

## FIRST DOCUMENTED VANCOMYCIN-RESISTANT *STAPHYLOCOCCUS AUREUS* IN THE UNITED STATES, MICHIGAN 2002

Dawn M. Sievert, M.S.

On June 14, 2002 a diabetic patient presented for a hemodialysis session with an apparent temporary catheter exit-site infection. The exit-site wound was cultured, and the swab and catheter tip were sent to two local hospital laboratories for testing. On June 18, the Michigan Department of Community Health (MDCH) was asked to confirm the presence of vancomycin-resistant *Staphylococcus aureus* (VRSA) (MIC>128 ug/mL) that was identified by the two clinical microbiology laboratories. One week later, VRSA was also isolated from an infected ulcer on the patient's foot. Vancomycin-resistant *Enterococcus* (VRE) *faecalis* was also identified from the catheter tip and the foot ulcer.

The patient was a 40 year-old, African-American female with diabetes, hypertension, peripheral neuropathy, peripheral vascular disease, and chronic renal failure, who had been

on hemodialysis since August 1999. The major medical illnesses during this time were infections and vascular complications of the right foot, which resulted in three sequential toe amputations over the past year and development of neuropathic resting foot ulcers on the plantar aspect of the right foot. As treatment for these foot ulcers, the patient received several courses of empiric antibiotic treatment, which included, but was not limited to, vancomycin.

MDCH, in conjunction with the CDC, immediately initiated an investigation to determine any spread of the VRSA organism beyond the case-patient in the healthcare and community settings, to evaluate infection control precautions at all affected healthcare facilities, and to facilitate and coordinate the patient's treatment.

To assess possible past cross-transmission, a VRSA carriage study was initiated.

The period of potential transmissibility was defined as beginning on April 25 and ending on July 2, 2002, the most recent date that vancomycin-susceptible *S. aureus* was isolated from multiple body sites through the date the patient began specialized treatment and wound management. Contacts at risk for potential VRSA transmission in the defined period were identified. These included current healthcare workers, current patients, and former patients from facilities where the case-patient was treated during the period of potential transmissibility; family members

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Contacts	Eligible n	Cultured n (%)	Colonized n (%)	
			<i>S. aureus</i>	MRSA
Hospital	340	195 (57)	65 (33)	13 (7)
Dialysis Center	171	151 (88)	38 (25)	<b>13 (9)</b>
Physician Office	24	13 (54)	2 (15)	0 (0)
Family / Friend	10	10 (100)	5 (50)	<b>2 (20)</b>
Business	2	2 (100)	0 (0)	0 (0)
<b>Total</b>	<b>547</b>	<b>371 (68)</b>	<b>110 (30)</b>	<b>28 (8)</b>

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and one friend who had extensive close contact with the patient; and technicians at a nail salon frequented by the patient during this period. All available contacts were cultured from a single anterior nares and from any catheter sites, open wounds, or skin lesions.

There was no transmission of the VRSA organism beyond the patient. In total, there were 547 contacts identified. Of these, 371 (68%) were available and cultured. Of the 371 contacts cultured, 110 (30%) were colonized with *S. aureus*, and 28 (8%) were identified as methicillin-resistant *Staphylococcus aureus* (MRSA) carriers. Fifteen of these MRSA-carriers were believed to be at greater risk for acquiring the VRSA strain. Therefore, pulse field gel electrophoresis (PFGE) analysis was conducted on these isolates and they were compared to the PFGE patterns from the patient isolates. The results revealed similar patterns between the patient's VRSA isolates, and the patient's and close friend's MRSA nares isolates.

Prospectively, the patient and the healthcare personnel providing direct patient care were evaluated weekly, and all hemodialysis patients were re-cultured one month after the initial survey. The results revealed intermittent recovery of VRSA from the patient's foot ulcer, MRSA from the patient's nares, and VRE *faecalis* from a peri-rectal swab. As before, no VRSA was identified from any of the healthcare providers or dialysis patients.

The infection control evaluation was accomplished through the review of policies and observation of current practices, which were found to be consistent with the recommendations for the respective settings.

The clinical evaluation and treatment program for the patient was devised through daily consultation with clinical specialists and public health authorities. As a result of the clinical treatment, the patient has markedly improved. The catheter exit site was healed within one

week of catheter removal. The foot ulcers were treated by an aggressive initial operative debridement and two weeks of antimicrobial therapy. Subsequently, the patient underwent twice-weekly assessment and treatment of the wounds, which included debridement, cleaning, culturing, application of gentian violet, and placement of a total contact cast to displace pressure from the foot.

Laboratory analysis of this VRSA organism indicated that the *S. aureus* acquired resistance to vancomycin through the transfer of the *vanA* gene from VRE *faecalis*. The information gathered from this investigation emphasizes the importance of accurate laboratory detection and susceptibility testing, vigilant surveillance for resistant organisms, stringent infection control practices, and effective and efficient use of antimicrobial therapy.

## 2002 West Nile and Other Arboviral Surveillance in Michigan

Mary Grace Stobierski, D.V.M., M.P.H., and Kimberly Signs, D.V.M.

The Michigan Department of Community Health (MDCH) was awarded \$90,000 from the Centers for Disease Control and Prevention (CDC) in 2000 for West Nile Virus (WNV) surveillance activities. These funds were used to support efforts in the Bureau of Epidemiology and the Bureau of Laboratories, as well as cooperative efforts with Michigan Department of Agriculture (MDA), Michigan State University (MSU) Department of Microbiology and Molecular Genetics, and the MSU Diagnostic Center for Population and Animal Health. This amount was increased to \$300,000 beginning July 2002. Supplemental funding of \$500,000 was awarded in October 2002. This interagency, collaborative arboviral encephalitis surveillance program has existed in Michigan for several years. This program was born out of the need to survey for Eastern Equine Encephalitis (EEE) virus activity. It also focuses on surveillance of St. Louis Encephalitis (SLE) because of an outbreak that occurred in 1975 and affected urban areas of lower Michigan.

West Nile Virus made its initial foray into Michigan in August 2001, when a dead crow found in Oakland County was determined to be WNV positive. The virus was subsequently found in birds in 18 counties, extending west to Ottawa County. There were positive mosquitoes found in Oakland and Macomb Counties. No human cases were identified in 2001. However, a vastly different pattern has emerged in 2002.

The following are some of the highlights of WNV activities in Michigan.

### Dead bird surveillance & testing.

Dead crows are a prime indicator of the presence of WNV in an area. Testing of these birds began in 2001 and continued in 2002. Citizen reports of dead crows were coordinated by calls into the state's WNV hotline, staffed by epidemiologists in the Epidemiology Section, Division of Communicable Disease and Immunization. Arrangements were made for these birds to be submitted to MSU for initial immunohistochemistry testing. If positive,

the birds were confirmed WNV-infected at the MDCH Laboratory. Almost 600 birds have been tested. In 2002, testing continued until one WNV-infected crow per county had been identified. As of December 4, 2002, 73 of Michigan's 83 counties had identified a WNV-infected bird.

**WNV Hotline.** A statewide, toll-free hotline, staffed by epidemiologists, has been in continual operation since May 1, 2002. The hotline provides general information about WNV infection and disease, disseminates information on where positive birds have been found, the numbers of human cases, and directions on how to submit bird or clinical specimens for testing. This hotline was staffed and monitored 24 hours a day 7 days a week, including holidays. Over 35,000 calls were received in the months of August and September alone.

**Laboratory Efforts at MDCH.** The MDCH virology laboratory currently performs testing for the detection of

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serum and/or cerebrospinal fluid IgM antibodies specific for WNV, EEE, SLE, and LaCrosse encephalitis virus. A funding award expanded laboratory capacity to include IgG testing for these viruses. In the future, Powassan virus testing will be added. In addition, arboviral culture and identification methodologies have been introduced into the laboratory that will provide confirmatory assays for any positive results obtained in the serology assays. In 2002 to date, the MDCH laboratory has received specimens from 2,036 individuals for arbovirus testing. In comparison, the laboratory received 159 specimens in all of 2001.

**Human cases of WNV.** Numbers of human cases of WNV erupted throughout the United States in 2002, with a particular emphasis in the middle portion of the country. Michigan was especially impacted with large numbers of cases: 523 cases and 41 deaths, by December 4, 2002. This is the second highest state total in the U.S.; only Illinois has higher total number of human cases. Numbers are expected to rise as testing continues on stored serum specimens.

Some unique aspects of WNV infection in humans were reported in 2002 and Michigan has been in the forefront of these aspects. Transfusion-associated cases of WNV have occurred, with ten investigations currently active in Michigan. A likely transfusion-associated case has had additional new implications because of the apparent maternal transmission to an infant less than one month old via breast milk. (Please see MMWR October 4, 2002 for details.)

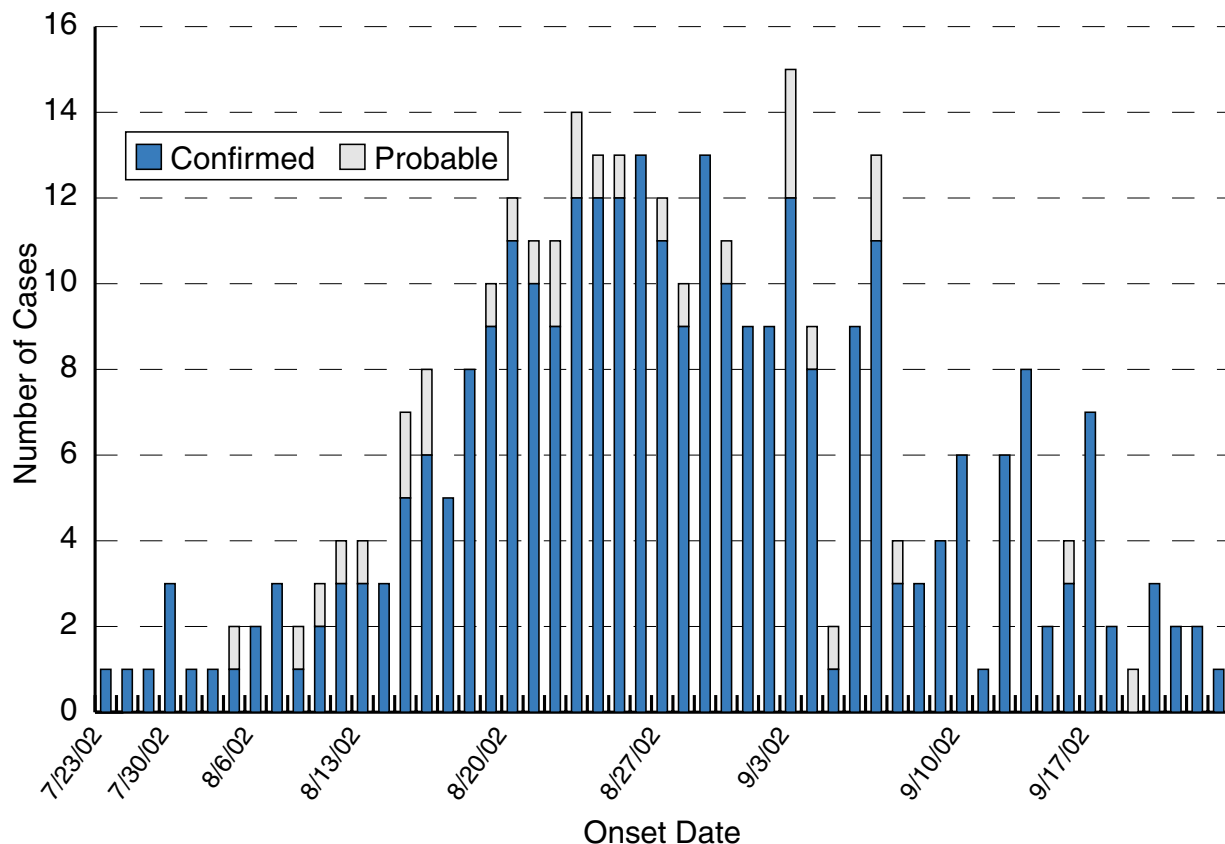
**Equine surveillance.** The MDA conducts surveillance for acute encephalitis in Michigan horses by fortnightly contact of all known equine and large animal practices in the lower half of the state. After rabies infection is ruled out, histopathology and immunohistochemistry are performed on suspect tissues at the MSU Animal Health Diagnostic Laboratory, then tissue is forwarded to the National Veterinary Services Laboratory in Iowa for further confirmation. Through December 4, 2002, the MDA has reported 347 equine cases of WNV.

**Mosquito Surveillance in Southeast Michigan Urban Areas.** MSU increased mosquito surveillance in the currently under-

surveyed southeast Michigan area. Gravid traps were placed in urban areas of Wayne, Oakland, and Macomb Counties to increase the total number of collection sites. Samples will be tested for WNV as well as SLE. This expanded effort will supplement already existing EEE surveillance occurring in these areas. Testing on these specimens will be initiated this fall at MDCH when laboratory capacity for this testing is available. Preliminary testing done at MSU has identified positive *Culex* sp. mosquitoes in counties in southeast Michigan.

In summary, WNV transmission is ending in the State of Michigan with the onset of colder weather. Currently, Michigan ranks second in the nation with the number of human cases and deaths. Resources statewide were invested in all aspects of WNV surveillance, from county-level dead bird estimates to the most advanced laboratory testing methods. This information is aiding the Bureau of Epidemiology in planning for the 2003 WNV season. As bird and human sample submission ends, the Bureau of Epidemiology together with other collaborative agencies will develop a complete picture of the WNV season and will continue to educate and disseminate this information to the public.

**Onset Date of Symptoms Among Human West Nile Virus Cases in Michigan as of October 4, 2002**



# Influenza Surveillance in Michigan

Kyle Enger, M.P.H.

Influenza activity in Michigan is most likely increasing as you read this. The previous two seasons were relatively mild, which was fortunate because there were also problems with vaccine supply during those seasons. Several different surveillance efforts are currently monitoring influenza activity in Michigan.

There are three main components of the surveillance effort; local health departments (LHDs), sentinel physicians, and sentinel laboratories. The LHDs are involved in passive surveillance by remaining alert to influenza-like illness (ILI) outbreaks so that action can be taken to limit them. When they detect an outbreak, they can request sampling kits from the Virology Section of the Bureau of Laboratories, which analyzes nasal or throat swabs to determine if the disease is in fact influenza, and if so, the specific strain. The samples are also tested for parainfluenza (paraflu), respiratory syncytial virus (RSV), and adenovirus, all of which can also cause ILI.

The sentinel physician component of the surveillance effort comprises 40 health care providers throughout the state, and has been gradually expanding since its inception in 1997. They define ILI as a disease of unknown cause with fever  $\geq 100^{\circ}\text{F}$ , accompanied by either cough or sore throat, and provide CDC and MDCH with weekly counts of visits due to ILI and visits for any reason. Weekly influenza activity is estimated by calculating the percentage of total patient visits due to ILI. These data are combined with similar data from every state to provide a national picture of influenza activity. These physicians also use the same sampling kits described above to provide six to nine samples per season to the MDCH Virology Section for further laboratory analysis.

The sentinel physician sites are widely distributed, although a few important areas such as the City of Detroit and the Western Upper Peninsula remain unrepresented. Over half (54%) are family practices, and the remainder are emergency medicine, internal medicine, infectious disease, pediatric, and student

health practices. The types of organizations represented include small independent practices, county medical centers, major hospitals, and residency programs.

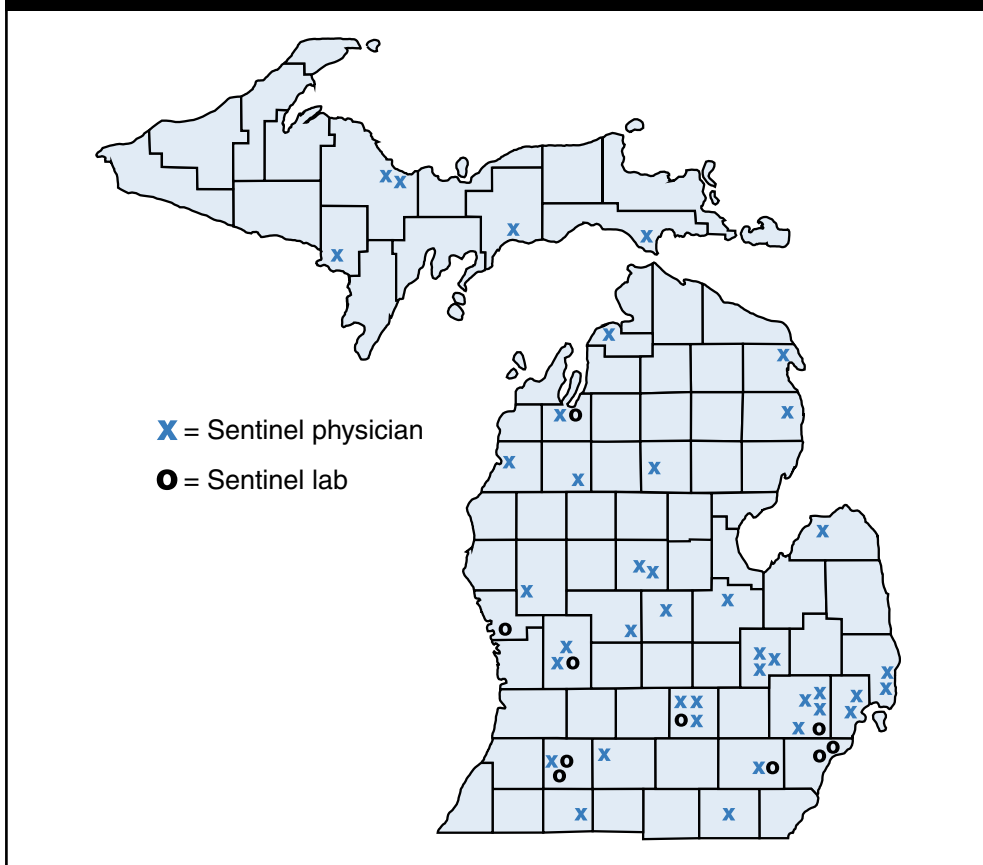
There are also nine sentinel laboratories, which report weekly on the numbers of positive tests for influenza, paraflu, RSV, and adenovirus. They also share samples with the MDCH Virology Section if further analysis is needed. Some sites also provide information on the total number of tests that are run each week, which allows calculation of the percentage of tests that are positive for influenza.

This season's vaccine contains the same H1N1 strain of influenza A virus as last season's (A/New Caledonia/20/99-like), but the other two strains have been changed. The new A strain is a H3N2 (A/Moscow/10/99-like). In particular, the new strain of influenza B in the vaccine (B/Hong Kong/330/2001-like) corresponds with a strain that made up the majority of Canadian influenza B isolates last season (1).

Although influenza vaccine availability was delayed during the past two influenza seasons, as of October 15 it is anticipated that Michigan physicians will receive their complete orders of vaccine before November. The amount of vaccine available has also increased. However, the CDC and ACIP are encouraging for the first time that children aged 6 months to 2 years be vaccinated against influenza (2), and this may strain the supply of vaccine this season. During the 2003-2004 season, influenza vaccine supplied by the Vaccines for Children program will be expanded to help meet that need.

1. CDC. Update: Influenza Activity—United States and Worldwide, 2001-02 Season, and Composition of the 2002-03 Influenza Vaccine. *MMWR* 2002; 51: 503-506.
2. Bridges, CB, et al. Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR* 2002; 51(RR03): 1-31.

Michigan Influenza Sentinel Surveillance Sites, 2002-2003



# MDCH and Planning for Chemical Terrorism

*Martha Stanbury, M.S.P.H.*

The possibility of terrorists employing chemical materials to inflict injury and social disruption has been a concern dating back at least to 1995 when the fertilizer ammonium nitrate was used to blow up an office building in Oklahoma City and sarin gas, a nerve agent, was dispersed in a Tokyo subway. Although anthrax and smallpox have been headlined in the past year as very real terrorist threats, most emergency planners believe that terrorists are more likely to use chemicals than biologic agents as weapons of mass destruction because of their availability and the visible drama of their effects. To appreciate the grave dangers of chemicals we only need to be reminded of the horrors following the accidental release of methyl isocyanate in Bhopal, India in 1984, where thousands perished in agony.

Just as with the response to bioterrorism, preparedness for a chemical terrorism event has been an extraordinarily high priority at all levels in the public and private sectors. Emergency responders such as firefighters and emergency medical services personnel generally know how to respond to hazardous materials incidents. They are highly trained and experienced because they must routinely respond to transportation chemical spills, fires involving chemicals, and other “hazmat” incidents. There

is a well established infrastructure to handle the hundreds of small chemical releases that occur annually in Michigan and the occasional large ones, such as the train derailment in Potterville earlier this year.

Unfortunately, certain aspects of chemical terrorist threats pose new challenges to emergency planners, responders, health care personnel, and public health. In the first place, an intentional event would most likely be designed to result in mass casualties; the scale of such an event could be much greater than that encountered in the usual hazmat incident and could overwhelm local or even regional capacity. Second, the agents involved in most accidental releases would be known or quickly identified, whereas the chemical in an intentional release may be difficult to identify for many hours. This means emergency responders and health care personnel treating victims would not have information vital to protect the public. Third, there are extremely toxic chemical warfare agents that are not routinely used in industry, but which could be obtained and used by terrorists. The Centers for Disease Control and Prevention has posted a list of chemicals of particular concern because of their toxic properties at <http://www.bt.cdc.gov/agent/agentlistchem.asp>

The Michigan Department of Community Health is supporting the Emergency Management Division of the Michigan State Police, the lead state agency who would respond to a chemical terrorism attack, as well as other agencies to ensure that Michigan is prepared for a chemical terrorist event. This means ensuring that public health staff are trained, that communications systems are in place, that agency roles and responsibilities regarding public health aspects of chemical terrorism are defined, and that resources and expertise are immediately available to address the health and public health aspects of such an attack. A chemical terrorism team, including a coordinator, an epidemiologist, and two toxicologists, is being assembled to undertake this initiative as part of the department’s overall anti-terrorism program in its Office of Public Health Preparedness. For more information, contact David Wade, Ph.D., in the Division of Environmental and Occupational Epidemiology at [wadedr@Michigan.gov](mailto:wadedr@Michigan.gov).

An excellent web site with information about chemical terrorism response for public health and health care providers and links to other web sites is <http://sis.nlm.nih.gov/Tox/ChemWar.html>

## New Grants

The Agency for Toxic Substances and Disease Registry (ATSDR) awarded a three-year cooperative agreement to the Division of Environmental and Occupational Epidemiology. ATSDR will provide \$144,000 per year to assess the relationship between exposure to certain criteria air pollutants and occurrence of adverse birth outcomes in specific zip codes in Allen Park, Detroit, and Lansing, Michigan. The project staff will link birth certificate data files with air monitor data for certain criteria air pollutants collected by the Michigan Department of Environmental Quality. The staff will use the linked data to examine whether the prevalence of births that are low weight,

small for gestational age, or preterm are elevated in areas where there are high levels of air pollution, as compared with areas of low air pollution, after adjustment for other risk factors.

The Division of Communicable Disease and Immunization has received supplemental funds to the Epi Lab Capacity Grant. A half million dollars was awarded to support West Nile Virus surveillance and laboratory associated costs. In addition, \$109,000 was awarded to expand and improve the statewide antimicrobial resistance surveillance system. The major activities will be to develop a comprehensive, long-term, strategic plan to combat antimicrobial resistance in Michigan and to

increase awareness and knowledge among professionals and the public about the prudent use of antimicrobial therapy.

The Centers for Disease Control and Prevention (CDC) awarded a three-year cooperative agreement to the HIV/AIDS Surveillance Section, Division of Communicable Disease and Immunization. The CDC will provide \$110,282 for the first year of funding for the Outcomes Assessment Through Systems of Integrated Surveillance (OASIS) project. The purpose of this funding is to characterize the sexually transmitted disease population in Michigan and to use database integration to determine co-morbidities and risk factors for gonorrhea acquisition.

# Survey of STD Service Provision and Case Reporting by Local Health Departments in Michigan

Dara Ganoczy, M.P.H.

During the summer of 2001, the Bureau of Epidemiology, in conjunction with the Division of HIV/AIDS and Sexually Transmitted Diseases (STD), conducted a survey of Local Health Departments (LHDs) in Michigan to assess STD service provision and case reporting practices in public health clinics. Survey results show that 42 of the 44 responding LHDs provide clinic-based STD services. Two-thirds of the clinics that were able to determine number of patient visits see less than 50 STD patients each week; almost 20% see 75 or more STD patients each week. One-third of clinics are open 40 or more hours per week, and two-thirds have evening or weekend hours. However, more than one-third of the clinics (37%) are unable to see everyone seeking services at their clinic because of staff or time limitations. The majority (57%) of clinics provide services free-of-charge, and an additional 40% charge based on a sliding scale. Almost all LHDs (90%) integrate STD and other services, while 10% offer dedicated STD sessions. The majority (57%) of persons seeking health services at LHDs are Caucasian, 37% are African American, 3% are Hispanic, and 2% are Asian/Pacific Islanders. Approximately half (52%) of the patients are 24 years or younger, 62% are female, and 61% earned less than \$15,000 per year.

The extent of STD testing at LHDs varies by disease. All of the LHDs test for gonorrhea and syphilis, but fewer test for HIV (98%), chlamydia (93%), trichomoniasis (86%), hepatitis B virus (HBV) (76%), herpes (76%), and human papilloma virus (HPV) (45%). Testing is often based on criteria such as age, gender, sexual history, and drug use, although many LHDs offer testing to every patient for HIV (59%), gonorrhea (57%), chlamydia (54%), and syphilis (49%). Pelvic exams are performed at all clinics, and 70% of LHDs offer Pap smears. Some LHDs offer pelvic exams (64%) and Pap smears (30%) to every female patient. Others provide pelvic exams and Pap smears upon request (26% and 23%, respectively), offer them to patients with STD symptoms (17% and 10%), or offer them to patients meeting

certain criteria (14% and 30%), depending on STD history, number of partners, age, and risk factors.

STD patient information is stored electronically by 60% of LHDs, and 95% collect behavioral information such as contraceptive use (97%), STD history (97%), number of sex partners (95%), drug use (92%), gender of sex partners (90%), exchanging money or drugs for sex (72%), and sex with anonymous partners (36%). However, most LHDs do not enter this information into a database, making it difficult to analyze and use for targeting interventions.

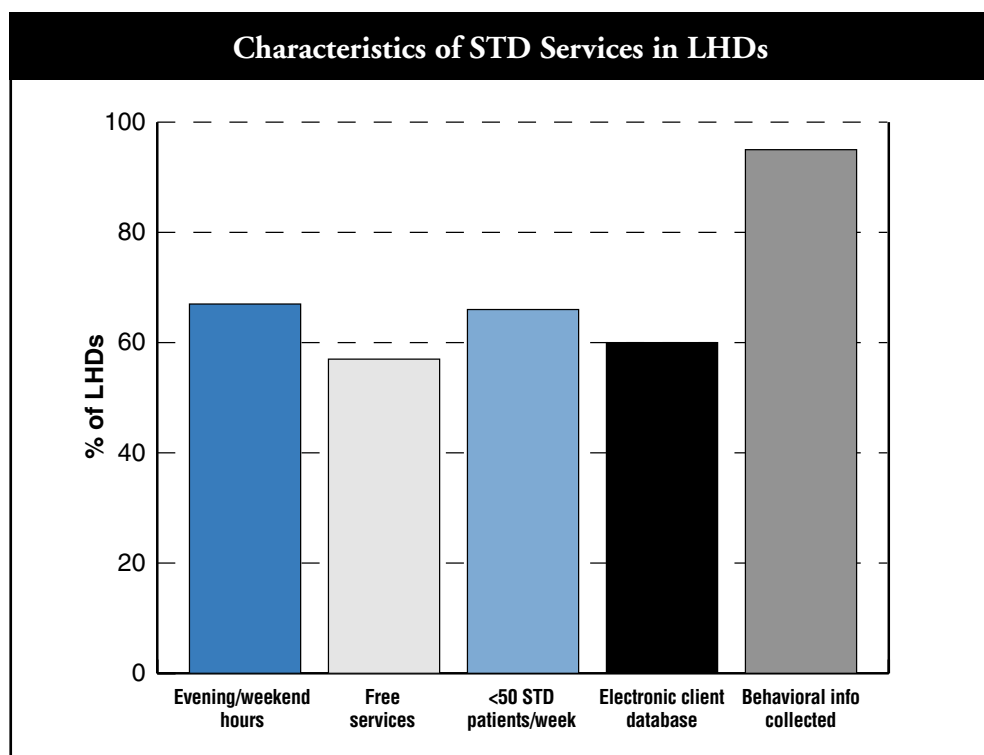
Follow up of gonorrhea cases is conducted by all LHDs to ensure treatment and obtain partner information. Although all LHDs also follow up chlamydia cases to ensure treatment, fewer obtain partner information (88%). Partner notification services are performed by almost all LHDs via phone call, letter, or home visit (95%), while 57% use patient-delivered referral cards as well. Approximately one-quarter of LHDs supply patient-delivered therapy for partners.

For patients presumed to have gonorrhea or chlamydia, 76% of LHDs always or

frequently prescribe treatment at the time of the patient's initial visit. However, only 21% of LHDs that treat at the initial visit always receive laboratory confirmation of infection. Because STD surveillance is based on laboratory reports, underreporting of gonorrhea and chlamydia may occur when patients are presumptively treated without laboratory confirmation. In addition, half of the LHDs have to call physicians to ensure that patients were treated because treatment information is not reported by the provider for the majority of patients.

To encourage reporting of cases, most LHDs stay in contact with physicians and laboratories in their jurisdictions. The most common method of physician follow up is phone calls (98%), followed by correspondence (66%), site visits (39%), and provision of summary reports as feedback (16%). Labs are also most often contacted by phone (84%) and, to a lesser extent, through correspondence (35%), site visits (26%), and provision of summary reports (7%).

A full report on the survey results will be sent to all LHDs this fall.



# Dioxin Contamination in Midland, Michigan

*Linda Larsen, Ph.D.*

The site assessment team, housed in the Toxicology and Response Section of the Division of Environmental and Occupational Epidemiology, works under a cooperative agreement with the Agency for Toxic Substances and Disease Registry (ATSDR) to conduct public health assessments for sites of environmental contamination. In May of 2001, the ATSDR and MDCH were petitioned by two environmental groups and a local citizen to conduct a public health assessment of dioxin contamination migrating downstream from Midland, Michigan. In March of 2001, MDCH released a Public Comment Release draft Public Health Consultation (PHC) for "Dioxin Contamination in the Tittabawassee River Floodplain South of Midland Michigan." The public comment period ran through June 15th and numerous comments have been received from local officials, the Dow Chemical Company, and private citizens.

Dioxins are a group of 210 chemicals with similar structures and chemical properties. They are the by-products of various industrial (bleaching paper pulp, chemical and pesticide manufacture) and combustion activities (burning household trash, forest fires, and waste incineration). Not all dioxins have the same toxicity or ability to cause illness and adverse health effects. The most toxic chemical in the group is 2,3,7,8-

tetrachlorodibenzo-para-dioxin (2,3,7,8-TCDD). Because it is the most toxic, 2,3,7,8-TCDD is the standard with which other dioxins are compared. The levels of other dioxins measured in the environment are converted to a "2,3,7,8-TCDD" equivalent concentration based on how toxic they are compared with 2,3,7,8-TCDD. These converted dioxin levels are then added together to determine the total equivalent (TEQ) concentration of the dioxins in a sample.

From April of 2000 through the summer of 2002, the Michigan Department of Environmental Quality (MDEQ) conducted soil and sediment sampling in the Tittabawassee River floodplain. Dioxin levels detected in these samples range up to 7,261 parts per trillion (ppt) total TEQs. The ATSDR's screening level for dioxin in soils is 50 ppt. Levels of dioxin in soil below 50 ppt are not expected to cause adverse health effects. The ATSDR's action level for dioxin in soils is 1,000 ppt. Dioxin levels greater than 1,000 ppt indicate the need to consider public health actions to limit or prevent exposures. Dioxin levels between 50 and 1,000 ppt indicate the need for further study and evaluation.

The PHC prepared by the MDCH in March of 2002 was based on the MDEQ investigations up to that time and concluded that there was not enough information to fully define the

public health risk posed by dioxins in the Tittabawassee River flood plain. Therefore, MDCH concluded that the floodplain posed an indeterminate public health risk. ATSDR and MDCH apply the indeterminate category to sites where additional data are needed to make a final public health decision.

The MDCH recommended that the MDEQ conduct further sampling to determine if there is dioxin contamination in the Tittabawassee River flood plain between the city of Midland and the confluence of the Tittabawassee and Saginaw Rivers. Additional sampling was conducted in the summer of 2002 and the results indicate that dioxin levels exceed the ATSDR action level in soil on private property and in public parks throughout the floodplain.

The MDCH is working with the MDEQ and the Michigan Department of Agriculture to address the dioxin contamination in the Tittabawassee River flood plain. A final PHC will be released when all the public comments received on the draft have been addressed and suggestions are incorporated into the document as appropriate. The PHC to address soil contamination is the first step in a much larger health assessment process that will continue to evolve as more information becomes available.

## Upcoming Conferences

**The 12th Annual Information Integration Conference for Community Health will be held March 26-27, 2003 at the Hellogg Hotel and Conference Center in East Lansing, MI. Registration materials and exhibitor and advertising opportunities will be posted at [www.malph.org](http://www.malph.org) under "events." Please contact Julie Zdybel with the Michigan Association for Local Public Health with any questions at: 517-485-0660.**

## Employee Focus: Nancy Tate

If you call the Infectious Disease Epidemiology Section within the Bureau of Epidemiology, you are likely to speak with Nancy Tate on the phone. Tate is one of the administrative assistants for the bureau and has been communicating with the public and assisting the infectious disease staff since December of 1999.

Tate began her career with the State of Michigan in January of 1978 for the Department of Treasury. She worked in several areas including data operations, tax collection, receipts processing, and alternative investments. In December of 1999 she accepted a position with MDCH. Hired under the newly awarded bioterrorism grant, she worked with both infectious disease and bioterrorism staff. With the formation of the new Office of Public Health Preparedness, which the bioterrorism

section is now a part of, Tate's responsibilities lie solely with the Infectious Disease Epidemiology section.

Tate is most well known around the Bureau of Epidemiology for her assistance during the anthrax crisis of last year. This work earned her, along with the other members of the Bioterrorism Section, the Director's Award for Team Excellence in December 2001. She was also heavily involved with the West Nile Virus season this past summer. During those times, nearly 90 percent of her day was spent simply fielding calls from the public and from local health departments.

In addition to this work, she has many responsibilities that keep the Division of Communicable Disease and Immunization running smoothly on a daily basis. She is responsible for processing

travel reimbursements, making travel arrangements, scheduling meetings and maintaining the general office environment. One of the things she enjoys most about her job is planning conferences. Her conference activities include gathering informational materials, planning refreshments, and overseeing registration. Tate has several goals in the coming years, including developing a new employee handbook and working with other secretaries in the division to create a secretarial manual.

Tate and her husband live in DeWitt and have four daughters. She enjoys attending her daughters' sports events, serving on various youth sports committees, entertaining at their swimming pool, working in her flower garden, and taking early morning walks with her husband and two dogs.

## New Employees

**Yvonne Y. Chan, M.D.**, is with the Preventive Medicine Residency Program at the University of Michigan. She will be at MDCH for her practicum through December. Chan is an endocrinologist and internist and was previously a clinical instructor at University of Washington, Seattle, where she did research in neuroendocrinology. She has also undertaken several missions with Médecins Sans Frontières in Africa since 1997.

**Liz Harton** is a CDC Public Health Advisor working with the immunization program in the Division of Communicable Disease and Immunization. She is coordinating state influenza immunization efforts and working on increasing awareness and efforts for all adult vaccination. Additionally, she will be collecting information regarding vaccine safety issues. Harton comes to us from Cleveland, Ohio, after a 10-year stint as a health programs manager for the U. S. Coast Guard in the eight states around the Great Lakes. Prior to that, she worked in the Peace Corps as a health extensionist for immunizations and maternal/child health. She also has

extensive experience in civil rights and employee relations.

**Lesley M. Chace, M.P.H.**, is a CDC Public Health Advisor (PHA) in the immunization program. She has worked 14 years as a PHA in a wide variety of disease prevention programs, at the local, state, national, and international levels. She has been with CDC's National Immunization Program since 1995, most recently working in Colorado. In August, Chace was assigned to work with the City of Detroit Health Department Immunization Program, where she is primarily responsible for managing the Vaccines for Children Program, coordinating quality assurance outreach to over 200 private clinics, and assisting the city's immunization program administrator with overall management and strategic planning.

**Emily Murray, M.S.**, has joined the HIV/AIDS Surveillance Section, working in the Detroit office as a data manager/epidemiologist. She graduated from the University of Florida in 2000 with a B.A. in anthropology. Emily interned at MDCH this past summer in the maternal and child health area of the Division of Epidemiology Services.

She recently graduated from Michigan State University with a master's degree in epidemiology.

**Marianne O'Connor, M.P.H., M.T.**, is a new HIV epidemiologist in the HIV/AIDS Surveillance Section, Detroit office. She will be working on the Evaluation of HIV/AIDS Surveillance Project for CDC. O'Connor is returning to public health after raising her children. She received her M.P.H. in epidemiology lab practice at the University of Michigan in 1985. She was then a senior medical technologist in microbiology at University Hospital in Ann Arbor until 1986 and has spent the intervening years in voluntary capacities including cancer research.

**Joyce Lai, M.P.H.**, joined the Surveillance Section, Division of Communicable Disease and Immunization as the regional epidemiologist for Public Health Preparedness Region II South. This region covers Wayne County, including Detroit, as well as Washtenaw and Monroe Counties. She attended the University of Michigan for her undergraduate studies in cellular molecular biology. After working in a

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gastroenterology immunology laboratory at the University of Virginia, she returned to the University of Michigan School of Public Health for her M.P.H. in hospital molecular epidemiology. She continued expanding her knowledge with advanced graduate work in epidemiology, looking in particular at the immune response to respiratory viruses such as influenza and respiratory syncytial virus.

**Jennifer Beggs, M.P.H.**, was recently hired as the regional epidemiologist providing epidemiological support to Public Health Preparedness Region 7, which contains 18 counties in the upper portion of the Lower Peninsula. She attended the University of Michigan where she received an M.P.H. in May 2002 after completing the Hospital and Molecular Epidemiology Program with a concentration in genetics. For the past two years, she has worked with several influenza-based clinical trials focusing on vaccine and anti-viral drug development. She also has been assisting with influenza surveillance in the Washtenaw County area and in Michigan's nursing homes. Jennifer enjoys volunteering and has worked with agencies such as the Lansing Area AIDS Network and Gateway, a low-income health clinic.

**Michael Kucab, R.S., M.P.H.**, has recently joined the HIV/AIDS Surveillance Section as a perinatal surveillance coordinator. He will

be responsible for pediatric HIV case finding and reporting as well as adult case finding and reporting for the Upper Peninsula and eastern Michigan counties. He was formerly the coordinator for Michigan's CDC Tuberculosis Genotyping Sentinel Site Project, which was limited to a five-year study. The study is shortly due for publication in CDC's Emerging Infectious Diseases Journal. Kucab has a Bachelor of Science from Michigan State University with a major in medical technology and an M.P.H. from the University of Michigan in health policy and administration.

**Naudia Pickens, M.P.H.**, has recently joined the HIV/AIDS Surveillance Section in the Detroit office as the perinatal surveillance coordinator. She also conducts adult surveillance for Lenawee, Monroe, and Washtenaw Counties. Pickens attended Harvard University, and as an Afro-American studies concentrator, she had an opportunity to take several classes at the Harvard School of Public Health. She joined the United States Peace Corps and worked in Burkina Faso, West Africa, as a community health worker for two years before attending the Johns Hopkins Bloomberg School of Public Health. Prior to joining the MDCH team, Pickens worked as an emergency substitute teacher for the Detroit Public Schools.

## Shelley Stonecipher: New EIS Officer

**S**helley Stonecipher, D.V.M., M.P.H., is a new veterinary epidemiologist in the Epidemic Intelligence Service (EIS) of the Centers for Disease Control and Prevention's applied public health training program. Stonecipher began her two-year assignment with the Division of Communicable Disease and Immunization in July 2002. She received both her bachelor's and doctoral degrees from Texas A&M University and her M.P.H. from Tulane University School of Public Health and Tropical Medicine in December 2001.

Stonecipher has been a practicing veterinarian for 10 years in both private practice and with humane societies. She has previously served as an expert witness in cruelty investigations. In 2000, she was the lead veterinarian responsible for the care and management of over 700 animals during a fire disaster. She has also taught elementary school children and lectured with the American Humane Association.

Her interests include the epidemiology of vector-borne diseases, human tuberculosis (TB), and Creutzfeldt-Jakob disease. Currently, she is working on evaluating the TB surveillance system in Michigan, assisting with West Nile Virus case investigations, and participating in a multistate *Listeria* outbreak investigation.

## Publications

**M**ichigan Department of Community Health. Investigations of West Nile Virus infections in recipients of organ transplantation and blood transfusion. *MMWR*. 2002; 51(39): 879.

Ognjan A, **Boulton M**, Somsel P, **Stobierski M**, **Stoltman G**, Downes F, Smith K, Chapman L, Petersen L, Marfin A, Campell G, Lanciotti R, Roehrig J, Gubler D, Chamberland M, **Montgomery J**, **Arole C**. Possible West Nile Virus transmission to an infant through breast-feeding. *MMWR*. 2002; 51(39): 877-878.

**Rafferty AP**, **McGee HB**, **Miller CE**, and Reyes M. Prevalence of complementary and alternative medicine use: state-specific estimates from the 2001 Behavioral Risk Factor Surveillance System. *Am J Public Health* 2002; 92(10): 1598-1600.

**Sidhu KS**, Kimmer RO. Fluoride overfeed at an elementary school in Michigan. *J. Environmental Health*. 2002; 65(3): 16-21.

**Sievert D**, **Boulton M**, **Stoltman G**, **Johnson D**, **Stobierski M**, Downes F, Somsel P, Rudrik J, Johnson W, Mitchell J, Chang S. *Staphylococcus aureus* resistant to Vancomycin. *MMWR*. 2002; 51(26): 565-567.

**Wilkins M**, **Bidol S**, **Boulton M**, **Stobierski MG**, Massey J, Robinson-Dunn B. Human Salmonellosis associated with young poultry from a contaminated hatchery in Michigan and the resulting public health interventions, 1999 & 2000. *Epidemiology and Infection*. 2002; 129(1): 19-27.

## Awards

**S**arah Lyon-Callo M.A., M.S., an asthma epidemiologist in the Division of Epidemiology Services, has been awarded the CDC National Center for Environmental Health (NCEH) Director's Award for Partners in Public Health. This award was presented to Lyon-Callo at the CDC National Asthma Conference in Atlanta, October 23-25. The award recognizes individuals or groups whose epidemiological work adds substantially to the body of knowledge in the scientific and public health community or directly impacts the prevention of disease or the occupational or environmental health of the nation. "Sarah Lyon-Callo serves as a true collaborator in our national effort to control asthma," NCEH said in a statement. "Ms. Lyon-Callo has consistently provided expertise in areas of asthma surveillance and program implementation to other state health departments that are just beginning to develop their asthma infrastructure. We are proud to have such a dedicated professional as a partner in our efforts to reduce the burden of asthma in the United States."

At the biannual Bureau of Epidemiology meeting on June 24, 2002, two bureau awards were given out. The Director's Award for Team Excellence was awarded to the STD Epidemiology Team of Garry Goza, M.S., Dara Ganoczy, M.P.H., Sarah Reagan, M.P.H., and Katie Macomber, M.P.H. The Director's Award for Employee Excellence was given to Executive Secretary Pam Masur.

## Annual regional immunization conferences draw more than 1,200 participants

**T**he six statewide regional immunization conferences held during October attracted more than 1,200 health care professionals. The Michigan Department of Community Health's Immunization Program strives to make this conference accessible to as many health care professionals as possible by taking the one-day conference on a road trip to six cities throughout the state. This year's conferences were held in Gaylord, Marquette, East Lansing, Kalamazoo, Troy, and Ypsilanti.

Presentations included a vaccine update, a session on emergency preparedness, a Michigan Childhood Immunization

Registry update, and a troubleshooting session where a panel of immunization experts answered audience questions on a variety of immunization issues. Speakers included two keynote speakers from CDC (Dr. Sharon Humiston and Dr. William Atkinson), as well as a variety of representatives from the Michigan Department of Community Health, local health departments, and community providers.

For more information, call Rosemary Franklin at 517-335-9485 or Darcy Wildt at 517-335-9486.

## Presentations

**B**ob Swanson and Theresa Hoyle from the Immunization Assessment and Local Support Section presented information on immunization registry certification at the National Immunization Registry Conference, October 28-30 in Philadelphia, Pennsylvania. Swanson spoke during the plenary on the registry certification process. He also presented during breakout sessions on a web-based training program for the Michigan Childhood Immunization Registry (MCIR), assessing community-based immunization levels using an immunization registry, and issues related to moving the registry to the World Wide Web. Hoyle presented on her work with health systems to increase immunization levels in the MCIR.

# MICHIGAN EPIDEMIOLOGY CONFERENCE 2003

March 13 & 14, 2003  
University of Michigan, Ann Arbor

**Day 1: Regional Epidemic Intelligence Service (EIS) Scientific Conference**  
**Day 2: Second Annual Statewide Epidemiology Conference**

Invitation extended to all individuals interested in Epidemiology throughout Michigan. The audience includes those working in state and local governmental health agencies, universities, hospitals, health insurance organizations, research institutes, consulting firms, pharmaceutical companies, and private industries.

Conference will include: presentations, invited talks, posters, MPHA Epi Section business meeting, information booths, job postings, and opportunities for career networking with colleagues in epidemiology and public health. This is a free conference, although registration is required.

### Invited Guest Speaker (Day 2):

Julie Gerberding, M.D., M.P.H.  
Director, Centers for Disease Control and Prevention  
Administrator, Agency for Toxic Substances and Disease Registry

In addition to her role as the Director of the Centers for Disease Control and Prevention, Dr. Gerberding is an Associate Clinical Professor of Medicine (Infectious Diseases) at Emory University in Atlanta. She is also a member of various societies, such as Phi Beta Kappa, American Society for Clinical Investigation, American College of Physicians, Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America. As Acting Deputy Director of National Center for Infectious Diseases, Dr. Gerberding played a major role in leading the CDC response to the anthrax bioterrorism events in Fall 2001. Dr. Gerberding has been with the CDC since 1998.

Sponsors: MDCH Bureau of Epidemiology  
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University of Michigan Department of Epidemiology  
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Michigan Association of Public Health and Preventive Medicine Physicians  
Michigan Association of Local Public Health

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## Second Annual Statewide Epidemiology Conference Registration Form

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Attn: Dawn Sievert, MS; Questions: Mark Schmidt, MPH (517) 335-8165 or Brad Carlson, MPH (313) 870-2735

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