in 1995, officially became the Vaccine-Preventable Disease (VPD) Epidemiologist in the ISDH Epidemiology Resource Center. In 2006, Wayne assumed the role of Invasive Disease Epidemiologist, and assumed his current title of Antibiotic Resistance Epidemiologist in

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2008. In this role, Wayne monitors antibiotic resistance infections, collaborates with healthcare associated infection activities, and supervises four other epidemiologists.

Reflecting on his 39-year career, Wayne recalls the 1989-1990 measles outbreak as one of the events he will vividly remember as an example of true public health work. During that school year, local health departments and the ISDH teamed to vaccinate over 100,000 children in neighborhoods, schools, and universities to combat the outbreak of over 400 cases. “It was really hard work but worth it. With similar kinds of efforts around the country we were able to eliminate indigenous measles in the United States. As a result, the two-dose measles vaccination series became part of the ACIP recommended schedule,” he explained.

Another significant event Wayne recounts is the case of a young child developing eczema vaccinatum, a severe complication following exposure to a household contact vaccinated for smallpox in 2007. Although an Indiana resident, the child was hospitalized in Illinois, requiring significant coordination during the investigation. “The staff at the hospital, the local health department, the Illinois and Indiana state health departments, the CDC [Centers for Disease Control and Prevention], everyone worked together to investigate and follow the care this patient received. I’ll never forget the first conference call we had on a Sunday. The child was not expected to survive, and was in grave condition for two weeks. Yet, he fully recovered. It was time-consuming, but again, well worth it considering the wonderful outcome. The partnerships were great, we pulled in experts from throughout the country, and there was great compassionate medical care. Quite an effort.”

As a result of his work, Wayne has co-authored several articles published in the *New England Journal of Medicine*, *Pediatrics*, *Vaccine*, and the *CDC Morbidity and Mortality Weekly Report*. His 2006 *New England Journal of Medicine* article on the 2005 Indiana measles outbreak was nominated for the CDC Shepard Award, which recognizes excellence in epidemiology. In addition to these achievements, Wayne also takes pleasure in seeing disease levels plummet after a vaccine is introduced. “Public health has a big role to play in the disease levels decreasing,” he adds.

One of the greatest challenges Wayne has experienced is the rate that information and technology change. “The medical information changes so much, so fast. When I started in Immunization, the CDC Advisor said that the VPD levels were constant, in maintenance phase. MMR, polio, and DTP were the only routine childhood vaccines given then. Hib (*Haemophilus influenzae* type B) was introduced in 1989-90, followed by many more vaccine and schedule changes. Look at the [childhood] vaccines we have now. We had no computers, and we actually used mimeograph machines when I first started.” He added that although changes can be challenging, he also has fun keeping up and has always enjoyed learning. For Wayne, that love of learning is important for a successful career. “A willingness to learn and continue learning allows you to better do your job and adjust. Education is a building block, and you keep building on that by continued learning. The more you learn, the more and better you can communicate.”

Wayne has enjoyed working throughout his career, explaining that public health is really important and he always had good supervisors and teammates. After retirement, he plans to travel more, spend more time with his granddaughter, attend ball games (of his beloved Butler Bulldogs and Cincinnati Reds), and ride his bike more often. He still plans to keep in touch with colleagues and information, and deeply appreciates the public health nurses

and local health department staff with whom he has worked over the years, noting their dedication, response to multiple demands, and action during crisis events. He shares the same gratitude for the ISDH epidemiology and laboratory staff “who have been wonderful to work with.”

To upcoming epidemiologists and public health professionals, Wayne recommends seeing change as not all bad and not all good. “You need to sort it out. Don’t throw away the past. A lot of good things have been done that need to be considered and built upon [when making changes]. Change also needs to be embraced and see what can be made better. Respect the past and other people—be open to other ideas and perspectives.”

Southern Tick-Associated Rash illness and the Lone Star Tick: It’s not Lyme disease

Jill Stauffer, MS
ISDH Field Epidemiologist – District 8

Southern tick associated rash illness (STARI), also known as Masters disease, predominately affects people in the Southeast and South Central states. The symptoms of this illness develop following the bite of the lone star tick (*Amblyomma americanum*) and are similar to those of early Lyme disease.

The circular lesion (rash) of STARI resembles the Lyme disease erythema migrans (EM) lesion that often appear at the site of the tick bite. The lesion is typically smaller in diameter and tends to have a central clearing (bull’s eye appearance) more often than the Lyme disease EM lesions. The rash usually develops within seven days of the tick bite and expands to a diameter of three inches or more. Other symptoms may include fatigue, fever, headache, muscle and joint pains. STARI has not been associated with the more serious arthritic, neurological, or chronic symptoms that can occur with Lyme disease. Antibiotics similar to those used for Lyme disease have been used in treatment. In regard to case management and reporting, it is important in patients with EM-like lesions to differentiate between STARI and Lyme disease.

The etiology of STARI is not known but studies have shown that it is not caused by *Borrelia burgdorferi*, the bacterium that causes Lyme disease. It has also been determined that lone star ticks are not capable of transmitting Lyme disease. There is currently no serologic test available to aid in diagnosis of STARI.

The lone star tick is predominately found in southern states and along the East coast into Maine. Over the past 20-30 years, the distribution, range, and abundance of ticks have increased. In Indiana, the lone star tick is found in more than two-thirds of the counties but is much more abundant in the southern counties. During all three life stages, the lone star tick will feed on humans and animals, including pets, which may bring the ticks into the home. The mouth parts of the lone star tick are longer than those of the dog tick. The saliva of the tick can cause irritation with redness and irritation but does not necessarily indicate an infection.

Limiting exposure to ticks can reduce the likelihood of infection with tick borne diseases. Effective ways to reduce exposure include avoiding tick habitats such as dense woods and brushy areas, using insect repellents containing DEET or permethrin, wearing long

pants tucked into socks, performing tick checks, and promptly removing ticks after outdoor activity. Persons should consult their health care providers if symptoms of rash, fever, headache, joint or muscle pains, or swollen lymph nodes occur within 30 days of a tick bite.

References:

American Lyme Disease Foundation, (2006). Other Tick-Borne Diseases Message posted to <http://www.aldf.com/stari.shtml#STARI>

Centers for Disease Control, (2010) Lone Star Tick a Concern but Not for Lyme Disease Message posted to http://www.cdc.gov/ncidod/dvbid/stari/stari_LoneStarConcern.html

Centers for Disease Control, (2009, Dec. 11). Southern Tick-Associated Rash Illness Message posted to <http://www.cdc.gov/ncidod/dvbid/stari/index.htm>

Pinger, R. R. (2009). Out for Blood: Spring Time is Tick Time. *Indiana Academy of Science, Newsletter*, 139

Wormser et al., (2005). Prospective Clinical Evaluation of Patients from Missouri and New York with Erythema Migrans-Like Skin Lesions. *Clinical Infectious Diseases, CID* 2005:41 (October),

Second in a series of three articles on the Indiana State Cancer Registry

**Indiana State Cancer Registry:
The Data Source**

Bridget Rans Strong, J.D.
Director, Indiana State Cancer Registry

Teasa Thompson, MPH
Comprehensive Cancer Control Coordinator

The last edition of the *Indiana Epidemiology Newsletter*, featured an overview of the Indiana State Cancer Registry (ISCR) operations. This article will highlight the various ways in which ISCR data is employed.

Several programs within the Indiana State Department of Health (ISDH) use data from the ISCR. (ITPC), Division of Nutrition and Physical Activity (DNPA), the Breast and Cervical Cancer Early Detection Program, and the Indiana Comprehensive Cancer Control Program (ICCCP) to ensure timely data are received for questions that arise. The ISCR works also with the Indiana Tobacco Prevention and Cessation initiative. The [Indiana Cancer Control Plan 2010-2014](#), released in January, 2010 is a great example of how ISCR data can be utilized. A section of the plan is devoted to the importance of data and includes ways to increase and promote evidence- based practices that are data driven. The Indiana Cancer Consortium (ICC) Data Committee focuses on implementing data-related strategies from the plan. Additionally, the data committee provides support to the other ICC committees and action teams.

The ICC is a statewide network of private and public organizations whose mission is to reduce the burden of cancer in Indiana through the development, implementation, and evaluation of a comprehensive plan that addresses cancer across the continuum, from prevention through palliation. The ICC is supported and guided by the ICCCP, which falls under the Chronic Disease Prevention and Control Division at the ISDH. Data collected and housed in ISCR's database is often utilized by the ICC and the ICCCP. Specifically, ISCR data has been used to generate burden reports and county fact sheets, which are very useful when working with community partners and the media. Working closely with the ICC helps spread the word about the data collected, which benefits ISCR tremendously by increasing awareness and utilization of cancer-related data.

Public requests are very common for the ISDH's cancer programs. Requests are most commonly come from media outlets, concerned citizens, and local health departments. Data matching and analysis are conducted to meet individual requestor's needs as much as possible.

The ISCR can also link local health departments with state initiatives addressing leading risk factors for cancer, such as tobacco (ITPC), nutrition, and physical activity (ISDH Healthy Communities Division and DNPA). According to the American Cancer Society, approximately two-thirds of cancer deaths can be prevented through lifestyle and behavioral modification.

Often, there are large-scale data requests from researchers around the world. Independent research facilities conducting statistics on drug treatments, local doctors conducting research on specific types of cancers that relate to their field of study, and universities conducting cancer research are all examples of data requests the ISCR receives. It is required by law to release information for legitimate research questions, provided they meet all criteria for use, maintenance of the data, and proper disposal of the data once the project is completed.

One of the main functions of the ISCR is to annually report data collected to two groups: the National Program of Cancer Registries (an entity of the Centers for Disease Prevention and Control that contributes to ISCR's funding) and the North American Association of Central Cancer Registries (NAACCR). Near the end of November, the ISCR compiles and submits data for a quality check. For example, this November, ISCR will submit combined cancer cases from 1995 through 2008 and 2009 separately. The submission will undergo several edit checks to determine whether Indiana has met the minimum quality necessary for inclusion in national publications, which determines if the ISCR can participate in national studies. Last year, Indiana received the "gold standard" from NAACCR, the highest standard rating.

The ISCR is always looking for new and innovative ways to distribute data collected and increase usage by the general public. One such method is the online report generator, located at <http://www.in.gov/isdh/24360.htm>. The report generator is a user-friendly, convenient way to obtain de-identified cancer information and features incidence and mortality data on a state-wide or county level for specific years or a span of several years. This is often the first stop for data seekers and can provide answers for a multitude of cancer-related data questions.

Secondary Attack Rate of Pertussis within a Household of Unvaccinated Children

Karen Gordon, BA
ISDH Field Epidemiologist – District 10

Pertussis, or whooping cough, is an acute bacterial infection of the respiratory tract caused by *Bordetella pertussis*. Even with high vaccination coverage levels for pertussis in children, the disease remains a cause of considerable morbidity in the United States. Although pertussis vaccine protects the vast majority of individuals, it is not 100% effective. Additionally, protection wanes over time so it is possible for a fully vaccinated person to contract this disease if sufficiently exposed and immunity is not sufficient. This case study examines a situation that occurred when one family member introduced this illness into a household of susceptible contacts.

A local health department (LHD) in Indiana received a call from a health care provider who had examined a child and suspected pertussis as the cause of infection. All other household members were symptomatic as well, including two parents and nine children ranging in age from 3 months to 13 years. Symptoms included paroxysmal cough, post-tussive vomiting, and in two cases, inspiratory whoop. One case had reported apnea. Two individuals were confirmed positive for *B. pertussis* by PCR. According to the case definition for pertussis, the remaining household contacts were epidemiology- linked and considered confirmed cases as well. The public health nurse contacted the mother to confirm family relationships and immunization status and relayed this information to the ISDH field epidemiologist.

The family did self-isolate upon learning of the diagnosis, and all cases received appropriate antibiotic treatment. Both parents had received their childhood immunizations but no booster doses of pertussis since that time. The oldest child had begun a primary series as an infant but it was incomplete. The mother explained that the series was interrupted after she read literature which questioned vaccine safety and necessity. The parents deferred vaccination from that point on based on philosophical reasons. None of the other children had any history of receiving pertussis vaccine. The children are home schooled, so immunization requirements for schools and day care facilities do not apply. The source of illness was undetermined, although the family reported frequent interaction at church gatherings. All family members developed cough onset within one week of the index case. All household members had prolonged, paroxysmal cough and followed similar courses of illness with a few exceptions. Fortunately, no one had symptoms severe enough to require hospitalization, including the three-month-old infant.

Transmission of pertussis from the index case to susceptible household occupants is very effective. Studies have shown secondary attack rates as high as 80% and greater among unprotected household contacts. A household is defined as all the persons who occupy a single housing unit as their usual residence or who live there at the time when the disease is contracted. The close proximity and long duration of being exposed to symptomatic individuals promote the infectivity of this organism.

The most effective strategy to prevent pertussis is vaccination of susceptible persons. The Advisory Committee on Immunization Practices (ACIP) recommends a four-dose series of DTaP, administered at 2,4,6, and 15-18 months of age, followed by a fifth booster dose given at 4-6 years. In 2005 and 2006, the ACIP recommended the replacement of a single Td booster with a dose of Tdap for adolescents (ages 11-18) and adults (ages 19-64) who have not previously received Tdap. Vaccination is especially critical for caregivers and families of new infants. A postpartum dose of Tdap before leaving the hospital or birthing center may be indicated for pregnant women with no previous history of Tdap. Infants who are too young to be fully vaccinated themselves are at greatest risk for hospitalization or death due to pertussis, making vaccination of children, adolescents, and adults extremely important. Deferring vaccination contributes to pertussis being among the most poorly controlled vaccine-preventable diseases in the U.S.

References

Centers for Disease Control and Prevention. Epidemiology and Prevention of Vaccine-Preventable Diseases. Atkinson, W, Wolfe, S, Hamborsky J, McIntyre L, eds. 11th ed. Washington DC: Public Health Foundation, 2009. Pertussis: Chapter 14

Centers for Disease Control and Prevention. Guidelines for the Control of Pertussis Outbreaks. Centers for Disease Control and Prevention: Atlanta, GA, 2000. (Amendments made in 2005 and 2006)

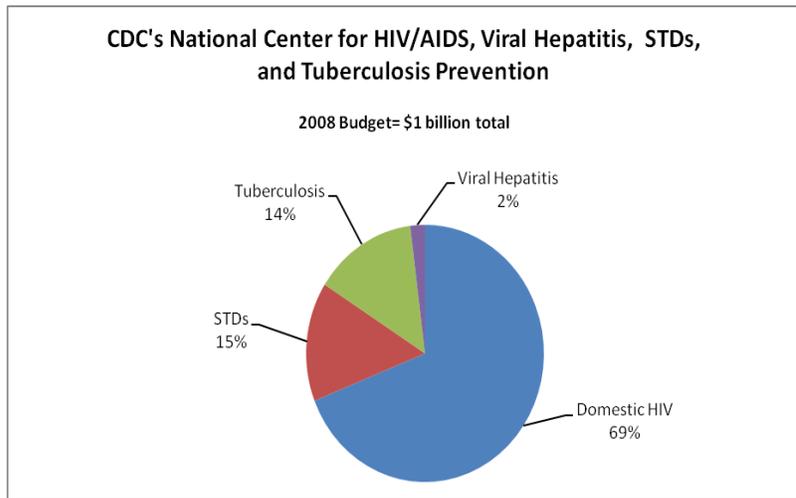
Centers for Disease Control and Prevention's (CDC) Web site on pertussis at <http://www.cdc.gov/vaccines/vpd-vac/pertussis/default.htm>.

Hepatitis C Surveillance

Sara Sczesny MPH, BS, MT(ASCP)
Hepatitis C Epidemiologist

Three to five times more people are living with chronic viral hepatitis infections than human immunodeficiency virus (HIV) infections in the United States. Approximately 2.7-3.9 million people in the United States have chronic viral hepatitis, but a true measure of the disease burden is hard to obtain since there is no national chronic-hepatitis surveillance program, even though both chronic hepatitis B and C are nationally reportable diseases. In 2008, viral hepatitis only received approximately 2% of the \$1 billion budget for the Centers for Disease Control and Prevention's (CDC) Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Diseases (STDs), and Tuberculosis Prevention (see Figure 1). In order for appropriate funding to become available to prevent and control chronic viral hepatitis, better surveillance data are needed. The Institute of Medicine's (IOM) *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C* explains these issues and many others regarding chronic viral hepatitis prevention and control. To view this report online, go to <http://www.cdc.gov/hepatitis/PDFs/IOM-HepatitisAndLiverCancerReport.pdf>.

Figure 1. Distribution of the CDC's National Center for HIV/AIDS, Viral Hepatitis, STDs, and Tuberculosis Prevention 2008 Budget



Public health surveillance plays a vital role in the prevention and control of hepatitis C infections. Hepatitis C surveillance data may be used to estimate the burden of disease, describe the distribution and spread of disease, to detect epidemics, to evaluate prevention and control efforts, and to drive public-health planning and policy. A

great deal of effort has been spent to ensure that Indiana has a useful chronic hepatitis C surveillance program, even though there are currently no federal funds supporting it. Now that the Indiana National Electronic Disease Surveillance System (INEDSS) is operational, the ISDH assessed hepatitis C surveillance data to determine how Indiana hepatitis C surveillance could best move forward. The 2008 data were analyzed and compiled into the *Hepatitis C Surveillance Report, Indiana, 2008* located at <http://www.in.gov/isdh/24973.htm>

It is clear that there is much room for improvement. There were major gaps in basic demographics such as age, county of residence, ethnicity, gender, and race. Other areas for improvement include patient education, risk factor collection, and vaccination history. One of the most disappointing findings of this report is that patient disease education status on 73% of newly reported chronic hepatitis C cases in 2008 was unknown/not reported. Although some of these cases may have been educated about their disease, their status was not reported to the ISDH.

As stated in the IOM report, these issues are not unique to Indiana, but public health professionals, can do something about these issues in our state. It is essential to notify all individuals in Indiana who have recently tested positive for hepatitis C infection for the first time of their test status, educate them about their disease, and encourage them to seek medical management or care. At the time of testing or during patient education, opportunities exist to collect demographics and risk factor data. The ISDH continues to strongly recommend completing the case investigation form for all cases of hepatitis C infection, acute and chronic, in Indiana. The form is available in INEDSS, as well as online at http://www.in.gov/isdh/files/hepc_final_20100224.pdf. The lack of adequate funding makes this a huge goal to achieve, but if public health professionals in Indiana strive to find ways to reach this goal, improvements will be seen in the quality of hepatitis C surveillance data. In turn, improvements will be made to prevention and control efforts in Indiana, and Indiana will be able to make evidence-based public-health decisions about hepatitis C.

In an effort to assist local health departments in improving hepatitis C surveillance at state and local levels, training workshops will be held in each of the Public Health Preparedness Districts. The training will provide tools to assist with hepatitis C surveillance and facilitate reporting. Topics to be discussed include:

- Describing the IOM's *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*
- Understanding lab results
- Making case determinations
- Using INEDSS for hepatitis C surveillance
- Completing the hepatitis C case investigation form

The dates for the district trainings are the following and forms will be distributed by the 10 field epidemiologists:

District 1- Tuesday, November 9, 2010 in Crown Point 12:00-4:00, **CST**

District 2- October 2010, date/location to be determined

District 3- November 2010, date/location to be determined

District 4- Friday, October 29, 2010 in Lafayette from 9:00-1:00

District 5- Friday, October 22, 2010 in Indianapolis, from 9:00-1:00

District 6- Thursday, September 30, 2010 in New Castle, from 12:00-4:00

District 7- No training scheduled, but may attend other district trainings if interested

District 8- Thursday, September 23, 2010 in Bedford from 9:00-1:00

District 9- Wednesday, September 22, 2010 in Versailles from 9:00-1:00

District 10- November 2010, date to be determined

October is National Liver Awareness Month. Viral hepatitis prevention is an essential component of maintaining liver health. To bring awareness to liver health during the month of October, the ISDH has partnered with Hepatitis Foundation International (HFI) to bring HFI's Viral Hepatitis Summit to Indianapolis, Indiana on Thursday, October 7, 2010. The summit will include nationally recognized speakers on topics surrounding viral hepatitis. Physicians, physician assistants, nurse practitioners, clinical nurses, public health nurses, case managers, counselors, and any other professionals that may interact with individuals at-risk for viral hepatitis infections are encouraged to attend. Completed registration forms should be sent directly to HFI. The agenda and registration form are located in the Training Room section of this newsletter or may be viewed online at: <http://www.hepfi.org/pdfs/Indiana%20Summit%20Registration%20&%20Agenda.pdf>.



Training Room

INDIANA STATE DEPARTMENT OF HEALTH IMMUNIZATION PROGRAM PRESENTS:

Immunizations from A to Z

Immunization Health Educators offer this FREE, one-day educational course that includes:

- Principles of Vaccination
- Childhood and Adolescent Vaccine-Preventable Diseases
- Adult Immunizations
 - Pandemic Influenza
- General Recommendations on Immunization
 - Timing and Spacing
 - Indiana Immunization Requirements
 - Administration Recommendations
 - Contraindications and Precautions to Vaccination
- Safe and Effective Vaccine Administration
- Vaccine Storage and Handling
- Vaccine Misconceptions
- Reliable Resources

This course is designed for all immunization providers and staff. Training manual, materials, and certificate of attendance are provided to all attendees. Please see the Training Calendar for presentations throughout Indiana. Registration is required. To attend, schedule/host a course in your area or for more information, please reference <http://www.in.gov/isdh/17193.htm>.



INDIANA VIRAL HEPATITIS SUMMIT

WHEN: Thursday, October 7, 2010 8:30 AM - 4:30 PM (registration and exhibits open at 7:30am)

WHERE: Wyndham Indianapolis West, 2544 Executive Drive, Indianapolis, IN 46241

WHAT: Hepatitis Foundation International announces a 1 day professional education and training Summit for health professionals and others working with people who are affected by or infected with viral hepatitis including:

- ✓ nurse practitioners
- ✓ physician assistants
- ✓ nurses
- ✓ counselors
- ✓ case managers
- ✓ others

PROGRAM OBJECTIVES:

- Describe viral hepatitis risk factors and recommend hepatitis testing for patients
- Discuss viral hepatitis transmission and prevention with patients using simple and clear language
- Explain viral hepatitis tests and their meanings
- Describe major functions of the liver and why the liver is a vital organ
- List counseling messages for newly diagnosed patients regarding treatment options and maintaining health
- Discuss the current treatment for hepatitis B and C including expectations for evaluation, duration, side effect management, and the need for support
- List patient support strategies to increase treatment completion

CONTINUING EDUCATION:

- ⇒ **6.5 contact hours for Nurses** -This continuing nursing education activity is pending approval by the Maryland Nurses Association, an accredited approver by the American Nurses' Credentialing Center's Commission on Accreditation.
- ⇒ **CEU credits for Addiction Professionals (6.5hrs)** -The Hepatitis Foundation International is an approved education provider with the NAADAC Provider Approval System, #693.

HOUSING: Wyndham Indianapolis West, 2544 Executive Drive, Indianapolis, IN 46241

Reservations - (317) 248-2481; To take advantage of the reduced room rate of \$99/night, mention group name "Hepatitis Foundation International" when calling.

*****Registration includes all sessions, meals, educational materials, CEUs, and exhibits*****

Full Name: _____ Title: _____
 Affiliation: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone: _____
 Email: _____

I would like CEUs for: _____ Nurses _____ Addictions Professionals _____ None
 Summit Registration Fee: \$75.00 Late Registration after Sept. 16, 2010: \$90.00

Payment Options: Check Visa MasterCard PO# _____
 Card #: _____ Exp. _____ CVV (on back of card) _____
 Name on Card: _____
 Signature: _____

Registration should be sent to:



Hepatitis Foundation International
 504 Blick Drive, Silver Spring, MD 20904
 Phone: 800-891-0707
 Fax: 301-622-4702
www.HepatitisFoundation.org



INDIANA VIRAL HEPATITIS SUMMIT

Thursday, October 7, 2010
Wyndham Indianapolis West, 2544 Executive Drive
Indianapolis, IN 46241

AGENDA

7:30 AM	Registration & Exhibits Open / Breakfast	
8:30 AM	Liver Health- Firing Up Prevention	Thelma King Thiel, CEO Hepatitis Foundation International
9:00 AM	Hepatitis B- Chronic? Carrier? When and How to Treat	Raymond Koff, MD University of Connecticut
10:00 AM	Break	
10:15 AM	Diagnosis and Treatment of Hepatitis C	Raymond Koff, MD University of Connecticut
11:15 AM	The Challenge of Addiction for Providers and Hepatitis Patients	Speaker TBD
12:15 PM	Lunch	
1:00 PM	Sorting Out the Diagnostics	Edward Marino, PA-C Porter Adventist Hospital, CO
2:00 PM	Communicating Through Interpreters	Martin George, President Language Training Center, IN
3:00 PM	Break	
3:15 PM	Depression, Mental Health and HCV Infection	Andrew Angelino, MD Johns Hopkins Medical Center
4:15 PM	Closing Remarks	
4:30 PM	Program Adjourned	



HEPATITIS FOUNDATION INTERNATIONAL
504 Blick Drive, Silver Spring, MD 20904
Phone: 1-800-891-0707 Fax: 301-622-4702

EPI-READY

ISDH is pleased to offer Epi-Ready Team Training in 2010. This training is intended to provide up-to-date foodborne disease outbreak investigation and surveillance training to public health nurses, environmental health specialists, and laboratorians from local health departments, private sector professionals, and others who have collaborated in conducting foodborne disease outbreak investigations. Training will include interactive group exercises, question and answer sessions, and didactic lectures on passive surveillance, outbreak determination, environmental assessment, epidemiological investigation, laboratory guidance, and final report writing. Trainings will be conducted over two days free of charge to attendees.

Five trainings are scheduled throughout the state. The goal is to have 60 attendees per session for a total of 300 public health and private professionals trained in foodborne disease outbreak investigation. You may attend a training session in an alternative date/location. Exact details and directions will be sent upon registration, prior to the training date.

Trainings

Sept 14-15: Allen County
Oct 13-14: Vanderburgh County
Oct 27-28: Porter County
Nov 9-10: Dearborn County
Dec 14-15: Marion County

***Please complete the form below and return via fax to (317) 234-2812,
ATTN: Trish Manuel Email tmanuel@isdh.in.gov, or call (317) 233-7125 to make your
reservation today!***

We look forward to seeing you this fall!

NAME _____

PHONE _____

EMAIL _____

COUNTY _____

_____ Sept 14-15: Allen County

_____ Oct 13-14: Vanderburgh County

_____ Oct 27-28: Porter County

_____ Nov 9-10: Dearborn County

_____ Dec 14-15: Marion County

ISDH Data Reports Available

The following data reports and the *Indiana Epidemiology Newsletter* are available on the ISDH Web Page:

<http://www.IN.gov/isdh/>

HIV/STD Spotlight Reports (June 2007, December 2007, June 2008, January 2009)	Indiana Mortality Report (1999-2007)
Indiana Cancer Report: Incidence; Mortality; Facts & Figures	Indiana Infant Mortality Report (1999, 2002, 1990-2003)
Indiana Health Behavior Risk Factors (1999-2008)	Indiana Natality Report (1998-2007)
Indiana Health Behavior Risk Factors (BRFSS) Newsletter (2003-2010)	Indiana Induced Termination of Pregnancy Report (1998-2007)
Indiana Hospital Consumer Guide (1996)	Indiana Marriage Report (1995, 1997, & 2000-2004)
Public Hospital Discharge Data (1999-2008)	Indiana Infectious Disease Report (1997-2008)
Assessment of Statewide Health Needs – 2007	Indiana Maternal & Child Health Outcomes & Performance Measures (1989-1998, 1990-1999, 1991-2000, 1992-2001, 1993-2002, 1994-2003, 1995-2004, 1996-2005)

HIV Disease Summary

Information as of June 30, 2010 based on 2000 population of 6,080,485)

HIV - without AIDS to date:

346	New HIV cases July 2009 thru June 30, 2010	12-month incidence	6.28 cases/100,000
3,989	Total HIV-positive, alive and without AIDS on June 30, 2010	Point prevalence	69.04 cases/100,000

AIDS cases to date:

352	New AIDS cases from July 2009 thru June 30, 2010	12-month incidence	6.31 cases/100,000
4,511	Total AIDS cases, alive on June 30, 2010	Point prevalence	78.06 cases/100,000
9,342	Total AIDS cases, cumulative (alive and dead) on June 30, 2010		

REPORTED CASES of selected notifiable diseases

Disease	Cases Reported in May - June MMWR Weeks 17-25		Cases Reported in January – June MMWR Weeks 1-25	
	2009	2010	2009	2010
Campylobacteriosis	130	128	263	278
Chlamydia	3862	3437*	11308	8826*
Cryptococcus	0	7	12	13
Cryptosporidiosis	41	32	122	97
<i>E. coli</i> , shiga toxin-producing	12	9	21	13
Giardiasis	41	35	106	129
Gonorrhea	1309	1247*	3678	2429*
<i>Haemophilus influenzae</i> , invasive	20	18	48	52
Hemolytic Uremic Syndrome (HUS)	0	0	0	0
Hepatitis A	1	2	9	9
Hepatitis B	15	8	40	33
Hepatitis C Acute	5	8	10	16
Histoplasmosis	18	19	66	51
Influenza Deaths (all ages)	2	1	3	2
Legionellosis	9	11	23	21
Listeriosis	3	3	5	6
Lyme Disease	17	20	20	29
Measles	0	0	0	0
Meningococcal, invasive	10	2	20	13
Mumps	0	1	1	3
Pertussis	49	155	151	269
Rocky Mountain Spotted Fever	1	0	1	0
Salmonellosis	128	88	236	204
Shigellosis	12	9	40	22

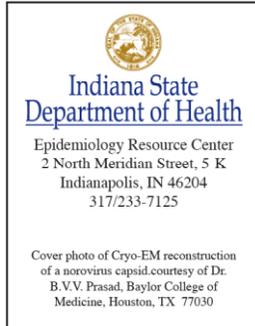
REPORTED CASES

 of selected notifiable diseases

Disease	Cases Reported in May - June MMWR Weeks 17-25		Cases Reported in January – June MMWR Weeks 1-25	
	2009	2010	2009	2010
Severe <i>Staphylococcus aureus</i> in Previously Healthy Person	1	3	9	11
Group A Streptococcus, invasive	32	19	128	64
Group B, Streptococcus, Invasive (All ages)	50	33	142	124
<i>Streptococcus pneumoniae</i> (invasive, all ages)	82	89	276	373
<i>Streptococcus pneumoniae</i> (invasive, drug resistant)	55	24	167	121
<i>Streptococcus pneumoniae</i> (invasive, <5 years of age)	7	4	24	31
Syphilis (Primary and Secondary)	18	31*	73	72*
Tuberculosis	27	15	59	38
Vibriosis	0	0	2	1
Varicella	8	20	65	138
Yersiniosis	2	1	7	5
Animal Rabies	7 (Bat)	6 (Bat)	10 (Bat)	6 (Bat)

***Note: data are provisional only due to migration to a new reporting system**

For information on reporting of communicable diseases in Indiana, call the *Surveillance and Investigation Division* at 317.233.7125.



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