MPHA
IMPACT newsletter.....
MICHIGAN PUBLIC HEALTH ASSOCIATION
Summer 2012

President's Message

While it's hard to believe that we are already halfway through 2012, the first six months of this year have been very busy for public health practitioners and advocates, including our members of MPHA. We have watched legislation at the state and national level that impact our ability to promote healthy communities, including some good (the recent ban on K2 and bath salts) and some bad (the repeal of the helmet law and local efforts to repeal fluoridation of water). And while the Supreme Court has upheld the constitutionality of the Affordable Care Act at the national level, battles over funding aspects parts of the law rage on, with funding for prevention and public health most frequently under attack.

Because of the impact policy decisions can have on public health practice, the MPHA Policy Committee has stepped up its activity in the past few months, meeting regularly to discuss the policies mentioned above and determine the role MPHA should take in policy debates. MPHA is also working with other Michigan health and environmental organizations in the newly established MI Air MI Health Coalition to support cleaner air policies in Michigan. However, MPHA's work on policy can only succeed if our members are active and willing to take action on critical issues.

Regardless of the policy debates in Lansing and Washington D.C., our members continue to promote awareness of public health and the professional development of Michigan's public health workforce. This spring, the MPHA Epidemiology Section drew large crowds to the MSU Union for their Annual Conference. Just a few weeks later, the Public Health Nursing Section held another successful Annual Meeting at the Kent County Health Department. Members of MPHA were also active in promoting Public Health Week 2012, including serving on the Michigan Public Health Week Partnership Committee. None of these events would have been a success without the volunteer efforts of our members!

While we celebrate our successes from the first half of the year, we look forward to what's planned for the remainder of 2012. This year's Michigan Premier Public Health Conference will be held in Big Rapids on October 3 and 4. MPHA will hold its annual member meeting on the evening of October 3 and we will be sending more information to you about this event. We are also excited about welcoming new members to the MPHA Board, including new members of our Executive Committee, and are excited about the energy and ideas they will bring to our organization. I wish you all a safe and happy summer and look forward to seeing you in the fall.

Molly E. Polverento, MSEd, MPHA President

Health Impact Assessment: Use in Public Health & Community Planning

Health Impact Assessment (HIA) is a fast-growing field that helps decision makers take advantage of opportunities to bring together scientific data, health expertise and public input to identify the potential – and often overlooked – health effects of proposed new policies, projects, plans and programs. HIA offers practical recommendations for ways to minimize risks and capitalize on opportunities to improve a community's health. In addition, it gives federal, tribal, state and local legislators, public agencies and others the information they need to advance smarter policies today to help build safe, thriving communities tomorrow. HIA can be used to assess a variety of projects and policies in the area of transportation, land use, food and agriculture, housing, safe routes to school, and climate action planning, gender pay inequity policies, among others.

A CDC priority is the development of public health capacity to bring health into policy and planning by utilizing tools such as HIA. MDCH, through its Michigan Climate & Health Program (MICHAP), had a number of capacity building initiatives, including: 1) offering (in 2011) HIA training for local health departments and city, county, and urban planners with Human Impact Partners; 2) providing technical assistance to local health departments throughout the HIA process; and 3) funding support to local health departments (LHDs) for climate change/ sustainability related HIAs.

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In This Issue...

Think Green & Save A Tree
Please don't print this newsletter unless it's neccessary

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About MPHA

Advocating Public Health since 1919

The Michigan Affiliate for the American Public Health Association since 1921

What is MPHA?

MPHA is an interdisciplinary society of health professionals and other citizens who are concerned about problems and issues affecting public health in Michigan. People from all walks of life share these concerns and are welcomed as members.

What is the purpose of MPHA?

- To promote public health in Michigan through education and advocacy.
- To conduct, or sponsor with others, research in public health and allied fields
- To disseminate information concerning developments in public health

What MPHA can provide for YOU?

- A forum for public health issues
- Input on priority issues selected each year by the membership
- Professional conferences
- Review of legislation and its impact
- Career development opportunities
- Leadership development
- Recognition and awards
- Affiliation with the American Public Health Association
- Peer-reviewed MJPH
- Camaraderie, collegiality, and fellowship

What YOU can provide MPHA?

- Help to develop goals and objectives for addressing public health issues through committees, divisions, task forces, or the Board of Directors
- Develop MPHA policies as a member of the Public Policy and/or Legislation Committees
- Participate in leadership within your professional group -- MPHA Divisions
- Serve on MPHA committees such as Awards, Membership, Program, Newsletter, etc.
- Plan, attend, interact, and assist with MPHA conference and seminars

If you are interested in joining MPHA, please visit http://www.mipha.org/join-renew.php

Health Impact Assessment... continued

In March 2012, the Michigan Department of Community Health (MDCH) funded Ingham County Health Department (ICHD) and the City of Grand Rapids for two HIA demonstration projects. ICHD, in partnership with the City of East Lansing, Public Sector Consultants, the Tri-County Regional Planning Commission, and the Marble Elementary Wellness Committee, is conducting an HIA of key motorized transportation elements in the City of East Lansing's draft Climate Sustainability Plan and Non-Motorized Transportation Plan. The City of Grand Rapids, in partnership with the Kent County Health Department, Grand Valley State University Community Research Institute, Disability Advocates of Kent County, and Public Sector Consultants Inc., is conducting an HIA on three proposed development scenarios for the Michigan Street Corridor. Both HIAs are funded from a grant from the Centers for Disease Control & Prevention (CDC) Climate Ready States and Cities Initiative.

MICHAP is currently conducting an HIA to assess the City of Ann Arbor's tree canopy cover and the health impact of increasing the number of trees in areas of the city most vulnerable to high heat events. This HIA couples canopy analysis data provided by the city's Planning Department and University of Michigan's Urban Planning students with Washtenaw County public health information on potential health effects of high heat events. The HIA results will be used to inform the way that urban forestry decisions are made for the City of Ann Arbor.

How is an HIA done?
HIAs consist of six steps that are similar to those in many other forms of impact assessment (e.g., environmental, social, and strategic) and include: screening, scoping, assessment, development of recommendations, reporting, and monitoring (Quigley et al. 2006; NAPSWG 2010). Within this general framework, approaches to HIA vary as HIAs are tailored to work with the specific needs, timeline and resources of each particular project. The six steps are:

Screening: Identify projects or policies for which an HIA would be useful.

Scoping: Determine which health effects to consider and develop a map of pathways to describe relationships between inputs and outputs. (e.g., the impact of x on y).

Assessment: Identify the appropriate and necessary data sources and methods that will be used to measure and describe current or existing conditions. Use available data, resources, and literature to describe the predicted health impacts.

Recommendations: Develop evidence-based recommendations to mitigate negative and maximize positive health impacts.

Reporting: Develop the HIA and present findings and recommendations to relevant stakeholders, interested parties, and decision makers.

Monitoring: Monitor the decision, implementation, health determinants, and outcomes affected by the decision.

HIA employs a holistic definition of health and considers a broad set of social and environmental conditions as determinants of health status. The scope of impacts analyzed within HIA can include physical and mental health outcomes such as mortality or disability in addition to behavioral factors, environmental, social, economic, and political conditions (Marmot and Wilkinson 1999).

How is an HIA started?
An HIA can be initiated by public health professionals, community groups and advocacy organizations, affected stakeholders, responsible public agencies, or policy makers who are interested in the consideration of health in a decision-making process. HIA can also be required by project-specific legislation or to comply with environmental impact assessment regulations. Generally, HIA should be carried out before a decision is made or policy is implemented to allow the HIA to inform the policy, plan, program or project. To find resources on HIAs and reports from communities that have undertaken them, go to:

Human Impact Partners (HIP) http://www.humanimpact.org/
Health Impact Project (HIP) http://www.healthimpactproject.org/
National Association of County & City Health Officials (NACCHO) http://www.naccho.org/topics/environmental/landuseplanning/HIAresources.cfm

Figure 1. Determinants of Health and Well-being
SOURCE: Adapted from: R. Bhatia, "Health Impact Assessment: A Guide for Practice," Oakland, CA: Human Impact Partners, 2011.

Laboratory Update

The Changing Landscape of Public Health Laboratories in Michigan

Landscapes can change over eons through subtle to persistent forces like rain and wind eroding mountains. Sometimes the changes are sudden and drastic like volcanos and earthquakes. The economic forces impacting public health laboratories in recent years have been of the later type- anything but subtle and have resulted in rapid, drastic changes.

One of the most notable changes was the closure of the Michigan Department of Community Health (DCH) Houghton branch laboratory in October, 2010. Bioterrorism suspect isolates, routine tests like chlamydia and syphilis are now transported and performed in the DCH central laboratory in Lansing. Clients seeking water testing can access it through local public health agencies, the Department of Environmental Quality Laboratory in Lansing or private environmental laboratories. Any additional cost including water sample transport is borne by the submitter.

The City of Detroit Department of Health and Wellness Promotion ceased to offer diagnostic, surveillance and bioterrorism testing in early 2012. The department's test menu is now limited to simple to perform, point of care tests that are in the regulatory classification of waived test.

With the closure of the Laboratory Response Network (LRN) reference lab services at the Northwest Michigan Health Department laboratory in Gaylord in 2010 and Houghton and decreased capacity in the Detroit lab, the Michigan network of public health facilities that can confirm bioterrorism agents initially isolated at clinical and hospital labs shrunk from seven to four. LRN reference labs remain active in Lansing, Kalamazoo, Grand Rapids, Saginaw and Oakland County. The added specimen transport time to the nearest LRN laboratory will compromise public health response initiation in the Upper Peninsula and northern Lower Peninsula.

The structure of the Michigan Regional Laboratory System was revised in response to economic and technologic changes. From 1994 until 2011, DCH lab scientists served as directors of local public health testing services enabling the agencies to meet federal CLIA laboratory regulatory requirements for testing at on-site clinics. Manufacturers of point-of-care test devices now offer a range of simple-to-perform tests that relieved users of more stringent quality assurance activities and made them eligible for CLIA Waived Certificates. Simultaneously, the DCH lab workforce shrunk placing a heavier burden for local public health testing oversight on the remaining individuals qualified to serve as laboratory directors. After a robust visioning and planning process, a new organizational structure for quality oversight and regulatory compliance was developed. Local public health agencies now hold their own CLIA certificates. However, technical and quality consultation and support is offered by laboratory professionals from traditional, complex testing services at Kalamazoo, Kent and Saginaw public health agencies. DCH continues to provide directors and quality oversight to the three complex testing public health laboratories.

Another change in the way testing services are offered at public health laboratories in Michigan is the change from providing chlamydia and gonorrhea amplified tests at 6 laboratories to 2 laboratories. Improved technology providing higher through put has allowed all specimens from family planning, adolescent health and local public health STD clinics that are supported by state and federal funds to be tested at either the Saginaw or Lansing laboratory. By consolidating this service to 2 locations, over $100,000 in labor, proficiency, and quality control testing costs can be redirected to client care. The Saginaw laboratory was selected based on a competitive process.

In another effort to manage quality control costs, reagent and supply waste and assure high quality test results, the DCH laboratory consolidated enteric bacteriology testing for stools and food samples from previously funded complex testing public health laboratories. When federal funding used to support local public health food testing was lost, the workload and ability to maintain proficiency in the testing at these labs was examined. The local public health laboratory in Kalamazoo was funded to maintain norovirus testing to provide surge capacity to the DCH laboratory. Saginaw and Oakland continue to offer internally funded norovirus testing for outbreak investigations within their jurisdictions.

In preparation for full implementation of the Affordable Care Act and to offset shrinking federal and state funding, the DCH laboratory is pursuing reimbursement for selected services. The laboratory has contracted with a medical billing service, JetCo, to submit invoices and track payments. The state laboratory now will be able to collect fees from Medicaid managed care organizations for services provided to enrollees. For STD and Family Planning clients not enrolled Medicaid or Plan First!, clinic personnel must now determine clients' ability to pay for testing services. A sliding fee scale will determine the clinic's and the client's contribution toward the test fee. The state laboratory will also now have the ability to invoice third party insurers for testing services provided to their clients. In STD and Family Planning clinics this means that clients must request confidential services to prevent an automatic explanation of benefits being sent to their home when insurers pay the invoice for services.

Internally, the state laboratory is persistently pursuing opportunities for efficiencies and improved services. Last year the entire staff was trained in Lean Process Improvement and two major projects were completed. The efficiencies gained helped the laboratory manage the effects of staff vacancies due to a retirement incentive and lost positions due to shrinking funding levels.

If you have any comments or suggestions, please contact us at MDCHlab@michigan.gov or call our Quality Assurance Officer, Dr. Jeff Massey at (5170335-8074.

Public Health Nursing Update

Public Health Nursing Section Annual Meeting

On April 11, 2012, the Public Health Nursing Section held its annual program and meeting in Grand Rapids at the Kent County Health Department. The program, titled Healthy Michigan 2020: What Really is Making us Sick?, focused on the social determinants of health and interventions to address them. Dr. Amy Curtis, epidemiologist and associate professor at Western Michigan University, set the background for the conference with her presentation titled "What are our Numbers? Health Status of Michigan." Her presentation provided current information about the health of Michigan citizens compared with the Healthy People 2020 leading indicators. Michigan is doing quite well in some areas, but has many challenges in several areas to reach the 2020 goals.

Dr. Renee Branch Canady, Health Officer of Ingham County Health Department, provided an engaging presentation centered around the social determinants of health using the life of Lillian Wald as a case study. Dr. Canady's content included a helpful model of disparities and definitions of disparities, social justice, health inequity, and health equity.

After lunch the 34 participants divided into roundtable discussion groups to exchange information about evidence-based programs to decrease smoking, obesity, and infant mortality among Michiganders. Jeanette Klemczak, currently transitioning from her position as Chief Nurse Executive in the Michigan Department of Community Health (MDCH), updated participants on the health of the Michigan nursing population. Ms. Klemczak's presentation focused on the recommendations of the MDCH Task Force on Nursing Practice reported completed April 2, 2012.

The Annual Meeting of the PHN Section members was held before the lunch break to inform members of the section activities and request suggestions for the coming year. Naomi Ervin provided a report from the chairperson. A treasurer's report from Sandy Walls and a report by Kathie Bappert on the work of the Task Force on Nursing Student Clinical Experiences were presented. The task force, composed of section members and representatives of the Nurse Administrator's Forum, also provided a written report for attendees. Members provided suggestions for improving communication with the section members.

Dr. Ervin thanked the conference planning committee for their work in putting together an excellent program. She also thanked the Michigan Public Health Training Center for assistance with planning the program and support for program expenses.

Masters of Public Health Projected for GVSU

Grand Valley State University is currently in the prospectus stage of developing a Masters in Public Health degree. The curriculum process is underway for an anticipated fall 2014 start date fora 60-student cohort. The program will include 60 credits including core public health courses and a student's choice of one of three emphasis tracks in Epidemiology, Health Promotion, and Health Administration. All courses will be held in a classroom/clinical setting at the College of Health Professions in downtown Grand Rapids.

Letters of support for the proposed MPH program are welcome and encouraged from local, state and national organizations to the program chair, Ranelle Brew, Ed.D. at brewr@gvsu.edu.

Upcoming Events

2012 National Conference on Health Statistics
August 6-8, 2012
Washington, DC
http://www.cdc.gov/nchs/events/2012nchs/

2012 National Conference on Health Communication, Marketing and Media
August 7-9, 2012
Atlanta, GA
http://www.cdc.gov/nchcmm

Michigan Premier Public Health Conference
October 3-4, 2012
Big Rapids, MI
http://www.mipha.org/event-calendar.php

APHA 140th Annual Meeting and Exposition
October 27-31, 2012
San Francisco, CA
http://www.apha.org/meetings/AnnualMeeting/

2012 MDCH Fall Regional Immunization Conferences
October 9 – Gaylord
October 11 – Marquette
October 18 – Troy
October 30 – Dearborn
November 1 – Bay City
November 2 – East Lansing
November 14 – Grand Rapids
November 15 – Kalamazoo

2012 Michigan Cancer Consortium
November 7, 2012
East Lansing, MI

Epidemiology Update

The Michigan Public Health Association (MPHA) Epidemiology Section held its 11th Annual Michigan Epidemiology Conference at the Michigan State University Union on March 30, 2012. The goal of the annual conference is to bring together individuals interested in epidemiology from organizations that include health systems, academia, non-profit organizations, industry, and government and to provide a venue to present and discuss the latest information from the field and showcase work in epidemiology across the state of Michigan. This year's conference was extremely successful in accomplishing this goal. The conference welcomed nearly 300 registrants representing epidemiology from all disciplines across the state of Michigan and from neighboring states of Ohio and Indiana.

This year's keynote speaker was Dr. W. Thane Hancock who is a Lieutenant Commander in the US public Health Service working as an Epidemic Intelligence Service Officer in the Outbreak Response and Prevention Branch of the Division of Foodborne, Waterborne and Environmental Diseases in the National Center of Emerging and Zoonotic Infectious Diseases of the Centers for Disease Control and Prevention. Dr. Hancock gave a timely presentation on national foodborne outbreak investigations, which included discussions of Listeriosis associated with cantaloupes and Salmonellosis associated with ground turkey, and how epidemiology led to public health action to control the outbreaks. Dr. Hancock highlighted the lessons learned in these outbreaks. He explained that during the Listeriosis outbreak, which was the deadliest foodborne outbreak in the United States in over 90 years, the use of pre-existing control groups for comparison analysis enabled accelerated identification of the suspected food vehicle and emphasized how the use of Shopper/customer loyalty card information provided critical clues in the Salmonellosis outbreak. Dr. Hancock also presented future challenges such as how non-culture based enteric disease testing methods are jeopardizing the existing system for multistate foodborne outbreak detection which relies on fingerprinting pathogen isolates.

A last minute change in the schedule of speakers occurred during the morning of the conference. The conference began with a plenary talk from Dr. Brandon Warrick, who is an assistant clinical professor of Emergency Medicine at Wayne State University, the assistant medical director of Emergency Medicine at Gratiot Medical Center in Alma, and an attending Toxicologist at the Children's Hospital of Michigan Poison Center. Dr. Warrick gave a riveting and comprehensive overview of synthetic drugs being created for recreational use. He presented an eye-opening discussion of how new analogs of these synthetic drugs are continually being created to evade laws that make these substances illegal. In his talk, Dr. Warrick described the coordinated response between the Poison Control Center and the Michigan Department of Community Health to an increase in hospitalizations and deaths due to bath salts in Michigan and outlined recent epidemiological data of synthetic drug abuse collected by Poison Control Centers. The change in the morning speaker order occurred because Dr. Warrick needed to hurry back to Detroit to be with his wife who began labor for the birth of their first child the morning of the conference. The Epidemiology Section was informed that early the next morning Dr. Warrick welcomed a beautiful baby boy into his family. Congratulations Dr. Warrick!

The morning ended with an exciting and informative topic in epidemiology, emerging and endemic vectorborne disease in Michigan. Dr. Ned Walker is a professor in the Department of Entomology and the Department of Microbiology and Molecular Genetics at Michigan State University, focusing on insect vectors of disease, the ecology and epidemiology of vectorborne diseases, and means to control vectorborne diseases. He spoke about the increasing endemicity of Lyme Disease in Michigan and the potential for further spread of the disease vector. Dr. Walker also discussed the concerns of diseases transmitted by mosquitos and how facets of the ecology as well as the economy of Michigan support transmission of diseases such as West Nile Virus

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Student Section

What Are Members Up to This Summer?

Bryan Buckley created this blog to archive his thoughts about public health in Antigua during a practicum working with the Ministry of Health this summer in the country of Antigua & Barbuda.

http://bryanobuckley.tumblr.com/

Karalyn Kiessling has an internship at the Calhoun County Public Health Department with the local epidemiologist.

Endia Santee is a Graduate Research Assistant for the Prevention Research Center of Michigan working on the HOPE Project (HIV/STI Outreach Prevention and Education). The PRC is in partnership with YOUR Center, the Genesee County Health Department, and the Saginaw Department of Public Health. My task is to recruit research participants, administer surveys, explain research rights to participants, and to create a comfortable atmosphere among those attending HOPE Parties. More information and detail of what HOPE is and those involved is located here: http://prc.sph.umich.edu/research/hope/

Cynthia Schauer, M. Ed., MT(ASCP), will be attending the 15th International Congress on Circumpolar Health in Fairbanks, Alaska in August (5-10). She is also beginning a project on infant mortality rates in Michigan and would appreciate any information anyone cares to share on infectious disease causes of IM.

Ranelle Brew, Ed.D. - Student Section Chair, traveled to Tacloban City, Philippines with six undergraduate Grand Valley State University students to work in rural health clinics during May 2012. A poster will be presented on this trip at the fall Premiere conference in Big Rapids.

Epidemiology Update... continued

and Eastern Equine Encephalitis. Dr. Walker stressed the importance of surveillance for diseases among humans, animals, and mosquitos to control these diseases and other non-endemic diseases such as Dengue because the physical and living landscape of Michigan is receptive to invasion and establishment of these pathogens.

The afternoon of the conference featured four breakout sessions consisting of twelve abstract submissions selected for verbal presentations. The topics included developments in social epidemiology, hospital and chronic disease epidemiology, infectious disease epidemiology, and women, children, and maternal health epidemiology.

Highlights of both the morning and afternoon breaks were the sponsor exhibits and poster sessions. The MPHA Epidemiology Section is greatly appreciative of the ongoing and generous support of its sponsors including the MDCH Surveillance and Infectious Disease Epidemiology Section, the MSU Department of Epidemiology, Altarum Institute, MAPPP, MPHI, ACIP of Greater Detroit, and the MSU Program in Public Health.

This year's conference marked the largest number of abstracts ever submitted for presentation at the Michigan Epidemiology Conference. Over 65 posters were displayed at the conference, encompassing epidemiological findings from students and professionals across the state of Michigan. The presenters had their posters judged by their peers and five posters tied with perfect scores. These included posters by three students, Kyle Enger, Hanna Oltean, and Fannie Rackover, and two non-students, Adrienne Nickles and Bethany Reimink. The MPHA Epidemiology Section awards one student and one non-student with the top score a year membership to MPHA. This year's winners were randomly drawn and the memberships went to Fannie Rackover and Adrienne Nickles. Congratulations also go to the MSU Department of Epidemiology and Biostatistics for winning the John Snow Award for being the university with the highest rate of abstract submission in 2012.

The MPHA Epidemiology Section is grateful for all of those who made this conference an overwhelming success. They would like to extend a special thank you to everyone able to participate in the conference both onsite and offsite, as this year the morning sessions were offered via live webcast courtesy of Utopia Productions, LLC. The section hopes to continue expanding the reach of the conference and boosting the interest in epidemiology in Michigan through future conferences. The 12th Annual Michigan Epidemiology Conference which will be held at the University of Michigan is tentatively scheduled for the spring of 2013. Please visit the MPHA Epidemiology Section website for more information and archived past conference materials at www.mipha.org/epidemiology.php .

Summary of the 2010 National Profile of Local Health Departments

In August 2011, the National Association of County and City Health Officials (NACCHO) released the 2010 National Profile of Local Health Departments. The purpose of the profile was to advance and support the development of a database for LHD's to describe and understand their structure, function and capacities. Data for the profile was collected via the distribution of a questionnaire via e-mail to the top agency executive at 2,565 LHDs throughout the country. Overall, the study had a response rate of 82%, or 2,107 of 2,565 LHDs. In Michigan, 42 of the 45 LHDs responded for a response rate of 93%. This article provides a brief summary of the results of the 2010 Profile.

Jurisdiction and Governance
The majority of LHDs in the United States serve small jurisdictions. Sixty-three percent (63%) of LHDs serve populations of less than 50,000, 32% serve populations between 50,000 and 499,999, and 5% serve populations of 500,000 or greater. These results also indicate that nearly half (49%) of the US population is served by 5% of existing LHDs. Individuals served by LHDs in small jurisdictions account for only 11% of the entire US population. Among the LHDs surveyed, 68% served counties, 21% served cities, 8% served a multiple county jurisdiction and 3.5% served multiple cities.

Financing
The median annual expenditure for all LHDs was $1.5 million. Median expenditures ranged from $512,000 for LHDs serving populations of 25,000 or less to $58.5 million for LHDs serving populations of 1 million or more. On a per capita basis, median expenditures were $41 for all health departments compared to a mean of $57. Median per capita revenues for all LHDs were $44 compared to a mean of $60.

Although an exact median expenditure figure was not provided for LHDs in Michigan, this figure fell somewhere between $35 and $44.99. Among the 42 LHDs in Michigan responding to the survey, 32% of reported revenues came from Federal Pass-Through funding (including PHER and ARRA), 17% from State-Direct funding, 16% from local sources and 12% from Medicaid and Medicare.

LHD Leaders
The majority of top executives in LHDs (91%) worked full-time in their position. More than half (57.6%) were female and 6.5% reported a race other than white. Compared to results of the 2008 Profile, the percentage of female executives increased somewhat and the percentage of executives reporting a race

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Oral Health Update

Despite the fact that community water fluoridation has demonstrated its worth, safety, and effectiveness for over 65 years, anti-fluoridation activity has resurfaced recently in Michigan communities such as Mt. Pleasant, Leslie, Hartford, Marysville and Hartland Township. Many communities are looking to cut costs and fluoridation is often considered. Some of the same claims from 50 years ago continue to be raised by those in opposition to fluoridation today. For example, it is mass medication, takes away freedom of choice, causes numerous health problems and cancer, and affects a person's IQ. Newer claims are that there is no difference in decay rates between fluoridated and non fluoridated communities, or that fluoride harms plants and animals in the wild.

The Centers for Disease Control and Prevention (CDC) has promoted community water fluoridation as "one of the 10 greatest public health measures in the 21st century." (CDC website June 2012). Fluoridation is a public health measure just like iodine in salt, Vitamin D in milk and vitamins and minerals in cereal. Fluoride can be administered to populations in different ways, but not with the simplicity and cost effectiveness of community water fluoridation.

It is easy for us to take fluoridation for granted. No longer do millions of Michigan residents lose their teeth by age 50. Between the 1950s and the early 1990s the prevalence of edentulism in the United States decreased from 50% to 42% among people aged 65 and older (Oliver & Brown, 1993). The benefits of community water fluoridation can reach all people in those communities regardless of income, age, or race. It truly is a practice that can reduce health disparities and bridge the gap offering improved health among different levels of socio-economic status and populations.

The Internet and social media have added multiple ways for the public to obtain and distribute misinformation; therefore, all health professionals need to be vigilant and proactive in their support for community water fluoridation as a public health practice. Community water fluoridation is evidenced-based with numerous systematic reviews over decades that support its safety and effectiveness. Current science is available to dispute many of the opposition's claims. You may be called upon by your community as a resident expert. Fluoridation remains a valuable resource for providing accessible preventive care to the full range of age and socio-economic groups and is a positive impact on oral health and social justice.

The Oral Health Section of MPHA recommends the following sites which the State considers reliable sources of information. These can also be found on our webpage www.mipha.org.

- The Centers for Disease Control and Prevention: http://www.cdc.gov/fluoridation/index.htm
- The National Institute for Dental and Cranial Research: http://www.nidcr.nih.gov/
- The PEW Center for the States: http://www.pewcenteronthestates.org/initiatives_detail.aspx?initiativeID=327831
- The American Dental Association: http://www.ada.org/sections/professionalResources/pdfs/fluoridation_facts.pdf
- I Like My Teeth: www.Ilikemyteeth.org
- A new site: www.fluoridescience.org will soon be available as a valuable resource

To obtain more educational materials about community water fluoridation or other oral health issues in Michigan please contact the MPHA-Oral Health Section:

Susan Deming, Fluoridation Coordinator
Mich Department of Community Health

News Update

MDCH Releases Health & Wellness Plan

Reducing obesity in Michigan is one of Governor Snyder's top health priorities. To address this priority, the Michigan Department of Community Health (MDCH) released the "Michigan Health & Wellness 4 x 4 Plan." Central to the plan is the 4 x 4 tool (http://www.michigan.gov/healthymichigan). The tool incorporates four key healthy behaviors with four key health measures. You can support the 4 x 4 Plan by personally adopting the 4 x 4 tool, promoting it to partners/posting it on your agency's website, and implementing the strategies in your work site or community.

Healthy Michigan: Each of Us Can Improve Our Personal Health By

Practicing four key healthy behaviors:
- maintain a healthy diet
- engage in regular exercise
- get an annual physical examination
- avoid all tobacco use

Being aware of four key health measures that are closely tied to several chronic diseases:
- body mass index (BMI)
- blood pressure
- cholesterol level
- and blood sugar (glucose) level

www.michigan.gov/healthymichigan

Summary of the 2010 National Profile... continued

other than white decreased slightly. Sixty-eight percent (68%) of top executives were 50 years of age or older. The mean length of time that top executives had been in their positions was nearly 9 years.

LHD Workforce
The majority of LHDs (87%) had less than 100 Full Time Equivalents (FTEs). About 15% of LHDs had less than 5 FTEs while 6% had 200 or more FTEs. As the size of the population served by an LHD increased, so did the percentage of minorities employed. Among all LHDs, 12% of staff were Hispanic. This percentage ranged from 4% in LHDs serving less than 25,000 people to 17% in LHDs serving a population of 500,000 or more. Among all LHDs, 31% were a race other than white. This percentage ranged from 9% in the LHDs serving the smallest population to 52% in those serving the largest populations.

Results related to the categories of workers employed by LHDs indicated that 97% of LHDs employed Administrative or Clerical personnel and 96% employed public health nurses. Eighty-one percent (81%) of LHDs employed environmental health specialists, 57% employed health educators, 55% employed nutritionists, and 28% employed epidemiologists. The estimated overall LHD workforce decreased by about 3% from 2008 to 2010. Despite this, certain occupations showed increases, including a 10% increase for nutritionists, an 11% increase for health educators and a 15% increase for epidemiologists.

With regard to workforce development activities, 84% of LHDs had written position descriptions for all of their staff members. Most LHDs indicated that they conduct formal performance evaluations (67%) and assess training needs (63%) for all of their staff members. Approximately half of LHDs have developed training plans for all of their staff and 38% have developed training plans for some of their staff.

LHD Activities
The most common activities performed by LHDs were provision of adult (92%) and child (92%) immunizations and communicable disease surveillance (92%). More than three-fourths of LHDs provided the following services: tuberculosis screening and treatment, food service establishment inspection, environmental health surveillance, and food safety education.

LHDs were most likely to provide screening for tuberculosis (85%), but also provided screening for high blood pressure (67%), sexually transmitted infections (64%), lead (63%) and HIV/AIDS (62%). The likelihood of offering screening for communicable diseases increased with the size of the population served by an LHD. Three-quarters of LHDs provided treatment for tuberculosis, 59% provided treatment for STIs and 21% provided treatment for HIV/AIDS.

Maternal and Child Health (MCH) services were also commonly provided by LHDs. Two-thirds of LHDs offered WIC services, 61% offered MCH home visits, and 55% provided family planning services.

Although 27 percent of LHDs offered oral health services, the percentage varied widely by the size of the population served. Among LHDs serving small populations (<25,000), 18% offered oral health services compared to 59% of those serving populations of 500,000 or more.

Community Health Assessment and Quality Improvement
Health departments planning to apply for National Public Health Accreditation must have completed a community health assessment (CHA), a community health improvement plan (CHIP) and an agency strategic plan. According to results of the 2010 Profile, 60% of LHDs completed a CHA, 51% completed a CHIP and 31% completed a strategic plan within the past 5 years. However, only 20% of LHDs had completed all three of these pre-requisites for national accreditation in the past 5 years. LHDs serving populations of 500,000 or more were more likely to report completion of the pre-requisites (32%) than those serving smaller populations.

With regard to quality improvement (QI) activities, 15% of all LHDs indicated that they have implemented a formal agency-wide QI program. Twenty-six percent (26%) of LHDs serving populations of 500,000 or more had a formal QI program compared to 18% of LHDs serving 50,000 to 499,999 and 12% of those serving less than 50,000. Among LHDs reporting any QI efforts (formal or informal), 39% reported using at least one QI framework, with Plan-Do-Study-Act by far being the most commonly used framework.

When asked about national accreditation, 50% of respondents agreed or strongly agreed that their LHD would seek accreditation in an unspecified time period and 29% intended to seek accreditation within the first two years of the program. About 14% disagreed or strongly disagreed that they would seek accreditation in an unspecified time period.

Information Technology
Over half of responding LHDs (56%) indicated use of an electronic syndromic surveillance system. Among those using such a system, 89% used the system to detect influenza-like illness and 74% used it to detect foodborne illness. With regard to social media, 28% of LHDs indicated use of Facebook and 13% reported use of Twitter.

The entire report can be found at the following link:
http://www.naccho.org/topics/infrastructure/profile/resources/2010report/upload/2010_Profile_main_report-web.pdf