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Texas Public Health Association
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President’s Message
Bobby Schmidt, MEd

Protecting the health and safety of Americans should be the top responsibility of our nation’s leaders. But experts say the country currently does not devote the resources needed to adequately help prevent disease and protect the health of Americans. Consequently, serious gaps exist in the nation’s ability to safeguard health, putting our families, communities, states, and nation at risk.

The nonprofit group Trust for America’s Health (TFAH) reports that public health spending is very uneven from state to state and is eroding in the face of the economic recession. Jeff Levi, executive director of TFAH, said overall public health spending, now about $35 billion a year, is about $20 billion short of what is needed.

A 2005 report by the Task Force on the Future of Public Health in Texas stated that “the health of Texans can be substantially improved through the increase of state resources for the delivery of public health services. A reasonable goal would be to move Texas from the state’s current level of 50% of the national average in per capita public health expenditures to 75% of the national average for such services by the year 2010.” We are now in 2011 and not much closer to this goal. This goal was mainly aimed at monies to support the essential public health services.

Public health advocacy groups must pool their efforts to advocate for increases in funding. This can best accomplished in Texas through advocacy groups such as the Texas Public Health Association (TPHA). Your involvement in TPHA can assist in achieving this task. I again challenge you to double the size of our organization by getting at least one member to join TPHA over the next year. Please see page 25 for information on joining TPHA.


From the Editor:
The Editorial Team of the Texas Public Health Journal hopes you had a great summer! We kick off the Fall 2011 Season with a selection of great Texas-related public health research articles. Proof once again, that we really do amazing public health work all over this big state of Texas. Our Texas DSHS Librarian column features the history of Consumable Safety Programs and ends with a tribute to a long-time and active TPHA member and DSHS Sanitarian, Mr. Rex Sherry. Our Poison Control expert has prepared three very timely articles to keep you informed on potential household hazards. With Fall comes a new semester for students of Texas Schools of Public Health. Read about opportunities for learning public health practice and how you can participate.

Finally, the TPHA News column is full of information on upcoming events including how our TPHA members are participating in the 2011 American Public Health Association meeting and ends with an unbelievable program for the 2012 Texas Public Health Educational Conference. The planning committee for this 2012 conference simply did tremendous work—and there is nothing simple about planning an annual state-wide meeting. We hope you will heed the call for nominations for TPHA awards and leadership positions. Nominate a deserving person for one of our TPHA awards and SERIOUSLY consider nominating yourself or someone else for a TPHA leadership position. Help TPHA continue to KEEP TEXAS HEALTHY! Thanks for reading.
Commissioner’s Comments

Knowing and Protecting

David L. Lakey, M.D.
Commissioner, Texas Department of State Health Services

I was in high school in 1981 when the first cases of a new and devastating disease were identified. The disease struck hard and fast and dominated headlines 30 years ago as doctors, scientists and public health officials frantically tried to figure out what this mysterious affliction was – and what it wasn’t. The disease was Acquired Immune Deficiency Syndrome, or AIDS. As it spread, it destroyed the immune systems of people. Myths and rumors about how AIDS was spread were as widespread as the disease itself.

Since then, our country has made tremendous progress. Medicines were developed to help manage the illness and its symptoms, and the public’s knowledge about AIDS has expanded. At the Texas Department of State Health Services and at the numerous local health departments and community organizations where many of you work or have worked, one of our critical missions is to continue to prevent the spread of AIDS.

We partner with local health departments and community based organizations to provide counseling, testing and partner interventions. Through counseling, people learn how to protect themselves and assess risk, or learn more about their diagnosis and obtain help in finding medical care. One of our key functions is tracking the disease, and we rely on the active surveillance of local health departments to help us report and monitor the disease. We use this surveillance data for epidemiologic assessment, research, evaluation and planning. Health departments large and small can exercise a leadership role with private providers by promoting prevention, routine testing and expedited partner therapy. We all must continue to work together to raise awareness in our communities about the importance of knowing one’s status.

That is perhaps the loudest drum we beat together – know your status. That’s the single most important factor in preventing the spread of infection. People who know they are infected change their behavior. However, as you are well aware, our challenge is that many HIV infected individuals still do not know their status. Furthermore, many do not even consider themselves at risk. More than 99 percent of newly reported HIV diagnoses in Texas are due to unprotected sex or sharing needles with people who are HIV infected, many of whom do not know they are infected.

Once infected with HIV, people typically have five to 10 years before symptoms of AIDS appear. The earlier people know they are infected, the better their own outcome. Most AIDS cases I encountered in my medical practice were diagnosed late in the disease spectrum. Even today, one out of three Texans newly diagnosed with HIV already has AIDS. When people with HIV are diagnosed early, treatment works better and there are more chances to prevent further spread. That’s the motivational message you and I must continue to promote.

We are making progress locally and statewide. The number of new HIV infections has remained stable in recent years, with about 4,500 new diagnoses annually. We know the infection rate among babies has gone down dramatically. The number of Texans dying from HIV/AIDS has stabilized at about 1,300 deaths each year. And the number of people living with HIV/AIDS in Texas is growing by a little more than 3,000 each year. Right now there are more than 63,000 Texans – or one out of every 387 – who are HIV infected.

Texas has had long, solid support from the state Legislature – even in lean economic times such as these – to pursue our goals of raising awareness, reducing the number of new infections and providing medications and other services to those infected. We screen, test and counsel Texans every day for HIV/AIDS.

AIDS is no longer the mysterious disease it was back in 1981. It no longer grabs the headlines as it did back then. But it is still around, and it is still spreading. But thanks to people like you, we have seized the momentum. Let’s keep it. Let’s continue to work hard together to stay on the offensive.
The advent of antiretroviral medications in the late 1980s, and particularly the introduction of Highly Active Antiretroviral Therapy (HAART) in the mid-1990’s, changed the face of HIV and AIDS. An HIV diagnosis was no longer considered a death sentence; people who were HIV positive could now live decades without developing AIDS and had vast improvements in their quality of life, lifespan and productive capacity. Antiretroviral therapy (ART) is currently the gold standard of HIV treatment. The various classes of ART drugs all work to help prevent HIV from systematically destroying the immune system, keeping overall viral loads low and immune system CD4 cell counts high. The issue of when to begin ART in an HIV positive individual is still a cause for debate. Recommendations on the ideal CD4 count to start ART vary, but recent studies are showing that starting therapy earlier can lead to better outcomes for the individual and the public.

**HIV Medications Lower the Risk of Transmission**

The HIV Prevention Trial Network (HPTN), a division of the National Institutes of Health (NIH), suspended their HPTN 052 trial this past May. This two-arm international Phase III multi-year study involved more than 1700 heterosexual serodiscordant couples. It was designed to determine whether starting ART immediately on diagnosis combined with usual HIV care reduced transmission to the unaffected partner more in the treatment group than in the control group in which ART was started only when CD4 counts dropped below a minimum threshold (250 cells/mm<sup>3</sup>) or when an AIDS-defining illness was diagnosed. The study found that HIV positive individuals immediately started on ART had a 96 percent reduction of HIV transmission to their HIV negative partners. In an unusual step, the study was terminated early; continuing the study was deemed unnecessary and would be unethical due to the overwhelming evidence that the ART was preventing transmission. It is known that ART therapy can decrease the viral load of an HIV+ individual, often to undetectable levels, which in turn leads to a better clinical outcome for the patient as well as a decreased chance of passing the virus on to others<sup>11</sup>. The National Institutes of Health (NIH) and the Centers for Disease Control (CDC) recommend that ART should be initiated when a CD4 cell count falls below 350 cells/mm<sup>3</sup>. The recommendation of the American Medical Association<sup>2</sup> between 350 and 500 cells/mm<sup>3</sup>. The World Health Organization raised their suggested threshold from 200 to 350 cells/mm<sup>3</sup> in 2010<sup>4</sup>. The recommended treatment threshold is trending towards higher CD4 levels with the recognition that treatment initiation at a higher threshold is a proven way to improve disease outcome.

**Implementation at the State Level**

The Texas Department of State Health Services (TX DSHS) follows national guidelines on when to start therapy, ranging from 350-500 cells/mm<sup>3</sup>. The individual’s starting CD4 count can make a significant impact on infectivity and morbidity depending on whether treatment was initiated at the high or low end<sup>1</sup>. The State of Texas should support a policy recommending treatment at 500 cells/mm<sup>3</sup>. This sends a message to the healthcare community that they should consider treatment with HIV earlier rather than later. Individuals who screen HIV positive need to be linked to a provider who can help manage HIV from the beginning, as one can already be in this range at diagnosis. From a public health standpoint, this measure can reduce the incidence of HIV, and fewer Texans infected with HIV leads to lower costs incurred and expenditure of resources by the state.

Other studies support this data: earlier treatment of HIV is correlated with lower mortality rates compared to those that start treatment at lower levels<sup>4</sup>. One observational study conducted from 1996-2005 found that waiting to start ART at a CD4 level of 350 cells/mm<sup>3</sup> increased the risk of dying by 69<sup>6</sup>. Earlier treatment will cause an increased financial burden on the Texas HIV Medication Program (THMP), but the decreased risk of dying and decreased infectivity can offset these costs in the long-term. Medications that are prophylactic for both prevention and disease progression help reduce costs on both ends of the spectrum.

The financial aspect cannot not be ignored. THMP had approximately $19 million in expenditures for FY2010, and an additional $9.2 million is requested for FY2012<sup>3</sup>. Costs of treatment average of $4,242 in state funds per person annually when ART is started at 350 cells/mm<sup>3</sup>. There are approximately 68,000 people living with HIV and/or AIDS in the state<sup>10</sup>, and in FY2010, 1,326 new cases of HIV were found in Texas, and of those an estimated 20-25% of will require assistance from THMP<sup>11</sup>.

Research has shown that initiating therapy at 500 CD4/mm<sup>3</sup> had a cost effectiveness ratio of $17,300 per quality-adjusted life-year gained<sup>4</sup>. This value is well below the generally accepted cut-off point which is approximately $40k per incremental life-year. This strategy will require a significant investment up front, but it needs to be examined as an investment in the health of Texans that has the potential to save the state millions of dollars and countless lives. This recommendation for policy is not intended to be the sole means for stopping the HIV epidemic in the state, but it seems to be a feasible way to reduce HIV transmission while increasing the life-expectancy of people living with HIV and AIDS.

**Practical Considerations**

Raising the recommended CD4 count for starting ART has financial and public health benefits, but it is important to remember that the decision to take medications for treatment of HIV ultimately lies with the individual. Many of these medications can cause side effects including diarrhea, nausea, skin changes, and hepatotoxicity<sup>6</sup>. Taking HIV medications is a full-time job; they have the potential to significantly interact with many other drugs, and the individual needs to be vigilant about taking medications. The regimen can be a grueling schedule of pills, often in large quantities. Medication routines and side effects are often cited as reasons why people choose to quit taking HIV medication<sup>6</sup>.

Consistent use of a latex condom is another practice that should always be stressed when interacting with an HIV positive individual. Low or undetectable viral loads brought about by ART can indeed lower the risk of HIV transmission, but are not intended to replace condom usage by any means. Condoms are significantly cheaper than ART without the side effects, but they cannot improve disease outcome for the individual.

It is important to recognize that the feasibility of both medication and condom adherence are points that need to be addressed by all healthcare providers, and the patient and doctor can develop a plan that is best suited to the patient’s lifestyle. The sociocultural aspects of an HIV positive person’s life are every bit as important to consider as their viral load and CD4 counts. As a state Texas can set the standard by recommending the consideration of earlier treatment for those who are HIV positive, and continually strive to make risk-reduction resources available and accessible to all.

TPHA Journal  Volume 63, Issue 4
TPHA Scholarship Recipient Essay 2011
Andrea Kaufman

Whenever I have thought about a career to pursue, I always knew I wanted to help people directly. I know that everybody plays a part in society that is vital to its functioning, but I want to play a role that involves direct communication with those in need. I have a passion for people and understanding the motive for human action. Social work has been my career choice that has met these goals.

I started volunteering at Bexar County Jail the summer after my freshmen year in college. I was thinking about becoming a psychologist working in a prison, so I volunteered at a local jail with a program called faith-based anger management. I went with a few other women and we spent the most amount of time with the illegal immigrants and occasionally with those with behavioral problems. I enjoyed hearing their stories and observing their conditions within the jail.

Two summers ago, I became a member of AmeriCorps, volunteering for 300 hours over the course of four months. I believe that volunteering was what sparked my desire to enter the social work sector of social service. I started my 300 hours of service volunteering with Child and Family Services at a group home in Middletown, RI for ages seven to twelve whose family has in some way neglected them. I played games with them and helped them with their homework during the school year. I continued volunteering with them during my second AmeriCorps term.

I returned to San Antonio for a few weeks during the summer and I began volunteering for the St. Vincent de Paul Society, a food pantry which gives groceries to those in need. Although that is their primary concern, they also help clients pay for rent and utilities. I think it is important to have a food pantry because it allows the clients to experience responsibility in trying to cook on their own and ration their food. Out of all of the places that I have volunteered, this was the one that provided the greatest sense of fulfillment for the community. When I was at Child and Family Services or St. Clare Home, I spent a few hours with each group trying to make their day a little better for them. St. Vincent de Paul addressed one of the most pressing needs of society. It really put Maslow’s hierarchy of needs into perspective.

I returned to Newport for the school year and I began volunteering at the food pantry for the Martin Luther King Jr. Community Center. When I first started there, I helped out with the Thanksgiving and Christmas baskets. Because of the generous giving of the community, we received several donations during this time. I was also in charge of counting the items that we received and organizing them into their respective rooms and shelves. Although I do not work with the clients, I see the duality of the community, both the needs and generosity.

My interest in working with the hungry encouraged me to continue working with them and the homeless. I was placed at a service organization for the homeless in the state in Providence, RI. Here, I provided case management to the clients as they entered the agency. We discussed obtaining their identification; obtaining housing; their physical and mental health; applying for food stamps, disability, and other financial benefits; and we provided clothing, hygiene products, showers, and laundry as needed. In addition, I spent some time advocating for the clients. Some of their most basic needs were not being met. There were many occasions when the staff would not allow the clients to use the restroom. Occasionally, they would use the lobby to do so, providing a dangerous environment for the rest of the clients. I also learned that the men’s restroom’s sink broke and they had no running water to wash their hands; in addition, certain staff members at the agency thought that the clients should not be provided with hand sanitizer because it was flammable. The homeless are limited in the hygiene products as it is. I approached the appropriate individuals in restoring the health needs and social justice of the clients of the agency.

This coming year, I am going to be an intern at Seven Hills Behavioral Health in New Bedford, MA. I am going to do assessments, treatment plans, and evaluations for a large range of individuals who abuse substances. I think this is a step toward my goal in working in the correctional system because of the amount of usage and the effects of withdrawal that inmates engage in before, during, and after incarceration. This summer, I have the fortunate opportunity to volunteer at Turning Around Ministries, an organization based in Newport, RI that provides services to the formerly incarcerated and those in need. We also do home visits to the recently housed individuals who were formerly chronically homeless. In addition, we travel to the Adult Correctional Institute in Cranston, RI to educate the inmates about the services that we provide.

Receiving this scholarship would allow me to continue my final year of my MSW program without worrying about how to fund my education. It will allow me to practice social work while improving public health.
ABSTRACT

The journey toward public health agency accreditation in the United States began with the 1988 Institute of Medicine (IOM) Study for The Future of Public Health. In 2010, the Public Health Accreditation Board (PHAB) completed the beta test on the voluntary national public health accreditation program. Part I of this series summarizes the history of the development of the public health accreditation process in the United States. Part II examines public health agency accreditation pros and cons and reviews the quantitative and qualitative research and quality improvement data to answer the questions: “To what extent does voluntary public health accreditation improve quality, outcomes, and service operations?” and “Can the public health accreditation standards apply equally to both large urban and small rural local health departments?” The authors determined the literature provided some degree of quantitative, qualitative and quality improvement evidence that accreditation can improve quality, outcomes, and service operations. However, there was limited evidence that small local health departments will be able to meet the same accreditation standards as large urban health departments without some accommodations.

Key terms: public health accreditation

Growing health threats and limited resources are plaguing the public health system.1 Public health services across the nation and within individual states are inconsistent and unpredictable.2,3 In an effort to improve quality, service value, and boost an organization’s visibility and competitiveness, many health and social service organizations have developed accreditation programs.4 Public health has followed suit and through the Public Health Accreditation Board (PHAB) is in the process of completing an accreditation program for state and local health departments. This article reviews the public health agency accreditation quantitative and qualitative research and quality improvement literature.

Review of the Public Health Accreditation Literature

A review of the public health and social services accreditation literature5-9 and private sector accreditation literature8 was conducted to answer the questions, “To what extent does accreditation improve quality, outcomes, and service operations?” and “Can the public health accreditation standards apply equally to both large urban and small rural local health departments?” Mays reported the “findings from 6 of 9 observational studies and 2 of 2 experimental studies which provide supportive evidence that accreditation programs have positive effects on the service quality, operations and outcomes of the organizations undergoing accreditation.”10 Mays concluded the studies reviewed moderately supported that accreditation is beneficial. Measuring the impact of public health interventions on community outcomes has been difficult, but The Guide to Community Preventive Services provides evidence of intermediate interventions resulting in positive outcomes.1 Hamm reviewed 14 private sector accreditation programs (listed in Table 1) and concluded the private sector pursues accreditation to improve quality “in their respective fields” and to promote wide-range and long-term institutional change to improve quality and performance.4

The RWJF and CDC’s Exploring Public Health Accreditation Project’s finance and incentive workgroup’s aim included identifying costs, funding, and incentives for a voluntary public health accreditation program.3 The workgroup conducted a survey to determine potential accreditation fees in which 37 state health officials and 215 local health officials reported available funds and perceived benefits would affect the fee their health departments would agree to pay. The authors did not identify the respondent’s perceived benefits, other than the belief accreditation will improve outcomes. Thirteen percent of the state health departments surveyed stated they could pay $10,000 or more and 25% of the LHDs agreed they could pay $5,000 or more for accreditation fees.7

In 2004, Thielen interviewed public health leaders from key organizations (NACCHO, ASTHO, APHA, NLDOH, CDC, and state and local health agencies) to assess their opinions on accreditation and their existing state or local evaluation programs. The state and local programs reviewed included: Michigan: From Contract Compliance to Capacity Assessment; Washington: A long History of Accountability; Missouri: A Voluntary Model; North Carolina: Starting with a Pilot Project; Illinois: A Case of Continuous Improvement; New Jersey: Adopting a Systems Approach; Ohio: Using Standards; and Florida: A Centralized Approach Using Quality Management. For example, North Carolina piloted a state accreditation program in six local public health organizations. The 10 essential services of public health and core functions are the foundation of their accreditation model, which concentrates on infrastructure rather than specific programs. The accreditation program assesses the LHDs disease reporting system, not just the vaccine preventable disease or the sexually transmitted disease reporting components. The model operates with one “uniform set of standards.”13 The North Carolina legislature supported the process by providing $50,000 to the Advisory Board and $50,000 to the participating health departments. Thielen reported the following: more LHDs engage in activities that could result in accreditation than state health departments; local leadership appears to drive success; state monies support most LHD accreditation activities; the public health 10 Essentials and NPHPSP sway activities; terminology affects acceptance; and consensus within public health leadership for the “vision for a national accreditation program” does not exist. The existing public health programs in the United States (listed above) differed related to mandatory or voluntary participation, self-reporting or third party evaluations, and use of standards or accreditation.8

The review of the literature also included editorials and opinion surveys, which presented arguments both for and against public health accreditation. Multiple authors stated public health accreditation would improve quality,4,6,8,10,11 improve accountability,1,9,10,12 result in consistent and reliable measures7,9 strengthen public health law,11-12 and boost the organizations visibility.9,13 Russo stated the expected potential benefits of accreditation in an editorial but provided no empirical evidence to support the proposed benefits. Brewer et al.14 conducted a qualitative study to identify the lessons learned from the five Multi-State Learning Collaborative (MLC) states (Illinois, Michigan, Missouri, North Carolina, and Washington) participating in the RWJF initiative to improve the public health department’s current performance and capacity assessment or accreditation programs. The researchers interviewed 15 individuals (seven from state health departments, six from public health institutes, and two local health department representatives) and asked seven open-ended questions. The questions related to pursuing accreditation and accountability programs, the foundation for their program, the established stan-
Concerns, barriers or challenges cited in the accreditation literature included: cost including staff time and resources; bureaucratic exercise without meaningful outcomes; and lack of recourse for those who do not pass. Bender et al. identified the following obstacles to accreditation: differences in health department structure/operations, distrust related to potential standards and accreditation review processes, decrease in standing for non-accredited entities, issues reaching accreditation with limited organizational capacity, political issues, possible impact on LHD funding, and apprehension about federal mandates for accreditation. Wholey et al. put forward six reasons accreditation could be detrimental including: 1) focuses on function and not content; 2) evidence base is weak; 3) costs may override advantages; 4) may have inadvertent effects; 5) limited recognition of workforce content; and 6) may not correspond with LHDs financials. The authors call for a debate about these issues.

Challenges to implementing successful QI measures in public health departments are numerous. They include the need for understandable and agreed upon measures, consideration for obstacles related to health department size, difficulty shifting from problem assessment to QI, current standards are broad and focus on systems, the need to collect the correct data for QI processes, and the breadth and scope of public health practice. Davis, Solomon, and Gorenflo surveyed 66 LHDs to determine the resources necessary to engage in QI activities and to produce best practice scenarios. The study identified that LHDs do not use formal QI processes, public health QI resources are useful, on-site help is appreciated and research related to QI sustainability and institutionalizing QI is necessary.

Baker et al. asked the questions, “Can voluntary accreditation move public health toward QI?” and “Has public health overrated accreditation’s benefits for quality?” The authors address the questions by proposing four ideas to structure further debate on the association between QI and accreditation. One, QI is a fundamental function of health departments as part of or separate from the voluntary accreditation process. Two, QI is essential to accreditation’s purpose and QI must be an integral part of the accreditation design. Three, the QI program must be separate but associated with accreditation. Four, to distribute QI endeavors through accreditation, public health leaders must develop QI responsive policies and systems.

In 2008 NACCHO surveyed 545 LHD’s QI status and related QI activities. In the past two years, 55% of the participants conducted formal QI activities. In the previous three years 70% engaged in QI activities. The authors believe the decline is most likely related to changing the vocabulary on the questionnaire (adding the quantifier “formal” to QI activity questions). LHDs serving small jurisdictions are less likely to conduct QI activities than LHDs serving large populations. QI activities are less likely in LHDs governed by local governments than in state governed LHDs. Small LHDs governed by local governments are less likely to train QI managers and staff and to use standard QI frameworks and tools. The authors attribute the differences to the small LHDs limited staff with similar occupations. They identified a need for more research into predictors and potential obstacles to QI programs in LHDs. For example, determine the role LHD size and workforce composition play in QI adoption.

The literature reviewed less evidence to answer the second question, “Can the public health accreditation standards apply equally to both large urban and small rural local health departments?” Mantone addressed the issue of whether public health accreditation standards can apply equally to both large urban and small rural LHDs. However, there was some evidence stating LHDs engaged more in activities that may result in accreditation than state health departments and state monies support most LHD accreditation activities. A significant difference exists between the amount of accreditation fees LHDs would be willing to pay compared to state health departments. Currently, there is no differentiation between the accreditation standards for rural and urban LHDs regardless of differences in size. Whether small LHDs with fewer than 20 employees can conduct the same tasks and meet the same standards as LHDs with 100 or more employees has yet to be determined. Russo believes accreditation provides a mechanism to advance regionalization across public health jurisdictions. Small LHDs with limited staff and resources may not have the capacity to meet the comprehensive accreditation standards. Regional agreements may increase efficiency and effectiveness without forcing agency consolidations and creating political obstructions. Both Kansas and Massachusetts are in the process of addressing this issue.

DISCUSSION

This review of the Public Health Accreditation literature was designed to answer two questions: “To what extent does voluntary public health accreditation improve quality, outcomes and service operations?” and “Can the proposed public health accreditation standards apply equally to both large urban and small rural local health departments?” The literature provided some degree of quantitative and qualitative evidence to assume a positive effect of accreditation’s effect on public health. The literature also identified public health agency accreditation pros and cons, and favored a voluntary public health accreditation program.

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and New Hampshire) are employing QI methods to increase health improvement planning capacity and processes. For example, one county health department is guaranteeing the Health Improvement Plan has a measurable objective for every strategic issue. Gillen, et al.22 concludes QI teams (consisting of state and local health depart-
ments and vital partners) using leadership, QI tools and methods can solve public health problems and “raise the standard of public health practice to a level where accrediting the work of the public health department has a firmer, more evidence-based, and solid founda-
tion.”22 The MLC project implies a robust connection exists between accreditation and QI, which strengthens accreditation and improves public health infrastructure and outcomes.22

The Beta Test PHAB accreditation standards and criteria do not consider LHD size, which may compel small rural LHDs applying for accreditation to regionalize or establish memorandums of under-
standing (MOU) or create agreements with larger state or regional health departments to meet the standards. One approach would be to adapt models developed in other states for accreditation of small LHDs. For example, Missouri has a voluntary LHD accreditation program fully operational since 2004. The 10 Essential Services of Public Health provide the foundation for the standards and criteria.7 A not-for-profit organization manages the accreditation process, which includes self-assessment tools, fees ranging from $2,000-$4,450, and an evaluation of program’s infrastructure versus using a program system approach. The model includes three levels of accreditation (primary, advanced, and comprehensive), which accommodate for differences in LHD size.7 The Missouri Primary Local Public Health Agency Accreditation allows smaller health departments in rural geographic areas to meet accreditation standards.21 The smaller a-
genies must conduct some components of all 10 essential public health services and maintain a qualified core staff including an administra-
tor, public health nurses, environmental public health specialist, and support staff. In addition, a physician and public health staff with expertise in health education, nutrition, computer technology and epidemiology must be accessible to the health department staff.24

The Washington State Public Health system revised their 2011 Ba-
sic Set of Public Health Standards to compensate for health depart-
ment size and structure.21 The Basic set includes 20 standards and 35 measures compared to the larger health department’s 24 standards and 79 measures. The Basic Set is a “stopgap” measure until more information on the challenges of organizational structure and size and its’ impact on accreditation is obtained.21 The PHAB Beta Test project did not compensate for LHD size and has not yet reported on any difficulties that may occur with smaller LHDs in meeting the accreditation standards. To further study the issue of applying accreditation standards equally to very small or very large health de-
partments PHAB scheduled a Large City/Metro Think Tank in May 2011 and plans to conduct a Small/Rural/Multi-jurisdictional Think Tank in early summer 2011.

CONCLUSION

In conclusion, the literature provided some degree of quantitative data supporting the question of whether accreditation improves qual-
ity, outcomes, and service operations, but primarily provided a list of pros and cons, editorials, and opinion surveys. The MLC22 best practices data does lend credence to the belief accreditation improves quality, outcomes, and service operations. One can deduce accre-
dititation improves quality, outcomes, and service operations from the MLC examples because QI processes can positively impact quality, outcomes, and service operations and QI is an integral part of accred-
ditation. Applying this reasoning to a voluntary national accreditation process whose standards focus on system, not program processes, may increase the likelihood of improved outcomes and consistent service operations. This leads to a potential conclusion that if a LHD meets the PHAB standards and criteria, its’ quality, outcomes, and service operations may improve because of increases in infrastruct-
ure, QI policies and procedures, and consistent and predictable ser-
vice operations.

The second question of whether public health accreditation can apply equally to large urban and small rural health departments was not addressed in the various organizational documents leading to the development of the PHAB process. The exceptions were Mays et al.1 who identified the need to evaluate the accreditation and perfor-
ance standard’s effect and for research to take into account a health department’s size and configuration7 and the Missouri and Wash-
ington State accreditation models, which support the belief that small LHDs will not be able to meet the same standards as large urban LHDs. It is apparent small rural LHDs do not have the same capacity as large urban LHDs, and it is logical that accreditation standards and process should reflect these differences. As a small rural health department reviewing the Beta Test PHAB standards and conducting a gap analysis, the Andrews County Health Department in Andrews, Texas does not have the capacity to meet the PHAB standards. One option is regionalization or partnering with a larger LHD or the Texas Department of State Health Services (DSSH) to provide the expertise and services not available at the local level. Major issues with this scenario include jurisdictional control, funding, and politics. Addi-
tionally, for Andrews County Health Department the nearest large LHD to partner with is 320 miles away.

PHAB is in the process of evaluating the state, LHD, and Tribal health department accreditation standards. Because the PHAB stan-
dards are not finalized, small health departments will have to wait on the final accreditation standards to determine their individual capacity to achieve accreditation. More quantitative and qualitative research is necessary to describe the small LHDs experience with the PHAB (2009) accreditation process, to determine barriers, strat-
egies, and best practices related to preparing for and implementing the PHAB accreditation standards and documentation.

REFERENCES


2. Beitsch LM, Mays G, Corso L, Chang C, Brewer, R. States gathering mo-


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Table 1
Private Sector Accreditation Examples*

<table>
<thead>
<tr>
<th>Association of Museums (AAM)</th>
<th>American Camping Association (ACA)</th>
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<tbody>
<tr>
<td>Accreditation Program American National Standards Institute (ANSI)</td>
<td>Personnel Certification Accreditation Program American Speech Hearing Association (ASHA)</td>
</tr>
<tr>
<td>Accreditation Program Accrediting Council for Continuing Education and Training (ACCET)</td>
<td>National Association for the Education of Young Children (NAEYC)</td>
</tr>
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<td>Accreditation Program Commission for Accreditation of Law Enforcement Agencies (CALEA)</td>
<td>National Association of Insurance Commissioners (NAIC)</td>
</tr>
<tr>
<td>Accreditation Program National Committee for Quality Assurance (NCQA) Joint Commission (formerly JCAHO)</td>
<td>The United States Chamber of Commerce (USCC) Accreditation Program.</td>
</tr>
<tr>
<td>The U.S. Department of Education</td>
<td>Underwriters Laboratories, Inc.</td>
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<td>Malcom Baldrige National Quality Awards Program</td>
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Implementation and Evaluation of a 2-1-1 Texas Awareness Campaign
Cassandra S. Diep, MS1, Elizabeth Kaster, MS1, Brittany Rosen, MEd, CHES1, Cortney Thomsen, BS, CHES1,
Matthew Lee Smith, PhD, MPH, CHES2
1Department of Health & Kinesiology, Texas A&M University
2Department of Health Promotion and Behavior, College of Public Health, University of Georgia
Department of Social & Behavioral Health, School of Rural Public Health, Texas A&M Health Science Center

ABSTRACT
Background: There are several populations considered to be underserved in the United States, especially in rural and disadvantaged areas, where health services and resources are limited and geographically dispersed. To combat these issues, federal and state governments have developed 2-1-1 Texas, a toll-free public resource for information retrieval and referral to health services (e.g., food, housing, employment, healthcare, counseling).

Objective: To assess awareness and utilization of the 2-1-1 Texas service on a large university campus in Texas.

Methods: Members of a university-sanctioned student organization distributed promotional items to tailgating fans before a college football game between two Texas teams. Members approached fans to inquire if they had ever heard of or used 2-1-1 Texas, recorded individuals’ answers, and asked pre-determined follow-up questions based on a decision tree. Members also educated fans about 2-1-1 Texas and its associated benefits.

Results: A total of 890 fans provided responses. Eighty-eight percent (n=783) of respondents reported they had never heard of 2-1-1 Texas. Of those who were aware of 2-1-1 Texas (12.0%, n=107), 15.9% (n=17) reported having called in the past. Some of the reported reasons for calling 2-1-1 Texas included seeking information about childcare services, recycling locations, drug education, hurricane relief, and free dental and healthcare clinics.

Conclusions: Findings indicate those needing health-related assistance may be unaware of the existence of free or inexpensive services. Despite the widespread availability of 2-1-1 Texas, additional marketing, awareness-raising, and educational events are needed to inform Texas residents about this and other related services.

Key Words (optional): Healthcare services, health promotion, college health

INTRODUCTION
Several populations are considered to be underserved in the United States, especially those in rural and disadvantaged areas, where health services and resources may be limited and geographically dispersed. Texas is no exception. In Texas, 17.5% of the state is categorized as rural, and 15.4% of Texans live below the poverty line. Individuals residing in rural or impoverished areas often lack access to sufficient medical healthcare services. In comparison to urban residents, rural areas have larger proportions of older adults, higher poverty rates, fewer medical professionals, less insurance coverage, and a greater overall need for healthcare management and assistance services. To address the need for healthcare accessibility and availability, federal and state governments have introduced services to improve health service linkages and coordination of health-related resources.

To help the public obtain health services information, the Texas Health and Human Services Commission created 2-1-1 Texas in 2005. The 2-1-1 Texas program is a toll-free public resource for information retrieval and referral to health and human services, which may be called from any land-based telephone line in Texas or Texas-based cellular telephone. Callers may inquire about and obtain information pertaining to a range of health-related issues, including but not limited to free or low-cost dental services; support groups; childcare services; drug and alcohol education; and resources during large-scale emergencies, influenza outbreaks, and natural disasters. In addition to Texas, 27 other states currently provide 2-1-1 services.

In 2009, 2-1-1 Texas received more than 2.4 million calls, up from 2.0 million calls in 2007 and 2.1 million calls in 2008. The call volume per household was lowest in the Texas-Mexico border region and in East Texas (i.e., less than 0.17 calls per household). The highest call volume per household occurred in the Gulf Coast area, San Antonio area, West-Central Texas area, and Dallas-Fort Worth area, where the rate was 2.50 calls per household. Statewide in 2009, the top three reasons for calling 2-1-1 Texas were to inquire about housing and utilities, income support and assistance, and healthcare services.

Although the annual number of calls to 2-1-1 Texas has increased since its initial year of statewide service delivery, 2-1-1 continues to be underutilized despite being free to Texas residents. With a Texas adult population of 17.9 million and 2.4 million calls to 2-1-1 Texas in 2009, only an estimated 13.4% of the Texas adult population used 2-1-1 Texas (i.e., assuming each person only called once). One explanation for the perceived underuse of this service may be a lack of knowledge and awareness about 2-1-1 Texas and the potential benefits it provides. The purpose of this study is to describe an event hosted by a university-sanctioned student organization to bolster awareness for 2-1-1 Texas during a college football game between two Texas teams, assess knowledge about and utilization of 2-1-1 Texas among football tailgaters, and educate the public about how this service may be used and its associated benefits.

METHODS
Design, Sampling, and Study Procedures
Data for this study were collected by undergraduate members of the Alpha Pi Chapter of Eta Sigma Gamma (ESG), a national health education honorary, during the Texas Tech University versus Texas A&M University football game in College Station, Texas on October 30, 2010. This particular game was chosen because most attendees were assumed to be Texas residents. ESG members recruited a convenience sample of tailgating fans in designated tailgating areas around the Texas A&M campus. Data were collected during a four-hour period before kick-off. The study received exempt approval from Texas A&M University’s Institutional Review Board.

The graduate ESG members created an evaluation instrument composed of a decision tree, which was reviewed by the Chapter’s faculty advisors. Prior to participant recruitment, graduate ESG members designed a survey protocol and provided a uniform training for undergraduate ESG members to promote data collection fidelity. Graduate ESG members mapped the designated tailgating areas on campus and strategically devised recruitment location assignments for data collection to ensure maximum coverage.

On game day, undergraduate ESG members were paired into groups, given area assignments, and deployed into the tailgating crowd. Paired teams of undergraduate ESG members approached tailgaters with 2-1-1 Texas promotional items, including specially designed 2-1-1 Texas koozies, which were offered as incentives to those who volunteered to participate in the study. Tailgaters were asked if they...
had ever heard of 2-1-1 Texas. ESG members recorded the responses and asked pre-determined follow-up questions based on the decision tree in the evaluation instrument. In addition to answering questions, tailgaters received information about 2-1-1 Texas and its benefits.

**MEASURES**

Data were collected using an evaluation instrument containing a decision tree (see Figure 1). The first item asked, “Before today, have you ever heard about 2-1-1 Texas?” Responses were recorded as yes or no. If the tailgater responded “no,” they were provided a short description about 2-1-1 Texas, how it can be accessed, ways it can be used, and its potential benefits. As a measure of knowledge, these respondents were then asked one of these follow-up questions: “Is 2-1-1 Texas a free service?”; “What is something you could ask 2-1-1 Texas?”; “When calling 2-1-1 Texas, do you need to give your ZIP code?”; or “What is the number to dial to access this free service?” If the tailgater responded “yes” indicating they had heard of 2-1-1 Texas, they were then asked the following two questions: “Where did you hear about 2-1-1 Texas?” and “Have you ever called 2-1-1 Texas?” If the tailgater responded yes to the latter question, they were then asked a final question: “Generally speaking, why did you call 2-1-1 Texas (i.e., for what reason)?”

**Study Sample**

A total of 890 tailgaters provided responses. All tailgaters were eligible to participate, so other than attending the football game, there were no specified criteria for excluding participants from this study. No identifying information was collected, so anonymity was maintained. By responding to the initial question asked, consent was implied for all participants.

**Analytic Methods**

Descriptive statistics were calculated to describe the awareness and use of 2-1-1 Texas among the tailgating fans. Analyses were conducted using Microsoft Excel 2007.

**RESULTS**

The vast majority of participants (88.0 %, n=783) had not heard about 2-1-1 Texas before game day. Of the 12.0% who reported being aware of 2-1-1 Texas, 15.9% (n=17) reported calling 2-1-1 Texas in the past. Among tailgaters who reported being aware of 2-1-1 Texas, reported sources of hearing about the service included work, school, media, medical services, family and friends, governmental entities, volunteering, and miscellaneous. As seen in Table 1, the most frequently reported sources of hearing about 2-1-1 Texas were the media (34.2%), work (17.8%), and family and friends (15.1%).

Figure 1. Decision tree to assess participants’ awareness and utilization of 2-1-1 Texas
Among tailgaters who reported calling 2-1-1 Texas (n = 17), reported reasons for calling included the desire to obtain information or resources about medical, childcare, emergencies, pet care, housing, recycling, and drug and alcohol resources. As seen in Table 2, the most frequently reported reasons for calling 2-1-1 Texas were medical reasons (50.0%) and emergency-related reasons (25.0%), particularly during hurricanes.

Table 1. Sources of awareness about 2-1-1 Texas, October 2010

<table>
<thead>
<tr>
<th>Source Category</th>
<th>Examples</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work</td>
<td>Working for a radio station, working for the state of Texas, co-workers</td>
<td>13 (17.8%)</td>
</tr>
<tr>
<td>School</td>
<td>Flyers, instructors, camps at universities</td>
<td>6 (8.2%)</td>
</tr>
<tr>
<td>Media</td>
<td>Radio, television, newspaper, Internet, advertisements on computer desktops, email, pamphlets, billboards</td>
<td>25 (34.2%)</td>
</tr>
<tr>
<td>Medical Services</td>
<td>Doctor, nurse, clinic, being in the medical field</td>
<td>6 (8.2%)</td>
</tr>
<tr>
<td>Family and Friends</td>
<td>Family, friends</td>
<td>11 (15.1%)</td>
</tr>
<tr>
<td>Governmental Entities</td>
<td>Tax county office, community city council, workforce center, driver’s license office, firemen</td>
<td>5 (5.8%)</td>
</tr>
<tr>
<td>Volunteering</td>
<td>Volunteering organizations such as United Way</td>
<td>1 (1.4%)</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Word of mouth, local connections, not remembering how they heard about it</td>
<td>6 (8.2%)</td>
</tr>
</tbody>
</table>

* Percentages calculated out of 73 responses.

Note. Not all respondents who reported hearing about 2-1-1 Texas before game day (n=107) provided a source, so total n may not sum to 107.

ESG members provided a short description of the service and associated benefits to those who reported being unaware of 2-1-1 Texas (n=783). These tailgaters were then asked to answer one of four predetermined follow-up questions. Over 800 correct responses were documented.

DISCUSSION

We found a vast majority (88.0%) of respondents had never heard about, much less called, 2-1-1 Texas prior to our awareness-raising event. Even though 2-1-1 Texas received more than 2.4 million calls in 2009,\(^4\) this only represents an estimated 13.4% of the Texas population, an amount slightly less than the proportion of individuals who are impoverished (15.4%) or who reside in rural areas (17.5%) of Texas.

Table 2. Reasons for calling 2-1-1 Texas, October 2010

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Examples</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Dental services, free dental services, health clinics, specialized doctors, medical problems, mental health services</td>
<td>6 (50.0%)</td>
</tr>
<tr>
<td>Childcare</td>
<td>Childcare services</td>
<td>1 (8.3%)</td>
</tr>
<tr>
<td>Emergencies</td>
<td>During a hurricane</td>
<td>3 (25.0%)</td>
</tr>
<tr>
<td>Pet care</td>
<td>Pet (exactly what reason regarding his or her pet was not documented)</td>
<td>1 (8.3%)</td>
</tr>
<tr>
<td>Housing</td>
<td>Available housing, what services and resources are available to those who moved</td>
<td>2 (17.7%)</td>
</tr>
<tr>
<td>Recyling</td>
<td>Recycling locations</td>
<td>1 (8.3%)</td>
</tr>
<tr>
<td>Drug and alcohol resources</td>
<td>Drug education, alcohol awareness</td>
<td>2 (17.7%)</td>
</tr>
</tbody>
</table>

* Percentages calculated out of 12 responses.

Note. Not all respondents who reported calling 2-1-1 Texas before game day (n=17) provided a source, so total n may not sum to 17.

As found in our study, promising avenues for increasing awareness about 2-1-1 Texas include media, work, and family and friends. These methods of communication may be particularly effective for underserved Texans or those residing in rural areas because they may be sources typically encountered by these populations. Media channels, particularly television and radio, can reach a large number of geographically-dispersed residents and populations. Radio has been shown to be an effective method of increasing listeners’ health-related knowledge and intentions to change health behaviors,\(^5,9\) so it may be a valuable mechanism for promoting local health resources such as 2-1-1 Texas. Also, because this service is also accessible via the Internet, future studies may investigate accessibility and use of the service via Internet-based technologies, including smartphones and portable devices. To increase awareness and utilization among Texans, we recommend 2-1-1 Texas improve their online presence.
by promoting the program with social media such as Facebook and Twitter.

Although only six people indicated hearing about 2-1-1 Texas from medical service sources, medical reasons were among the top three reported reasons for calling the service statewide in 2009. The small number of our study participants reporting hearing about 2-1-1 Texas from medical-related sources seems intuitive because those with access to healthcare may not require this 2-1-1 service when compared to their counterparts with limited healthcare accessibility. However, healthcare-related entities, especially those that are subsidized, have potential to initiate additional efforts to increase awareness of this service within clinic, hospital, or healthcare settings. Further, opportunities exist for physicians to recommend 2-1-1 as a resource to their patients to learn about additional community-based services or to use it as another referral avenue. Efforts to increase awareness about 2-1-1 Texas among physicians, nurses, and other healthcare professionals may be necessary and valuable.

Limitations
Several limitations of the study must be acknowledged. Although this study was intended to be purely descriptive, we were unable to pilot test the instrument prior to full implementation; this limited our ability to determine the validity and reliability of data collected with our instrument. Responses provided by tailgaters were documented by tally marks and reported in aggregate. Each study participant did not have an independent record, so count data were used. Further, because ESG members frequently approached groups of tailgaters rather than interacting one-on-one, accurate documentation of each participant’s response may have been compromised.

This study used a convenience sample of tailgaters at one football game at one university campus, so the study sample may have differed from other groups of Texans and results may not be generalizable beyond this sample. Additionally, collecting data on a college campus may have introduced inherent bias because our participants may have been more educated or had more insurance coverage than other Texas population groups. Finally, our study used cross-sectional data and participants were not monitored over time to determine if our initiative altered their use of 2-1-1 Texas. Although the effectiveness of our effort could not be determined, that consideration was beyond the scope of our study.

Implications
We believe this is the first study to examine awareness and use of 2-1-1 Texas. Despite the study’s limitations, it provides important evidence about the need for increasing awareness of the service. Findings from our study suggest conducting awareness-raising campaigns during large events can be effective because of their ability to reach a large number of people in a limited time. Findings also suggest brief education can increase knowledge about the utility of this service. We recommend that similar awareness-raising campaigns be conducted during sporting events, university-sponsored service projects, fraternity and sorority events, and community events (e.g., 5k fun runs, fairs, and festivals). Further, using university-sanctioned student organizations (such as Eta Sigma Gamma) shows promise for initiating similar awareness-raising events; such groups have members with the basic competencies required of public health and health education professionals. Student-driven events can raise awareness beneficial for public health while giving students practical opportunities to apply and develop skills associated with research, teaching, and community service.

CONCLUSION
Residents in rural and underserved areas lack access to health services and resources. Despite the widespread availability of 2-1-1 Texas, those needing health-related assistance may be unaware of the existence of free or inexpensive health and human services in their area. Services such as 2-1-1 Texas are important for coordinating services and agencies and connecting people to much-needed resources. Campaigns to raise awareness may capitalize on media outlets and increase awareness through medical settings. In addition, awareness-raising events may be initiated by university-sanctioned student organizations to target events with large audiences. Although underutilized, 2-1-1 Texas has the potential to serve millions of Texans. There is great need to increase awareness about this service as a community resource, especially in rural areas and among underserved populations with limited access to care.

REFERENCES
ABSTRACT
The purpose of this pilot study was to assess safety hazards in the homes of older Mexican Americans living in underserved low-income neighborhoods known as colonias in a Texas-Mexico border area. This was a cross-sectional, non-randomized exploratory study with a sample of 60 Mexican American families with an older relative living at home 50 years of age and older. Certified promotoras (community health workers) conducted face-to-face interviews and used a direct observation assessment tool. The majority of households with an older person (63.3%) did not have smoke detectors or fire extinguishers (80%). The number of home hazards was presented in seven categories and the associated hazards items ranged from 2 to 6 for each category. More than one-third of homes with an older person (36.6%) had one to three home hazards and 24.9% from four to 6 hazard items. Unsafe characteristics of the households included hazardous floors (slippery surfaces (27.6%) and loose mats (26.2%) and bathrooms (no grab rails (64.9%), no slip resistant mats (52.6%), and having toilets not being close to the bed (19%)..

The study results suggest that many older border Mexican Americans are living in potentially hazardous home environments in the colonias. This population is at risk of unintentional injuries due to inadequate home safety practices. Home safety education initiatives are critical to empower this vulnerable population in improving the safety of their homes.

Key terms: home safety, colonias, elderly, home environmental hazards.

INTRODUCTION
Unintentional falls are the leading cause of nonfatal injury among adults 50 years and older in the United States. The prevalence of fall injuries in this age group nationwide was 46% and it is estimated that 64,000 persons 50 years of age and older die every year due to a fall. In Texas, falls account for 37.1% of unintentional injuries and are a leading cause of death in older adults. In 2007, more than 50,000 adults 50 years of age and older in Texas were hospitalized due to a fall. Some studies have found that older Hispanics have similar fall rates when compared to their non-Hispanic white counterparts with a prevalence of falls as high as 31.8% among older Mexican Americans.

The built environment, including hazards in homes, is one of the most main factors of falls among older adults. Most common home hazards that result in accidental injuries include slippery and obstructed pathways, inadequate lighting, unstable furniture, and clutter in hallways. Research shows that home safety interventions reduce falls among those with history of falls and result in participants following recommendations and making safety changes in their homes. Although research suggests that a key component in management of falls risks in adults is minimizing home hazards there is paucity of studies assessing the home environment among adults to determine falls-related safety levels.

The purpose of this study was to investigate safety hazards in the homes of Mexican American adults 50 years of age and older living in impoverished neighborhoods known as colonias in South Texas.
cluded in the study and completed the assessment. A majority of the participants were Hispanic and born in Mexico. The mean age of respondent was 61.31 ranging from 50 to 89. Most participants were female, married, and uninsured. Of those who were born in Mexico (91.7%), almost half reported to have lived in the U.S. for more than 20 years. A majority of participants had less than a high school education and of those, 88% had completed 5th grade or less. More than half of participants (59.3%) reported an annual income of less than $9,999. Only 8.6% of respondents reported to have suffered a fall-related injury in the past year.

**Table 1. Demographics of Participants**

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<th>Sex (n=60)</th>
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<td>55-64</td>
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<td>65-74</td>
<td>13</td>
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<td>75-84</td>
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<tr>
<td>85+</td>
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<td>11-19</td>
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<td>26.4%</td>
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<td>&gt; 20</td>
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<td>49.1%</td>
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<td>Non-Hispanic</td>
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<td>23.3%</td>
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<th>Education</th>
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<td>&lt; High School</td>
<td>50</td>
<td>83.3%</td>
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<td>&gt; High School</td>
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<td>Insured</td>
<td>18</td>
<td>30.5%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>41</td>
<td>69.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; $9,999</td>
<td>35</td>
<td>59.3%</td>
</tr>
<tr>
<td>$10,000-$19,999</td>
<td>17</td>
<td>28.8%</td>
</tr>
<tr>
<td>&gt; $ 20,000</td>
<td>7</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameron</td>
<td>26</td>
<td>51%</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>25</td>
<td>49%</td>
</tr>
</tbody>
</table>

**Demographics of Participants**

We identified seven categories of hazards and associated hazard items ranged from 2 to 6 items for each category in Table 2. Respondents were more likely to report hazardous floors and bathrooms. In the floor hazard category, the most frequently reported hazard item observed was slippery floor surfaces (27.6%) followed by loose mats (26.2%). The bathroom category had the highest number of home environmental hazards, such as not having grab rails (64.9%) or slip resistant mats (52.6%), and the toilet not being in close proximity to the bedroom (19.0%). Of all 25 hazard items to which the participants replied ‘Yes’ or ‘No,’ 40% (10 items) had hazard prevalence rates more than 25%. Of those, 6 hazard items had a prevalence rate of more than 50%. Table 2 also shows a summary of the number of hazard items per household. More than one-third of the homes (36.6%) presented one to 3 home hazard items and 24.9% from four to 6 hazard items. Only a few homes (8.4%) presented from seven to 10 hazard items.

**Table 2. Home Safety Assessment**

<table>
<thead>
<tr>
<th>Number of Hazard items per household **</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>10 (16.7%)</td>
</tr>
<tr>
<td>1-3</td>
<td>22 (36.6%)</td>
</tr>
<tr>
<td>4-6</td>
<td>15 (24.9%)</td>
</tr>
<tr>
<td>7-10</td>
<td>5  (8.4%)</td>
</tr>
</tbody>
</table>

* Considers only the number of respondents who replied ‘Yes’ or ‘No’, excluded responses with missing values or ‘not applicable’

** Out of a total of 19 hazard items; The excluded items were ‘difficulty with toilet transfers,’ ‘difficulty with bath transfers,’ ‘difficulty with shower transfers,’ ‘difficulty carrying meals,’ ‘hazardous paths,’ and ‘poorly fitting shoes.’

The relationships between socio-demographic characteristics and the number of households exposed to one or more hazard items are shown in Table 3. Relative to younger participants (50 to 64 years of age), participants aged 65 or older were more likely to be exposed to the furniture hazard category (4.9% vs. 27.8%, p<0.05) and storage hazard category (2.6% vs. 22.2%, p<0.05). Compared to participants who have lived in the U.S. less than 20 years, participants who have lived more than 20 years in the U.S. were more likely to live in a house with the floor hazard category. Participants with no health insurance were less likely than those who were insured to be exposed to the furniture hazard category in their house (2.4% vs. 33.3%, p<0.05).

**DISCUSSION**

This study assessed home environmental safety hazards among older Mexican Americans living in colonias in the Texas-Mexico border region. Our findings are consistent with other research studies reporting similar number of hazards per home and bathrooms as the most hazardous area.13 Research shows that home hazards reduction is effective if targeted to older individuals with history of falls and mobility limitations.8 Another study reported that the number of haz-
ards in the home increases as the odds of injuries requiring medical attention increase.\textsuperscript{9} Reduction in environmental hazards can be accomplished using a multifactorial approach \textsuperscript{14} in older people homes that decreased the risk of falling.

Several limitations were presented in this study such as the small size of the targeted population and there was a limitation in getting permission from a number of participating households to assess bathrooms and bedrooms which resulted in missing information for some of the hazard categories.

Due to limited financial resources many families in the border region lack of fire extinguishers and smoke detectors despite that Texas State laws require having them at home. Many older border Mexican Americans are living in potentially hazardous environments. Home safety education initiatives are critical to empower this vulnerable population in improving the safety of their homes.\textsuperscript{15} Further research in home safety education targeting low-income older Mexican Americans along the border is warranted. Also, due to the fact that many colonias have inadequate infrastructure (e.g. Lack of electricity and potable and/or running water, plumbing issues, and other housing conditions that could cause pest infestations) which this study did not investigate, additional sanitation studies are needed to examine the hazardousness of these infrastructure-related factors and their effects on the health status of colonias residents.

Findings from this exploratory study have important implications for housing policy makers due to the number of hazards identified in the households targeted which are a potential risk for injury in elderly. Furthermore, the priority of factors in this specific population is: floor, mobility, bathroom, light, furniture and storage.

There is a need to enforce home regulations to decrease the number of risk hazards that can contribute to falls in vulnerable populations such as the elderly. In order to achieve that milestone there is a need for evidence-base housing hazard assessment prevention programs for economically, socially disadvantaged communities such as colonias in South Texas.

**ACKNOWLEDGMENTS**

This research was supported by the Texas A&M Health Sciences Center, South Texas Center, and Texas A&M School of Rural Public Health.

**REFERENCES**


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FEDERAL DISASTER ASSISTANCE BROADENED TO INCLUDE FIVE MORE TEXAS COUNTIES

AUSTIN, Texas - People in Colorado, Houston, Leon, Travis and Williamson counties in Texas whose homes or businesses were damaged or destroyed as a result of the recent wildfires can now register for federal and state disaster assistance. Residents in Bastrop, Colorado, Houston, Leon, Travis and Williamson counties can register for assistance online at www.disasterassistance.gov, via smartphone at m.fema.gov or by also calling 1-800-621-FEMA (3362) or (TTY) 1-800-462-7585. If you use 711-Relay or Video Relay Services (VRS), call 1-800-621-3362. FEMA's mission is to support our citizens and first responders to ensure that as a nation we work together to build, sustain, and improve our capability to prepare for, protect against, respond to, recover from, and mitigate all hazards. Follow us on Twitter at http://twitter.com/#!/femaregion6, the R6 Hurricane Preparedness website at www.fema.gov/about/regions/regionvi/updates.shtm and the FEMA Blog at http://blog.fema.gov.

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TDEM: 512-424-2138
SBA: 916-764-9917

TPHA Journal Volume 63 Issue 4 17
ABSTRACT
The National Cancer Institute (NCI) has developed a framework for estimating the cost of cancer care using linked data from Surveillance Epidemiology and End Results (SEER)-Medicare databases. However, for states that are outside of SEER areas and for those lacking cancer registry-claims linked data, using the NCI framework presents a challenge. We illustrate an adaptive use of the NCI method with Texas as an exemplar. We estimated that for 2007 the cost of cancer care in Texas was $7.7 billion; approximately $1.0 billion for lung/bronchus cancer, $1.1 billion for colorectal cancer, $955.5 million for prostate cancer, and $923.7 million for breast cancer. Our estimates include the cost of care associated with eighteen common cancer sites as well as costs for each Health Service Region (HSR) in the state. This study is the first to estimate cancer care costs using Texas Cancer Registry (TCR) incidence data, which currently meet national high quality data standards. The study demonstrates that it is feasible for a state to estimate the cost of cancer care using an adapted NCI method and state cancer registry data. This method can be used to examine issues related to cancer costs, including regional disparities in the cost of care.

INTRODUCTION
As the growth of national health expenditures outpaces inflation and the growth in Gross Domestic Product,1 cancer costs are expected to increase at a faster rate than overall medical expenditures.2 According to a National Institutes of Health analysis, national costs for cancer care was estimated to be 125 billion in 2010 and are projected to reach at least $158 billion (in 2010 dollars) – an increase of 27 percent over 2010.3 Factors contributing to the increased cost of cancer care include: (a) population growth, (b) aging of the population, (c) medical price inflation, and (d) the development of more advanced and more expensive treatments.2, 3

In recent years, national efforts to evaluate the costs of cancer have been documented. For example, the National Institutes of Health estimated the overall costs of cancer in the U.S. for 2007 at $219.2 billion, $89.0 billion for direct costs of all health expenditures, $18.2 billion for indirect morbidity costs and $112.0 billion for indirect mortality costs.4 Accurate cost estimates are critical at the state-level for the formulation of state cancer programs and policies. It is more reliable to evaluate cancer costs for a state based on state-level information, rather than a proportion of national costs because each state has a unique demographic structure (e.g. a younger population and a large Hispanic population in Texas).3

A variety of data sources and methods can be used to produce cost estimates for cancer care.5 In 2000, at the request of the Texas Comprehensive Cancer Control Coalition, Dr. David C. Warner led a research team to estimate the cost of cancer in Texas for 1998. They built a cost estimate for cancer care based on the best available information related to various medical cancer care expenditures. The data sources they used included: Texas Hospital Discharge data for inpatient care, Medical Expenditure Panel Survey data for outpatient care and emergency services, and Health Care Financing Administration and National Association for Home Care data for home health and hospice care.3

Newer methodologies developed by the National Cancer Institute (NCI) use cancer registry-claims linked data and should allow more precise estimates of the cost of cancer care.7,8 That is, the cost of care in any given year can be determined by multiplying cancer prevalence by unit cost (or monthly net cost), specific to cancer site, stage and phase-of-care.3, 4 In 2000, when Dr. Warner’s team conducted the costs of cancer study, the Texas Cancer Registry (TCR) data were not complete or of sufficient quality for such estimation. Currently, The TCR data meet the national high quality data standards of the Centers for Disease Control and Prevention, as well as the standards for gold certification from the North American Association of Central Cancer Registries.7 Therefore, these data can now be employed in the NCI methodology for estimating the cost of cancer care.

Using Texas as an exemplar, the present study applied and evaluated the NCI method7, 8 in combination with state-level cancer registry data to estimate the cost of cancer care for a state.

METHODS
Using a three-step approach, we adapted the NCI methodology7, 8, 10 to estimate the costs of cancer care. First, we used TCR incidence data from 1997-2006 to estimate the number of prevalent and incident cancer cases in 2007. At the time of the study, vital statuses in the TCR data were complete to 12/31/2006. Prevalent cases were those who were diagnosed with cancer and were still alive as of 12/31/2006. The 2007 incident cases were estimated from the 2001-2006 TCR incidence data. The monthly vital statuses of these patients for 2007 and 2008 were estimated by applying conditional survival probabilities to all 2007 cancer cases according to their date of diagnosis.

In the second step, we estimated the extent to which each phase of care (initial, continuing and final phase) was utilized. The initial phase of care is defined as the first 12 months following diagnosis and the final phase is the last 12 months of life. The continuing phase includes the months between the initial and the final phases.7, 8, 10, 11

Figure 1 illustrates how we determined the months of care received for each phase for all cancer patients in the year 2007. For example, cancer cases diagnosed before 12/31/05 (A, B and C) only received continuing and/or final phase of care. Specifically, case A was predicted to be alive as of 12/31/08. We determined that case A received 12 months of continuing care during the study period (year 2007) since the study period began after the initial phase (first 12 months after diagnosis) and ended before the final phase (last 12 months before death). Case B was predicted to die of cancer in the middle of year 2008. We determined that case B received Bx months of continuing phase and By months of final phase of care, where Bx + By =12. Case C was predicted to die of cancer in 2007. We then determined that Case C received only Cx months final phase of care, where Cx<=12. Cancer cases diagnosed in the year 2006 (D, E and F) would have received initial+continuing phases of care (for case D, who was alive as of 12/31/08), initial+continuing+final phases of care (for case E, who died of cancer during 2008), and final phase of care only (for case F, who died of cancer in the year 2007). The incident cancer cases diagnosed in the year 2007 (G, H and I) would have received initial phase of care only (for case G, who was alive as of 12/31/08), initial+final phases of care (for case H, who died of cancer during 2008), and final phase of care only (for case I, who died of cancer during 2007) during the study period (Figure 1).

In the third step, we applied a matrix of monthly, phase-specific NCI estimates of net cost of care to the estimated cancer care utilization. All computations were stratified by age, primary cancer site, cancer
stage, phase of care and Health Service Region (HSR). The total cost of cancer care was then estimated by summing up costs across strata.

RESULTS
Using 1996-2006 cancer incidence data from the TCR, we estimated that there were 490,452 prevalent cancer cases and 95,458 incident cancer cases in Texas in 2007. These cancer cases were associated with 814,224 months of initial phase, 5,147,100 months of continuing phase, and 314,754 months of final phase cancer care in 2007. The estimated cost of cancer care in Texas in 2007 was $7.7 billion: $2.1 billion for initial phase of care; $3.9 billion for continuing phase of care; and $1.7 billion for final phase of care. Estimates of cost by primary cancer site indicate that approximately $1.0 billion were for lung/bronchus cancer, $1.1 billion for colorectal cancer, $955.5 million for prostate cancer, and $923.7 million for breast cancer (Table 1).

Table 1. Cost of Cancer Care in Texas by Primary Cancer Site, 2007

<table>
<thead>
<tr>
<th>Cancer Site</th>
<th>Cost (unit = $1,000,000), by Phase of Care³</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Initial</td>
</tr>
<tr>
<td>Brain CNS</td>
<td>60.1</td>
</tr>
<tr>
<td>Breast, female</td>
<td>272.9</td>
</tr>
<tr>
<td>Cervix uteri</td>
<td>30.2</td>
</tr>
<tr>
<td>Colorectal</td>
<td>296.1</td>
</tr>
<tr>
<td>Corpus uteri</td>
<td>50.5</td>
</tr>
<tr>
<td>Esophagus</td>
<td>23.2</td>
</tr>
<tr>
<td>Gastric</td>
<td>40.8</td>
</tr>
<tr>
<td>Head and neck</td>
<td>85.7</td>
</tr>
<tr>
<td>Leukemia</td>
<td>58.5</td>
</tr>
<tr>
<td>Liver and bile duct</td>
<td>32.8</td>
</tr>
<tr>
<td>Lung and bronchus</td>
<td>222.2</td>
</tr>
<tr>
<td>Lymphoma</td>
<td>128.8</td>
</tr>
<tr>
<td>Melanoma of skin</td>
<td>40.2</td>
</tr>
<tr>
<td>Ovary</td>
<td>58.6</td>
</tr>
<tr>
<td>Pancreas</td>
<td>34.7</td>
</tr>
<tr>
<td>Prostate</td>
<td>208.3</td>
</tr>
<tr>
<td>Renal</td>
<td>107.6</td>
</tr>
<tr>
<td>Urinary bladder</td>
<td>48.0</td>
</tr>
<tr>
<td>Other sites</td>
<td>304.2</td>
</tr>
<tr>
<td>All Cancer</td>
<td>2,103.3</td>
</tr>
</tbody>
</table>

³ The initial phase of care is the first 12 months following diagnosis; the final phase is the final 12 months of life, and the continuing phase is all the months between the initial and final phases.

Figure 1. Months of Cancer Care Needed in the Year 2007, by Phase of Care
Table 2 breaks down these costs by the four most prevalent primary cancer sites (female breast, colorectal, lung and prostate cancer) and Health Service Region (HSR). There were significant variations in the cost of cancer care among HSRs. HSRs 3 and 6, which include Dallas and Houston, respectively, had the highest costs in cancer care ($1.9 and $1.7 billion, respectively). Figure 2 shows the distribution of per capita cost of cancer care by HSR. Each Texan spent between $264 (HSR 11) to $471 (HSR 5) for cancer health care during 2007. HSRs 4 and 5, which include Tyler and Beaumont, had the highest per capita cost of cancer care ($454 and $471, respectively).

<table>
<thead>
<tr>
<th>HSR</th>
<th>Cost (unit = $1,000,000), by Primary Cancer Site</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
</tr>
<tr>
<td>1</td>
<td>304.1</td>
</tr>
<tr>
<td>2</td>
<td>232.4</td>
</tr>
<tr>
<td>3</td>
<td>1,928.2</td>
</tr>
<tr>
<td>4</td>
<td>488.8</td>
</tr>
<tr>
<td>5</td>
<td>350.3</td>
</tr>
<tr>
<td>6</td>
<td>1,733.7</td>
</tr>
<tr>
<td>7</td>
<td>874.9</td>
</tr>
<tr>
<td>8</td>
<td>842.1</td>
</tr>
<tr>
<td>9</td>
<td>200.5</td>
</tr>
<tr>
<td>10</td>
<td>217.0</td>
</tr>
<tr>
<td>11</td>
<td>525.4</td>
</tr>
</tbody>
</table>

Figure 2. Per Capita Cost of Cancer Care in Texas by HSR, 2007.

DISCUSSION
The present study is the first to estimate the cost of cancer care using Texas Cancer Registry (TCR) incidence data, which currently meets national high quality data standards. The study demonstrates that it is feasible for a state to estimate the cost of cancer care by using an adapted NCI method and state cancer registry data.

In 2002, when Warner et al. conducted the 1998 cost estimates, TCR data were not complete enough in terms of case ascertainment and follow-up. Therefore, they employed an approach which built a cost estimate for cancer care from the best available data for each cancer care component, including Texas Health Care Information Council (THCIC) hospital discharge data for inpatient care, Medical Expenditure Panel Survey data for outpatient care and emergency services, National Association for Home Care data for home health care and Hospice care. Current completeness and quality of the TCR data enabled us to build our estimates based on both incident and prevalent cancer cases. This should greatly improve the quality of the cost estimates.

There are several advantages to using NCI unit cost estimates in estimating the cost of cancer care. First, the estimates were based on the Surveillance, Epidemiology and End Results (SEER)-Medicare linked data, which provide a longitudinal profile of cost across the whole trajectory of cancer treatment and are considered to be the best source regarding the cost of cancer care. Additionally, estimates...
were based on actual payments rather than charges. Lastly, estimates represent all components of cancer care, including inpatient hospital stays, outpatient visits, physician, hospice, home health care, and durable medical equipment.

Several methodological limitations need to be noted for these estimates of the cost of cancer care. First, the NCI cost estimates were based on data for Medicare cancer patients and there is some concern that they might not be accurate for younger patients. On one hand, younger cancer patients tend to seek more aggressive surgical and adjuvant treatments than older cancer patients, which increases costs. On the other hand, younger cancer patients might have fewer comorbidities and complications than older cancer patients, thereby reducing costs associated with management of comorbidities and complications. To evaluate the effect of patient age on the cost of cancer care, we analyzed 2006 Medical Expenditure Panel Survey (MEPS) data and found that the average annual cost for younger (<65 years old) and older (65+ years old) cancer patients were very close ($10,583 for younger and $11,477 for older cancer patients). This justifies our use of NCI unit cost estimates for all cancer patients. The second limitation is that the cost matrix is estimated from cancer cases in SEER areas, which might not be the same for cases in Texas. Future study to develop a Texas-specific cost matrix and compare it to the SEER-area cost matrix is needed. Lastly, we note that non-melanoma skin cancers and in-situ cervical cancers are not required to be reported to the Texas Cancer Registry. Thus, the corresponding costs for these cancers were not included in our estimates.

Cancer registry and claims data are among the best data resources for studies of the cost of cancer care. Adaptive use of the NCI method can address a variety of cancer related issues at both the state and national level. For example, cost of cancer reports can be updated regularly and in a timely fashion to reflect changes in mortality, and availability of more accurate data. It is also possible and worthwhile to explore the extent of geographic variations in the cost of cancer care. Additionally, the costs and benefits of screening and cancer prevention and should be modeled. Applications include but are not limited to the estimates of efficacy, efficiency and effectiveness of cancer prevention and categorical estimates for specific diseases, such as breast cancer. Finally, this method can be used in comparative studies to investigate the economic impact and relative value of public, private and voluntary cancer control programs as well as to estimate the cost of the Texas Cancer Plan.

ACKNOWLEDGEMENTS

This project was funded by the Texas Department of State Health Services, Texas Cancer Registry and was partially supported by the Clinical Translational Sciences Award (CTSA) from the National Institutes of Health, National Center for Research Resources. This study builds upon the hard work and dedication of the Texas Comprehensive Cancer Control Coalition, whose leadership and insight is sincerely appreciated. Special thanks for the investment, dedication, and hard work of Texas’s cancer registrars, health care facilities, cancer treatment centers, ambulatory surgery centers, pathology laboratories, and physicians responsible for cancer data collection across the state. We also acknowledge members of the Advisory Committee to the Texas Cancer Registry for their ongoing support and leadership. We also want to express our heartfelt appreciation to those who have greatly supported our study by providing important data elements or information. Finally, we thank Ms. Alisha R. Goldberg, the Research Communications Manager in the Institute for Translational Science at University of Texas Medical Branch, for her editorial assistance in manuscript preparation.

REFERENCES

African American Teenage Smoking Attitudes and Beliefs Toward Cigarette Smoking Cessation Program Advertisements: “Putting Emphasis on the Real”

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ABSTRACT
A qualitative approach was used to investigate attitudes, beliefs and norms about participation in smoking cessation programs among a sample of African-American high school students (n = 100), aged 14 to 19 years in the United States who were current smokers. Interestingly, both males and females were drawn to advertisements that featured factual cigarette information transmission. In addition, both males and female believed that advertisements that featured attractive female smokers who were dealing with smoking related hygiene (yellow teeth, bad breath) and mortality issues were attention getters. These findings confirm that African American smokers may be more drawn to smoking prevention and cessation advertisements that emphasize information that is “real” and sources who are female and “attractive” compared to socially reinforcing, rewarding, or facilitating themes.

INTRODUCTION
The carcinogenic effects of tobacco are well known among the United States population, including among most teenagers; however, recent reports released by the American Cancer Society have revealed that in 2010, 16.9% of American, 16.4% of Hispanic-American twelfth grade youth were current cigarette smokers. Data also show that African American teens smoke less than and initiate smoking later than White and Hispanic American teens. Despite these findings, African Americans are more likely to smoke cigarettes with a higher tar and nicotine dosage, making it harder for them to quit. This paradox exists in health disparities research where African American cigarette smokers consume fewer cigarettes per day, yet experience higher rates of tobacco related disease compared to White or Hispanic American smokers. Thus, African Americans bear a disproportional burden of the health consequences of cigarette smoking compared to the other major racial and ethnic groups.

Compared to white smokers, African-American smokers have higher incidences and mortality for tobacco related cancers, including oral cavity and pharynx, esophagus, cervix, larynx, stomach, pancreas, and lung. Explanations for the paradox are unknown, but if solved, may hold promise in the development of more effective African American cancer reduction strategies.

The data related to successful methods that may be used to motivate youth to participate in smoking cessation programs is limited and there has been no research published on cessation models and message styles that may be relevant among African American youth smokers. What is generally known is that the way in which recruitment messages are communicated to the target audience determines the impact they will have on motivating youth to cease tobacco use. As a result, smoking cessation program planners who are involved in recruitment should be keenly aware of how messages are communicated to specific cultures and racial groups. Psychosocial health behavior theories may provide direction for exploring modeling and message style factors for participation in smoking cessation programs. According to Bandura, providing a model of thought and action is one of the best methods of providing information about the rules for conducting a new behavior. There are several properties of attentional processes that influence the exploration and perception of what is modeled. Specifically, an individual’s rate and level of attention to smoking cessation messages are affected by the salience, affective valence, prevalence, complexity, and functional value of the cessation models and message styles.

Another theoretical model that can be used to support this study is the elaboration likelihood model (ELM). The elaboration likelihood model of persuasion is a model of how attitudes are formed and changed. More recent adaptations of the ELM have added an additional role that variables can serve. They can affect the extent to which a person has confidence in, and thus trusts, their own thoughts in response to a message. Keeping with our source expertise example, a person may feel that “if an expert presented this information, it is probably correct, and thus I can trust that my reactions to it are informative with respect to my attitude”.

To investigate these attentional processes, a qualitative approach to explore the beliefs and attitudes toward various smoking cessation program recruitment advertisements as well as to capture the language of the African American high school students in our sample who reported that they were current smokers, that is, had smoked cigarettes in the last 30 days, was undertaken. The aim was to increase understanding of culturally appropriate recruitment strategies.

METHODS

Recruitment
Members of the project team met with administrators from two large high schools in the southwestern United States to secure approval to conduct the study on their campuses. Administrators were asked to identify participants who might be interested in participating in focus group discussions concerning attitudes, beliefs, and perceived norms toward various smoking cessation program advertisement. Project staff explained the participation requirements and procedures to interested students. A two-step process was used to identify and recruit current smokers. First, potential participants were asked, “Have you used cigarettes in the last 30 days?” Smoking status was based on the Youth Risk Behavior Survey’s (YRBS) definition of a current smoker as one who has smoked a cigarette during the last 30 days. Second, participants who self-reported that they had smoked cigarettes in the past 30 days were then invited to participate in the project. Those who agreed to participate and complete the participant consent forms met with members of the research team two or three days later for the focus groups. Written informed consent from parents/guardians and assent from the students was required for study participation. The study was approved by the University of Texas at Houston Health Science Center Internal Review Board.

Focus Group
The focus group methodology suggested by Krueger was used. All TPHA Journal Volume 63, Issue 4
of the focus group meetings were tape-recorded. Male and female researchers with over fifteen years experience in conducting qualitative research conducted all of the focus groups. More specifically, two facilitators trained in qualitative research methods conducted all of the focus groups. There were twelve focus groups with approximately 7-10 students in each group. The focus group meetings were held in a quiet classroom after school in the fall of 2010. Each session began with a general introduction and an overview of the confidential nature of the focus group. This was followed by a demographic question to assess and identify ages and an “icebreaker” question: “What do you like to do in your spare time”? Participants were then asked to review 12 different smoking cessation program recruitment advertisements. After five minutes, participants were asked the following question: “Provide the top four advertisements that would draw your attention to participate in a stop smoking program and explain why you selected them in that specific order”. The interviewers used neutral probes at least twice to elicit full responses to each question. The focus groups ended with a typical closing and appreciation expressed to the participants for their participation. All focus group interviews were transcribed verbatim. Transcripts were then coded and subsequently abstracted to identify themes related to attitudes, beliefs and perceived norms for participation in smoking cessation programs. During the data analysis phase of the research, after data collection, transcripts were coded according to participants’ responses to each question and/or to the most salient themes emerging across the set of focus groups. Transcripts were coded by three researchers and subsequently abstracted to identify themes. This process was done iteratively to test, revise, and refine the thematic classifications. Comparisons and contrasts of the categorizations by ethnicity and gender were performed to discover similarities and differences between the groups.

RESULTS

Characteristics of Sample
A total of 581 African American students from two schools were recruited for participation in this study. Of this number, 126 youth stated they were current cigarette smokers and 100 (79.4%) agreed to participate. The majority of the sample was comprised of boys (61 participants or 61% of the sample). The participants ranged in age from 15 to 19 years, with relatively equal proportions of students representing ages 15 to 18 and a smaller percentage of 19 year olds: age 15 years, (n=13); age 16 years, (n=37); age 17 years, (n=29); age 18 years, (n=18); and age 19, (n=3).

Provide the top three advertisements that would draw your attention to participate in a stop smoking program and tell why you made the choices you did.

Among males, the top two advertisements that drew their attention dealt with female smoking prevention and cessation encouragement: an attractive female with cigarettes and yellow teeth with the theme “You are what you eat” (38%) an attractive female smoking cigarette with theme “Sucker – tobacco companies get rich; you die (26%).” Interestingly, other advertisements that drew attention were reflective of factual cigarette information transmission: cigarettes and information on chemicals in cigarettes with theme “Chemicals found in cigarettes” (21%) and a zombie monster pictured with information on cigarette withdrawal symptoms with the theme “Without nicotine replacement (10%).” (Table 1)

| Provide the top four advertisements that would draw your attention to participate in a stop smoking program? | African American |
| --- | --- | --- |
| Males n=61 | Females n=31 | |
| Picture of Attractive Female with Cigarettes as Teeth | Picture of Cigarette and Information on Chemicals in Cigarettes | |
| Theme - “You are what you eat” | Theme - “Chemicals found in Cigarettes” |
| N=23 (38%) | N=12 (39%) |
| Picture of Attractive Female Smoking Cigarette | Picture of Attractive Female with Cigarettes as Teeth | |
| Theme - “Sucker – Tobacco companies get rich you die” | Theme - “You are what you eat” |
| N=16 (26%) | N=8 (26%) |
| Picture of Cigarette and Information on Chemicals in Cigarettes | Picture of Attractive Female Smoking Cigarette | |
| Theme - “Chemicals found in Cigarettes” | Theme - “Sucker – Tobacco companies get rich you die” |
| N=13 (21%) | N=5 (16%) |
| Picture of Zombie Monster and Information on Cigarette Withdrawal Symptoms | Picture of a Man Jumping | |
| Theme – Without nicotine Replacement | Theme – “Don’t stop trying to quit smoking and dipping” |
| N=6 (10%) | N=4 (13%) |
| Other advertisements | Other advertisements | |
| N=3 (5%) | N=2 (6%) |

Note: Percentages are shown in parentheses.
Females reported very similar results compared to their male counterparts. Like males, one of the top advertisements among females was also related to factual cigarette information transmission, that is, information on chemicals in cigarettes with the theme “Chemicals found in cigarettes” (39%). Females were also attracted to two of the same female sourced smoking prevention and cessation encouragement advertisements, that is, attractive female with cigarettes as teeth with theme “You are what you eat” (26%) and attractive female smoking cigarette with theme “Sucker – tobacco companies get rich; you die (16%).” An additional advertisement that drew attention from females dealt with positive social reinforcement of smoking prevention and cessation: Specifically, a picture of a young man jumping with theme, “Don’t stop trying to quit smoking and dipping (13%).” (Table 1)

DISCUSSION

The current study used a qualitative approach to investigate relevant attitudes and beliefs of various smoking cessation program recruitment advertisements among a sample of 100 African American youth smokers, 15 to 19 years old. Interestingly, both males and females were drawn to advertisements that featured factual information about the effects of cigarette smoking. Examples of participant statements were “It is being real with you about the real stuff that is in cigarettes that people don’t know (male)” and “It is telling you what is in it; it is breaking it down; it will make you think twice about it and want to stop smoking (female).”

How messages are communicated to the target audience determines the impact they will have.2-24 Cigarette smoking prevention and cessation advertisements thus need to pay close attention to how their messages are communicated to specific racial groups.25-26 According to Shade,27 African Americans cognitively process communications differently from “mainstream” individuals in various ways; they prefer intuitive rather than inductive reasoning and they place heavy emphasis on facts and message styles to determine credibility of the communication. The present data confirm that many African American smokers may be more drawn to smoking prevention and cessation advertisements that emphasize information that is “real” or “tell it like it is” compared to socially reinforcing, rewarding, or facilitating themes.

In addition, both males and females believe that advertisements that featured attractive female smokers who were dealing with smoking related hygiene (yellow teeth, bad breath) and mortality issues were attention getting. Examples of participants’ statements were: “That girl looks alright and stuff, but those teeth look like they have been through some things; I don’t need to be a part of that (male)” and “We as women are very vain about our looks and this girl doesn’t have herself together (female)”. In general, if one is to learn from any health promotion/health education campaign, including one for smoking prevention and cessation, attention must be paid to the advertisement.28 According to social cognitive learning theory, in order for a message to have persuasive impact, the message must be attention getting as well as arousing.18 Studies have shown that the perceived attractiveness of the source in an advertisement can produce conclusions by the receiver relative to the source’s expertise and trustworthiness.29,30 This is confirmed by the fact that many young adults start smoking to confirm their independence and glamour that is a reproduction of what they have seen in many cigarette promotional advertisements.31-32 Because both males and females in this study paid high attention to attractive female sources, further research needs to be conducted to investigate the effect African American females as message sources for smoking prevention and cessation program advertisements have on recruitment.

The present study provides preliminary insight into relevant attitudes and beliefs related to smoking prevention and cessation program recruitment advertisement among African American teen smokers; however, there are three methodological limitations. First, the nature of the study precludes any conclusions about the prevalence of these attitudes and beliefs. Accurate prevalence estimates are critical before any policy-related recommendations could be extended. Second, the generalizability of our findings is limited because the respondents were a convenience sample recruited from two large high schools in the southwestern region of the United States. Larger studies with a more diverse geographic sample are needed to more precisely estimate the attitudes and beliefs among teens. Finally, the data are exclusively qualitative. More etiological and quantitative research should be conducted to understand the social, cultural, and intra-personal forces that operationalized to produce African American smoker’s attitudes and beliefs towards smoking prevention and cessation program recruitment advertisements among African American teen smokers.

Despite these limitations, this qualitative study provides groundwork for more extensive research on the development of culturally appropriate smoking prevention and cessation program recruitment messages for African American teens. Specifically, the information from this study can be used by administrators, teachers, and health educators to tailor and customize smoking prevention and cessation recruitment interventions to African American teenagers. We could not find any previous research that examined similar questions looking at cigarette smoking cessation program advertisements among African American teenagers. Further studies should be conducted with representative samples of youth to confirm this study’s findings.

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To help you prepare for the holidays ahead, our poison control expert has compiled three very important poison control messages for you. Please pass along to friends and family. Tell them you read it in the Texas Public Health Journal. The journal striving to keep Texans healthy!

**Nutmeg: An Unexpected Substance of Abuse**

Mathias B. Forrester
Texas Department of State Health Services, Austin, Texas

Nutmeg is derived from the dried seed kernels of the evergreen tree *Myristica fragrans* native to the Banda Islands of Indonesia. It may be used as a stimulant and abortifacient and to relieve flatulence, promote menstruation, and treat diarrhea. However, its primary use is as a spice. In the United States, nutmeg may be found in baked goods and Christmas drinks.1,2

Nutmeg contains volatile oils consisting of alkyl benzene derivatives (myristicin, elemicin, safrole, etc.), terpenes, and myristic acid. Myristicin and elemicin may be metabolized to compounds have hallucinogenic effects similar to lysergic acid diethylamide (LSD).3,4 Because of its euphoric and hallucinogenic effects, nutmeg has a long history of abuse as a legal, low-cost alternative to other drugs.4,5 Its cause of its euphoric and hallucinogenic effects, nutmeg has a long history of abuse as a legal, low-cost alternative to other drugs.4,5

Various videos have been posted on YouTube demonstrating how to use nutmeg to get high. These videos have raised concerns that they might lead to a resurgence in intentional abuse of nutmeg.1,12

Poison centers receive calls about potentially adverse nutmeg exposures.5,9,12-14 Most calls that are received involve intentional abuse or misuse of the substance. Of 119 nutmeg exposures reported to California poison centers during 1997-2008, 72% were intentional.5 Of 17 nutmeg ingestions reported to Texas poison centers during 1998-2004, 60% involved intentional abuse or misuse.14

When the Texas poison center analyses were updated through 2010, 48 total nutmeg exposures were found. It is unclear why the number of nutmeg exposures identified by Texas poison centers is less than half that identified by California poison centers during a similar time period. It may be that fewer nutmeg exposures are reported to Texas poison centers or that fewer Texans use nutmeg. Although the annual number of nutmeg exposures reported to Texas poison centers remained relatively constant during 1998-2007 at 1-4 exposures per year, 22 (46% of the total exposures) were reported in the last three years (2008-2010). This increase might be due to increased awareness of nutmeg as a substance that can be used recreationally.

Twenty-nine (60.4%) of the nutmeg exposures involved intentional misuse or abuse of the substance. Table 1 compares intentional misuse or abuse to all other reasons for exposure to nutmeg reported to Texas poison centers. The majority of exposures involved males, particularly among those exposures that were due to intentional misuse and abuse. Most of the patients who intentionally misused or abused nutmeg were adolescents whereas all of the other patients were evenly distributed among the various age groups. The majority of exposures for any reason were by ingestion; although 14% of intentional misuse or abuse exposures occurred by inhalation, none of the other exposures occurred by that route. While most of the exposures for other reasons were managed on site (that is, at home), roughly equal proportions of exposures due to intentional misuse or abuse were managed on site or referred to a healthcare facility by the poison center. Although the preponderance of the intentional misuse and abuse exposures were potentially serious (that is, involved moderate or major effects or were judged to be potentially toxic), the majority of exposures for all other reasons were not considered to be potentially serious. This pattern of exposures was similar to that observed by the California poison centers.8 These data suggest that most nutmeg exposures reported to poison centers are likely to be due to intentional misuse and abuse of the substance. Such exposures could potentially result in serious outcomes and thus may need to be managed at a healthcare facility. Potentially adverse exposures for other reasons are less likely to result in serious outcomes and may be managed at home.

### Table 1. Nutmeg exposures reported to Texas poison centers during 2000-2010

<table>
<thead>
<tr>
<th>Variable</th>
<th>Intentional misuse/abuse # (%</th>
<th>All other # (%</th>
<th>Total # (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient gender</td>
<td>Male</td>
<td>20 (79)</td>
<td>10 (53)</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>10 (37)</td>
<td>9 (47)</td>
</tr>
<tr>
<td>Patient age (years)</td>
<td>&lt;12</td>
<td>2 (7)</td>
<td>6 (32)</td>
</tr>
<tr>
<td></td>
<td>13-19</td>
<td>16 (55)</td>
<td>6 (32)</td>
</tr>
<tr>
<td></td>
<td>&gt;20</td>
<td>8 (28)</td>
<td>6 (32)</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>3 (10)</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Route</td>
<td>Ingestion</td>
<td>25 (86)</td>
<td>17 (90)</td>
</tr>
<tr>
<td></td>
<td>Inhalation</td>
<td>4 (14)</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td>Ocular</td>
<td>0 (0)</td>
<td>1 (5)</td>
</tr>
<tr>
<td></td>
<td>Unknown</td>
<td>0 (0)</td>
<td>1 (5)</td>
</tr>
<tr>
<td>Management site on site (e.g., home)</td>
<td>12 (41)</td>
<td>15 (79)</td>
<td>27 (56)</td>
</tr>
<tr>
<td></td>
<td>already at route to HCF</td>
<td>4 (14)</td>
<td>1 (5)</td>
</tr>
<tr>
<td></td>
<td>referred to HCF</td>
<td>13 (45)</td>
<td>3 (16)</td>
</tr>
<tr>
<td>Medical outcome</td>
<td>None</td>
<td>0 (0)</td>
<td>5 (26)</td>
</tr>
<tr>
<td></td>
<td>Minor</td>
<td>2 (7)</td>
<td>3 (16)</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>7 (24)</td>
<td>2 (11)</td>
</tr>
<tr>
<td></td>
<td>Major</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td>Death</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td>not followed - minimal</td>
<td>6 (21)</td>
<td>6 (32)</td>
</tr>
<tr>
<td></td>
<td>not followed - toxic</td>
<td>14 (48)</td>
<td>2 (11)</td>
</tr>
<tr>
<td></td>
<td>unrelated effect</td>
<td>0 (0)</td>
<td>1 (5)</td>
</tr>
</tbody>
</table>

HCF = healthcare facility

*estimated

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8. Carstairs SD, Cantrell FL. 2009. The spice of life: a 12 year review of
Potential Hazard of Button Battery Ingestions by Young Children

Button batteries (aka disc batteries), are 8-23 mm in diameter and are found in a variety of household products such as hearing aids and handheld devices. Because of their common presence in the home, there is a risk that button batteries may be ingested. The majority of button battery ingestions involve children 0-5 years in age.1,2 Young children ingest batteries most often directly from the products in which the batteries are being used. Smaller proportions of the ingestions involve batteries that are left lying around loose or batteries in which the batteries are being used. Concern about the possibility that children may swallow batteries has led to product recalls.3

The majority of pediatric ingestions of button batteries are harmless, particularly if the battery has safely passed into the stomach.3,4 However, if the battery becomes lodged in the esophagus, injury may result through direct pressure against the surrounding tissues, leakage of the alkaline electrolyte from those types of batteries that contain such substances, and generation of external current that causes electrolysis of fluids in the surrounding tissues, producing hydroxide. This last situation may result in severe tissue damage such as burns or perforations in as little as two hours. Deaths of young children who have ingested button batteries have been reported.4,5 The proportion of button battery ingestions that resulted in major or fatal outcomes has increased more than six-fold over last 25 years.1 This has been attributed to increased use of the 20-mm-diameter lithium coin battery.

During 2000-2009, 1,341 button battery ingestions by children 0-5 years in age were reported to Texas poison centers. The number of reported ingestions increased from 53 in 2000 to 171 in 2004 then remained relatively constant during the rest of the time period. The distribution by age was 104 (7.8%) <1 year, 263 (19.6%) 1 year, 280 (20.9%) 2 years, 291 (21.7%) 3 years, 240 (17.9%) 4 years, 153 (11.4%) 5 years, and 10 (0.7%) exact age unknown. The children were 693 (51.7%) male, 640 (47.7%) female, and 8 (0.6%) unknown gender. The majority (1,281 or 95.5%) of the ingestions occurred at the child’s own home, 37 (2.8%) at another home, 6 (0.4%) in a public area, 5 (0.4%) at school, 2 (0.1%) at a healthcare facility, 1 (0.1%) at a workplace, and 9 (0.7%) at an other or unknown location. Six hundred and four (45.0%) of the children were referred to a healthcare facility by the poison center, 372 (27.7%) were managed on site (such as at home) by the poison center, 338 (25.2%) were already at or en route to a healthcare facility when the poison center was contacted, and 27 (2.0%) were managed at an other or unknown location. Half (670 or 50.0%) of the ingestions resulted in no effect, 21 (1.6%) in minor effects, 24 (1.8%) in moderate effects, 64 (4.8%) were not followed by judged to be non-toxic, 412 (30.7%) were not followed but judged to result in at most minimal clinical effects, 145 (10.8%) were not followed and judged to be potentially toxic, and 5 (0.4%) were judged to have effects unrelated to the battery ingestion. No deaths were reported. Specific adverse symptoms were reported in a small number of the ingestions. Most of these symptoms were gastrointestinal in nature, consisting of vomiting (n=13), abdominal pain (n=10), diarrhea (n=8), oral irritation (n=3), throat irritation (n=3), nausea (n=2), weight loss (n=1), constipation (n=1), dysphagia (n=1), and melena (n=1).

Detailed triage guidelines for the management of button battery ingestions have been developed.6,7 However, health professions may want to try to prevent such ingestions in the first place through public education. Parents may be instructed to secure the battery compartments of products in which the batteries are used, to not leave batteries lying around loose, and do not allow children to play with batteries.2

REFERENCES

American Mistletoe Ingestions: A Potentially Toxic Winter Exposure

American mistletoe (Genus Phoradendron) is a partially parasitic plant that grows in large, dense clusters on the trunks and branches of deciduous and evergreen trees. It has smooth-edged, oblong, leathery leaves and clusters of white or pink berries. The plant grows between New Jersey and Florida west to Oregon and California and is reported to be very prevalent in Texas. Mistletoe is widely used for Christmas decorations in the United States.1,2

American mistletoe leaves and stems, and to a lesser degree berries, are toxic. The plant contains lectins or toxalbumins, primarily phoratoxin, which is related to ricin. These compounds inhibit protein synthesis in the intestinal wall. Ingestion may result in irritation of the digestive tract, leading to vomiting, diarrhea, abdominal cramping, and dehydration. Lowered heart rate may occur. Symptoms appear to depend on the amount ingested.3 Deaths have been reported with American mistletoe ingestion but appear to be rare.4,5

During 2000-2010, 305 mistletoe ingestions were reported to Texas poison centers. Although mistletoe ingestions were reported in every month of the year, there was a seasonal trend with 105 (34.4%) reported in December and 184 (60.3%) reported during November-January. Males accounted for 171 (56.1%) and females 134 (43.9%) of the patients; 233 (76.4%) of the patients were age 0-5 years, 56 (18.4%) 6-19 years, 15 (4.9%) age 20 years or older, and 1 (0.3%)
unknown age. The majority (257 or 84.3%) of the ingestions occurred at a residence while 40 (13.1%) occurred at school, 5 (1.6%) at a public area, and 3 (1.0%) at an other unspecified location. The ingestion was unintentional or accidental in 285 (93.4%) cases, intentional in 19 (6.2%) cases, and was an adverse reaction in 1 (0.3%) case.

The patient was managed on site (that is, at home or where the exposure occurred) in 269 (88.2%) of the cases, was already at or en route to a healthcare facility when the poison center was called in 13 (4.3%) cases, was referred to a healthcare facility by the poison center in 19 (6.2%) cases, and was managed at an other unspecified or unknown location in 4 (1.3%) cases. Most (154 or 50.5%) of the ingestions where known or expected to result in no adverse effects, 137 (44.9%) were known or expected to result in at most minimal adverse effects, and 9 (3.0%) were known or expected to result in serious effects; in 5 (1.6%) of the ingestions, the effects were considered to be unrelated to the mistletoe. The adverse clinical effects reported in 2 or more ingestions were vomiting (20), diarrhea (7), abdominal pain (5), nausea (5), fever (2), mydriasis (2), and coughing (2).

The pattern of mistletoe ingestions observed by Texas poison centers was similar to that reported by a national study of mistletoe exposures reported to poison centers during 1985-1992 and a study of mistletoe exposures reported to poison centers in Kentucky, Georgia, and Indiana during 1990-1993.3,5

Although mistletoe ingestions may occur at any time of the year, they are most likely to occur during the Christmas holiday season (November-January). Although mistletoe contains toxic substances, most ingestions, particularly those involving only several leaves or berries, are likely to result in no or minor effects and can be managed at home. However, patients ingesting larger amounts may require medical evaluation.6,7

REFERENCES

What’s in My Food and Water?*
Carolyn Medina, M.A., MLIS
Librarian, Texas Department of State Health Services, Austin, Texas

Imagine a world where there are no governmental regulations. Businesses are free to sell any product they want, make any health claims they please, and nobody concerns themselves with the purity of air or of water. Welcome to conditions in the majority of states in America in the year 1905. Commerce flourished, inventions were being produced at an amazing rate. However, as we now know, freedom from government regulation can also bring with it unfortunate health consequences. Statistics are scarce for the early 1900s but it is estimated that in 1900 “in some U.S. cities, up to 30% of infants died before reaching their first birthday.”6 Especially in the summer, infants would die from typhoid fever, scarlet fever and diphtheria, partially due to the lack of refrigeration, conditions at dairy farms, and the lack of milk pasteurization.

Around that time, American chemists had begun to use microscopes to look at the makeup of our food and water. Based on his findings, Harvey M. Wiley, the Chief Chemist at the Bureau of Chemistry in the federal Dept. of Agriculture, was adamant that a law was needed to protect consumers from adulterated food and misbranded food. He published a book listing what should and should not be in their food.3 In part due to his efforts, the first federal law was passed, the Pure Food & Drugs Act in 1906. That same year Upton Sinclair had published his bestseller, “The Jungle,” describing the horrible conditions at meat packing plants. This book helped lead to the first federal meat inspection law, also passed in 1906.4 The era of federal regulations to improve health conditions had begun.

Even before the federal government acted, some states were using scientific methods to study the safety of food and water. A major player in this effort was a remarkable woman named Ellen Swallow Richards, born in 1842. Miss Swallow was curious about everything in her world and attended Vassar College. In 1870, however, her greatest desire was to continue her studies of basic chemistry. She was persistent in her requests and became the first female allowed to study at the Massachusetts Institute of Technology. She did not have to pay tuition; allowing her professors to explain that she was not actually enrolled as a student if problems or complaints arose. She flourished at MIT and in 1872 was asked to assist her professor in a chemical study of the state’s water supply. She tested the water to determine whether the chlorine content of water was due to its nearness to the ocean or due to pollution from the state’s many farms, paper mills, and villages.5

Mrs. Richards graduated from MIT but never left. In 1876, she established a woman’s laboratory at MIT to enable other female students to enroll and also study chemistry. She wrote that the question was, “Have women the mental capacity for scientific work?” This question arose because Mrs. Richards kept being asked by female school teachers if they could study at MIT. She knew that MIT needed a better facility if it were to allow more women students. She arranged private funding from a women’s association to buy equipment (mostly microscopes and spectroscopes) and MIT donated the space for a new Women’s Laboratory. Hundreds of women studied there, especially the school teachers who took the scientific methods they learned back to their local schools. Mrs. Richards later wrote, “Our students have proved that the most severe training does not make women repulsive and does not unfit them for housewifely duties.”6 In 1875, she herself had married Robert Richards, a professor of mining at MIT. They took a “romantic” honeymoon to Nova Scotia, accompanied by her new husband’s mining students who planned to do field work. Partly out of necessity, Mrs. Richards became interested in applying the scientific method to her housewifely duties; finding ways to make housework more efficient and the home environment healthier. In the process she basically invented the field of home economics, which she called euthenics. She also continued to work as an instructor in sanitary chemistry at MIT from 1884 until her death in 1911.
Mrs. Richards was interested in the composition of food from an early date. In 1878 she began examining staple food products for the State of Massachusetts. Her results were published in the annual report of the MA Board of Health, Lunacy and Charity. Between 1882 and 1884, Massachusetts passed its first Food and Drug Acts. In 1885, Mrs. Richards wrote a book called, “Food Materials and Their Adulterations” based on her food research. But this energetic and amazing woman lived in Massachusetts. What about Texas? When did Texas first begin to enforce food safety standards? According to the Texas Health Bulletin, the first Food and Drug Division at the state health department was established in 1925. A milk grading and labeling law was passed in 1937. Inspectors were hired to investigate chemical or bacterial contamination and to ensure that items were labeled correctly as to their contents and their weight. Their goal was “education and cooperation rather than seeking prosecution.” As part of the educational mandate, in 1938 Lewis Dodson established a system of foodhandling schools in Texas. Based on the lessons being taught, a 16 mm film was made called, “Hash Slingin’ to Food Handling.” This film was used all over the United States and in several foreign countries. It explained the chain of contamination that happens if proper sanitary precautions were not used. By 1949, the lessons included 1) bacteriology, 2) prevention of food contamination and spoilage (especially at the point of origin); 3) habits and methods of controlling disease spreaders such as insects, rodents, and man through good housekeeping; 4) legal aspects of operating a food establishment (explaining the laws on cleaning and sanitization); and 5) the importance of personal hygiene and hiring healthy food handlers. If 80% of a restaurant’s staff passed the course, the business received a placard of approval from the State Dept. Health. Also in 1949 a scandal erupted concerning horse meat being sold for human consumption. That year the Texas Legislature passed a bill known as the Horse Meat Law. A key player in exposing the sale of horse meat was Joe F. Lakey. He was director of the Texas Food and Drugs Division of the state health department for over twenty years. In 1962 he worked on a national committee to make the federal Food and Drug Administration more effective. Shortly before his death in 1964, Mr. Lakey was awarded the Harvey M. Wiley award.

It is interesting to note how a combination of increasing scientific methods and knowledge, along with a few scandals, often intersected to create the conditions necessary to pass many of our safe food laws. Thanks to the early efforts of men like Mr. Wiley and women like Mrs. Richards, we now insist on truthful labeling and contents in our food supply.

Acknowledgement: Special thanks to Dr. Catherine Cooksley who provided pictures from an American History Museum exhibit in Washington, D.C. from July 2010, inspiring this column, and introducing me to the amazing legacy of Mrs. Ellen Swallow Richards.

*This column is dedicated to the memory of Rex Sherry, a food and drug inspector and trainer, who spent 34 years at the state health department. He passed away on August 24, 2011.

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Nancy Crider, DrPH, RN
TPHTC Governmental Public Health Practice Award Winners to be Recognized

On October 4, 2011, ten outstanding public health graduate students, recipients of the first TPHTC Governmental Public Health Practice Award, will be recognized at the University of Texas School of Public Health, Houston for their achievements. During the ceremony, the students will have the opportunity to present their summer 2011 internship projects. Public health professionals from various local, county and regional health departments who served as student preceptors will also be recognized. Student awardees include: Marlisa Allen, Nora Defee, Paula Lynse, Aldo Martinez, Thanh-Uyen Nguyen, Saurabh Pawasker, Gaurav Poudyal, Arianne Rhea, Elise Russo, and Andria Stevens.

The competitive award, funded through the HRSA, Public Health Training Center Grant, is designed to build public health capacity by providing the hands on experience necessary to excel in governmental public health practice following graduation. The goals of the program are: To prepare students to take advantage of career opportunities in health departments through applied opportunities; To expose students to career opportunities in governmental public health; To orient interns to the practice, policies and skills necessary to thrive in the public sector and to assist governmental public health in recruiting qualified candidates. TPHTC anticipates offering ten ($2,400) awards for summer 2012. The call for applicants for the 2012 TPHTC Governmental Public Health Practice Award will be announced at the October 2011 ceremony. For more information, contact Natarsha D. Horton at tphtc@uth.tmc.edu or (713) 500-9389.

Crider receives National Safe and Healthy Housing Coalition Award

Nancy Crider, DrPH, RN, program manager of the Texas Public Health Training Center at The University of Texas School of Public Health, has been awarded the National Safe and Healthy Housing Coalition Award for 2011. Since 2007, Crider has been a “Healthy Homes” instructor and champion. She has helped develop the Healthy Homes for Community Health Workers curriculum and has implemented the training in both Texas urban and border communi...
The National Safe and Healthy Housing Coalition, nominated 19 individuals and organizations from a variety of sectors (housing, public health, energy efficiency, environment and community development) for the 2011 award. The nominees have made extraordinary contributions to the healthy homes movement through their efforts focusing on those whom are disproportionately impacted by unhealthy housing conditions, including low-income families and individuals, people of color, children and older adults.

In addition to working with the Housing Coalition, Crider has championed health programs with the Head Start and the Houston Independent School District. She brought Integrated Pest Management (IPM) programs to HUD housing properties and Section 8 housing voucher properties and is an instructor for both the National Center for Healthy Housing and the Northeast IPM Center. Crider’s recent doctoral dissertation "Integrated Pest Management in Multifamily Housing for the Elderly" served as a demonstration project for the Houston Housing Authority to adopt policies supporting IPM in Houston properties.

The National Safe and Healthy Housing Coalition is the policy arm of the National Center for Healthy Housing. The Center is the only national scientific and technical non-profit organization dedicated to creating healthy and safe homes for America's children through practical and proven steps. NCHH develops scientifically valid and practical strategies to make homes safe from hazards, to alert low income families about housing-related health risks, and to help them protect their children.

UTSPH visits Kickapoo Tribe with Healthy Homes

As a training partner with the National Center for Healthy Housing (NCHH), The University of Texas School of Public Health (UTSPH) visited the Kickapoo Traditional Tribe of Texas in Eagle Pass to present “Healthy Homes” training in Spanish, to more than 40 community health workers from the tribe, Eagle Pass and Pueblos Negros across the border in Mexico. Nancy Crider, DrPH, RN and Rosalia Guerrero, training specialist of the Texas Public Health Training Center, conducted the workshop at the request the Environmental Protection Agency’s Office of Children’s Health. Participants included traditional Promotoras, representatives from the Mental Health and Mental Retardation (MHMR) agency, the school district, housing, nurses, a doctor and the Kickapoo Chief’s wife. “It was such an honor to have her there,” said Ms. Guerrero. Healthy Homes is a century-old concept that promotes safe, decent and sanitary housing as a means for preventing disease and injury. The Kickapoo Indian Reservation in Texas is located near Eagle Pass on the Rio Grande River along the U.S.-Mexico border. Housing in the community consists of mobile homes and single-family homes set beside traditional Native American dwellings. Antonio Garza, DrPH, EPA representative for the Kickapoo tribe and UTSPH alumnus, arranged the workshop for the tribe.

Recently Archived Grand Rounds are available 24/7 at http://www.sph.uth.tmc.edu/research/centers/tphtc/
- The Changing Face of C. difficile Infection (CDI) - July 13, 2011 - Herbert Dupont, MD
- Gender Disparities in Physical Health Among Older Adults - June 8, 2011 – Bridget Gorman, PhD
- Public Health Surge Capacity Needs Associated with the Recent Japanese Nuclear Power Plant Disaster - April 5, 2011 – Robert Emery, DrPH
- Health Promoting Work Breaks - March 16, 2011 – Wendell Taylor, PhD, MPH
- Influenza Pandemics: Where We're Been and What's Next - March 9, 2011 – Cathy Troisi, PhD

The mission of the TPHTC is to improve the state's public health system by strengthening the technical, scientific, managerial and leadership competencies and capabilities of the current and future public health workforce. TPHTC provides face to face and online training that reach audiences across Texas. Monthly Grand Rounds hosted by local health departments keep public health practitioners engaged, challenged and up-to-date. Community Health Worker (CHW) Certification & Continuing Education prepares CHWs and Promotoras to improve access and provide health services to minorities and underserved communities. Offerings include 160 hours of core curriculum leading to state certification and ongoing continuing education for CHWs and CHW Instructors.

For further information or to schedule onsite training for your organization contact Nancy Crider at nancy.m.crider@uth.tmc.edu; Cara Pennell at clpennel@srph.tamhsc.edu; or Jeffrey Moon at jmoom@hsc.unt.edu Texas Public Health Training Center website www.txphtrainingcenter.org

Public Health Practicum Program: Practical Approach to Train Tomorrow’s Leaders is a “Win-Win” Experience for All

All MPH and DrPH students at The University of Texas School of Public Health (UTSPH) are required to complete a practicum (in-
ternship) as a requirement for graduation. Students complete their practicum opportunities throughout Texas and around the world in governmental, non-profit, industrial and international public health settings.

The practicum is a win-win opportunity for students, public health organizations and community preceptors. Students work with their community preceptor and faculty sponsor to create a learning contract, each of which lists the individual learning objectives and the final product the student is expected to complete by the end of the opportunity. The final product is completed by the student to make a meaningful contribution to the host organization - each varies according to the needs of the host organization and goals of the student.

To see examples of practicum experiences completed by UTSPH students, please visit the Office of Public Health Practice website (http://www.sph.uth.tmc.edu/academics/public-health-practice/ Click the REPORTS tab and then open the PRACTICUM e-BOOK link.) Here students describe their practicum experience in a one page magazine-style summary – they include a brief overview of their duties, highlights of their practicum, and public health significance of their experience. The e-magazine captures the breadth of experiences that are public health.

To post a practicum opportunity, please go to the website for the Office of Public Health Practice and complete the online form (http://www.sph.uth.tmc.edu/practica/default.aspx?id=1674, click Post A Practicum). Once this form has been submitted, our searchable database will be updated with your posting and the Office of Public Health Practice will receive an email alert. Your posting will be an-

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nounced to all UTSPH students. Interested students will contact you directly, based on the contact information you provide on the form.

If you have questions regarding the UTSPH student practicum program, please email Linda Lloyd (Linda.E.Lloyd@uth.tmc.edu), Brenda Brown (Brenda.E.Brown@uth.tmc.edu), or Angie Lloyd (Angela.D.Lloyd@uth.tmc.edu) in the Office of Public Health Practice. We thank those of you who have participated as community preceptors and welcome others who are interested!

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**TPHA News and Information**

**TPHA Governing Council and Executive Board Actions**
The TPHA Quarterly business meetings were held at the TALHO offices on July 9th. We thank TALHO for donating meeting space for this meeting.

The following action items were recorded during the July 9th meetings:

**Governing Council**
The April Governing Council meeting minutes were approved.

**Strategic/Business Plan**
It was agreed that the officers would draft a business plan for each of the goals of the strategic plan and will include a market needs and assessment, product or service, operations and management, finances and financial projections, issues and solutions and implementation detail for each of the goals. If you would like to volunteer for this task, contact TPHA at txpha@aol.com.

**Constitution and Bylaws**
Governing Council voted on the following changes (bolded text) to bylaws section 2.02.3:

- Fellow: Active or associate members who are in good standing for five (5) continuous years with a recognized professional status and who have been actively engaged in the Association’s mission and activities, and qualified according to the procedures prescribed by the Governing Council. Additional dues paid by this class of members are used to support keynote speakers at the annual meeting general assembly dedicated to Fellows. This action item must be voted on by governing council members at a second reading to take place September 27, 2011.

**Legislative**
Copies of the Public Health Coalition recap of legislation tracked by the group were distributed. For a list of tracked public health legislation visit [www.texaspha.org](http://www.texaspha.org).

**Membership**
A list of current active TPHA members who will be invited to apply for fellow membership status was presented. TPHA will host its 3rd Annual Fellows Breakfast during the 2012 AEC in Arlington.

**Site Selection**
Dr. Thomas Schlenker, Director, San Antonio Metropolitan Health District has agreed to host the 2013 annual education conference in College Station. The title of the conference is *Health Disparities: Opportunities and Challenges for Public Health Practice* and is scheduled for September 28th.

**TPHA Mid-Year Conference**
The Texas A&M School of Rural Public Health is hosting the mid-year TPHA conference in College Station. The title of the conference is *Health Disparities: Opportunities and Challenges for Public Health Practice* and is scheduled for September 28th.

**Editorial Board**
National Public Health Week (Texas) activities previously published in the TPH Journal were also published in the APHA Nations Health on page 30.

Carolyn Medina was recognized for her contributions to the journal and thanked for her service on the Editorial Board.

**Affiliate Representative to the Governing Council of APHA (ARGC) Report**
- Catherine Cooksley (APHA CoA Chair-Elect) announced that each year the APHA committee on affiliates sponsors a scientific session. This year TPHA member, Dr. Hardy Loe, will be presenting a 1 ½ hour workshop: Session 3213.0 “Societal Approach to Build Healthier Communities” will discuss broadening the role and functions of public health and the growing importance of collaborative relationships with the larger society to achieve improved population/individual health status. This will be an interactive planning session with a “take home plan” that affiliates can take back to their states. If you will be attending the APHA annual meeting in Washington DC, please plan to join and participate on Monday October 31, 2011 at 12:30 PM. Check the APHA program for location.

TPHA members attending the APHA annual meeting are also invited and encouraged to attend the Affiliates Reception held on Saturday night, October 29, 2011 at 7 PM.

The Governing Council voted to sign a memorandum of understanding (MoU) with APHA assuring that students transferring from one state affiliate to another receive benefits of membership in APHA affiliates. The purpose of this MoU is to demonstrate the commitment of Affiliates to assure the benefits of student membership in one’s public health association will remain with a student as they transition between states as a result of graduation, job acquisition, or other circumstance for the duration of their student membership eligibility status.

TPHA Governing Council members voted to sign-on to a request from APHA to support the Prevention and Public Health Fund letter to congress. APHA urges congress to oppose any plan that would disproportionately cut spending for important public health programs.

**APHA Kellogg Grant Final Report**
Kay Reynolds reported that the APHA grant period has ended. She went over highlights of the final report (document available at [www.texaspha.org](http://www.texaspha.org)). The grant allowed TPHA many opportunities for growth and enhancement and we need to continue working to get more funding through grants to continue this work.

**APHA President-Elects Meeting**
Kay Reynolds reported that she attended the mid-year APHA President-Elects meeting and during this meeting she was able to visit with congressional offices including the offices of Senator Kay Bailey Hutchison. The meeting was an opportunity to learn more about APHA and the benefits it provides.
to affiliates. They discussed membership and how to analyze membership seasonal patterns.

**Partnerships, Councils and Boards**

**Public Health Accreditation Council of Texas (PHACT)** - PHACT is holding the Texas Public Health Accreditation Conference October 11-12 at the JJ Pickle Research Campus on Burnet Road. The conference title is “Past, Present, Future: Where We Have Been, Where We Are, Where We are Going”. Participants will learn from, and share with, each other on the processes and tools used to prepare and submit an application for accreditation.

**New Business**

**Public Health Museum of Texas** - Carolyn Medina was appointed to represent TPHA on the Public Health Museum. The Texas Association of Local Health Officials (TALHO) currently is housing the public health museum exhibit cases pictured below. It was announced that the Texas Medical Association will be displaying an exhibit on the History of Public Health in their lobby.

**2012 Policy Forum** - TPHA has agreed to work with TALHO to plan a Public Health Policy Forum in 2012.

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**Executive Board**

The April Executive Board meeting minutes were approved. Financial reports including the 2011 operating budget, co-sponsored events report and fund balances and the final APHA grant report were presented.

The Executive Board thanked Carol Galeener for donating her hours resulting in a $1,500 monetary contribution from the employee volunteer matching gift donation program sponsored by ExxonMobil.

The Executive Board voted to approve expenditures of up to $1,176 in scholarship funds pending receipt, review and approval of qualified applicants.

**TPHA Awards Scholarship to Andrea Kaufman**

The membership committee voted to award the 2010 TPHA Scholarship to Andrea Kaufman. Andrea currently holds a BA in Psychology and Religious and Theological Studies and is seeking her Masters of Social Work. Ms. Kaufman’s TPHA member sponsor was Linda Hook and mom is TPHA member Linda Kaufman. Look for Andrea’s application essay on page 5 of this issue of the Texas Public Health Journal. Congratulations Andrea!

**TPHA Call to Leadership**

TPHA is looking for dynamic new leaders and we need your help! Become a voice for public health in Texas. Harness the energy of public health advocacy-run for office in TPHA!

We need nominees to run for the following positions:

**Governing Council: 3 positions (3 year terms)**

**GOVERNING COUNCIL**

4.01. There shall be a Governing Council which shall consist of the officers of the Association; the Executive Board; nine (9) members to be elected from the membership consistent with Article Two for three (3) year terms that are staggered so that one-third (1/3) retire each year; the Chair of each Section; one (1) representative to be appointed by each affiliated society; and the affiliate representative to the Governing Council of the American Public Health Association. Such representatives to Governing Council shall be members of the Association.

4.01.1. The President of the Association shall serve as Chair of the Governing Council.

4.02. The terms of the Governing Council members shall begin at the close of the annual meeting at which they are elected and terminate at the close of the annual meeting at which their respective terms expire.

**Second Vice President**

6.08. Second Vice-President/Membership: For nominations to the office of Second Vice-President/Membership, an individual shall be and Active Member in good standing for the preceding five (5) consecutive years, a current Fellow in the Association, a present or past member of Governing Council, and a participant in two or more annual meetings.

6.08.1. The Second Vice-President/ Membership shall oversee and be responsible for the Association’s memberships. (S)He shall function as an ex-officio member of the membership committee.

For more information about either the Governing Council or duties of the Second Vice President read these bylaws.

To nominate someone (can be yourself), obtain their permission to be placed on the ballot then submit their name and contact information to: Terri Pali TxPHA@aol.com fax: (512) 336-0533.

Nominees will be asked to submit a short biography along with statements of how they plan to carry out their duties and responsibilities. These documents will become part of the association records. Elections will be held and results announced at the TPHA Annual Education Conference in Arlington, Texas on March 22, 2012.

Please consider this very important challenge to become a leader in TPHA!

**TPHA Annual Education Conference**

The TPHA Annual Education Conference is scheduled for March 21-23, 2012, Arlington, Texas. Look for information on session topics and speakers in this issue.

**Sheraton Arlington Hotel**

1500 Convention Center Drive

Arlington, Texas 76011

Room rates: $99 single/$139 double (please note: Single rooms are limited availability and will be available on a first come-first served basis).
Call for NOMINATIONS for the 2012 TPHA AWARDS

HONORARY LIFE MEMBER
One of the greatest distinctions bestowed on a member of the Texas Public Health Association is that of Honorary Membership. Any active member may nominate a prospective candidate for Honorary Membership by writing to the Awards Committee. The following criteria are required of nominees for Honorary Membership:

- Must have been an active continuous member of TPHA for at least 20 years and must have attended ten or more annual meetings.
- Must have served the Association contributing to annual and regional meeting programs, holding office within the Association, and participating in Association committees.
- Supporting documentation such as letters from employers, individuals, public citizens or community groups, schools or colleges, or businesses; news clippings, photographs; journal articles; or other documentation pertinent to the nomination.

JAMES E. PEA VY MEMORIAL AWARD
The James E. Peavy Memorial Award is presented annually to the public health worker in Texas who has made significant contributions to the advancement of public health knowledge or practice or who has demonstrated a genuine concern for the health needs of society. This award is the Texas Public Health Association’s highest accolade for outstanding health professionals; it consists of a $500.00 honorarium and plaque. The award serves as a living memorial to James E. Peavy, M.D., who served as Commissioner of Health in Texas from 1959 until his retirement in 1975. Dr. Peavy was an active member of the Texas Public Health Association for 39 years and was made an Honorary Member in 1969. The following criteria are required of all nominations:

- Eligible once every five years
- Members may apply or may be nominated by TPHA members

Letter of Application/Nomination must include but not be limited to:

- Name - Demographics (address, work phone #, etc.)
- TPHA section and length of membership
- TPHA activities and contributions
- Statement of need

DEADLINE: January 15th

Send letter of nomination/application via email at txpha@aol.com with “Conference Scholarship” in the subject line. For more information E-mail: Txph@aol.com

Member Correspondence
We would like to communicate with our members more frequently and would prefer to utilize email when possible. If you have a new email address please let the TPHA office know by emailing Terri at txpha@aol.com.

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SAVE THE DATE
Texas Public Health Association
88th Annual Education Conference
“Pitching Public Health: A Home Run for ALL”
March 21-23, 2012

Sheraton Arlington Hotel
1500 Convention Center Drive
Arlington, Texas 76011

Room rates: $99 single/$139 double
(please note: Single rooms are limited availability and will be available on a first come-first served basis)
Call: (800)442-7275  Room block open until March 1, 2012 12:00 p.m.
Group Name: Texas Public Health Association 2012 Annual Convention

Parking-complimentary
High speed internet in all guest rooms-complimentary
20% discount offered in Cactus Pear restaurant and Marketplace Café
### Day One – March 21, 2012

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
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<tbody>
<tr>
<td>9 am– 11:30 am</td>
<td>Preconference #1-CPRIT</td>
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<tr>
<td>9 am– 11:30 am</td>
<td>Preconference #2-Emergency Preparedness</td>
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<tr>
<td>9 am– 11:30 am</td>
<td>&quot;Just For Students&quot; Session</td>
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<td></td>
<td>Melissa Oden, DHEd, LMSW-IPR, MPH, CHES</td>
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<td>This &quot;students only&quot; session provides a place for Public Health Students to</td>
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<td>learn about the history of TPHA, as well as an opportunity to network with</td>
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<td>each other and with key TPHA members who act as mentors during this</td>
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<td>session. This fun, interactive workshop will provide students with the</td>
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<td>knowledge they need to experience a successful TPHA AEC.</td>
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<tr>
<td>11:30 am-12:30 pm</td>
<td>Governing Council Meeting</td>
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<td>1 pm-3:15 pm</td>
<td>Opening Plenary Session</td>
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<td>Bobby Schmidt, MEd, TPHA President, Presiding</td>
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<td>Welcome Remarks</td>
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<td></td>
<td>Lou Brewer, RN, MPH, Director, Tarrant County Public Health Department</td>
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<td></td>
<td>Richard S. Kurz, PhD, Professor and Dean, University of North Texas Health Science Center School of Public Health</td>
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<td>Mayor/Elected Official to welcome TPHA to Arlington, Texas</td>
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<td></td>
<td>Dr. David Lakey, Commissioner of Health, Texas Department of State Health Services (invited)</td>
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<td></td>
<td>Tom Suehs, Executive Commissioner, Texas Health &amp; Human Services Commission (invited)</td>
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<tr>
<td>3:30-5:00 pm</td>
<td>Research Paper Presentations</td>
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<td>Patricia Diana Brooks, Moderator</td>
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<tr>
<td>5:15-7:15 pm</td>
<td>Grand Opening of Exhibits and Poster/Educational Materials Displays</td>
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</tbody>
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### Day Two – March 22, 2012

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Title</th>
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<tbody>
<tr>
<td>8:30 – 9:30 am</td>
<td>Plenary Session</td>
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<tr>
<td></td>
<td>Social Determinants of Health: Potential for Change in Public Health Practice-Panel</td>
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<td></td>
<td>Ben G. Raimer, MD, Chair, Governor’s Task Force for Health Disparities,</td>
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<td>Moderator</td>
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<td></td>
<td>Alexandra Nolen, PhD, MPH, Director, Center to Eliminate Health Disparities, UTMB</td>
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<td></td>
<td>Eva Moya, PhD, LMSW, Assistant Professor, Department of Social Work,</td>
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<td></td>
<td>College of Health Sciences, The University of Texas at El Paso</td>
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<td>9:45 – 10-45 a.m.</td>
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<tr>
<td>Concurrent Session 1</td>
<td>Concurrent Session 2</td>
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<tr>
<td>Using Public Policy to Improve Public Health-State and Local Policy Perspectives</td>
<td>Health Information Technology</td>
</tr>
<tr>
<td>Tate Erlinger, MD, MPH, Texas Department of State Health Services and George T. Roberts, Jr., FACHE, CEO, Northeast Texas Public Health District</td>
<td>Susan McBride, PhD, RN Professor Texas Tech University Health Sciences Center School of Nursing</td>
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<tr>
<td>Concurrent Session 4</td>
<td>Concurrent Session 5</td>
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<tr>
<td>Community Resiliency and Emergency Management</td>
<td>Preparedness and Response at Ranger Stadium</td>
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<tr>
<td>Rebecca Knight</td>
<td>Curtis Dunn, EMT, Texas Rangers Ballpark in Arlington, Texas, Retired Firefighter</td>
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**12 -1 pm LUNCH ON YOUR OWN**

**1:15-2:15 pm**

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<thead>
<tr>
<th>Concurrent Session 7</th>
<th>Concurrent Session 8</th>
<th>Concurrent Session 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPIDEMIOLOGY AND CAPACITY BUILDING</td>
<td>Age Well, Live Well</td>
<td>Using Public Policy to Improve Public Health-State and Local Policy Perspectives</td>
</tr>
<tr>
<td>Building Epidemiology and Response Capability in Texas-2010-2011</td>
<td>Ken Bomar, Texas Department on Aging and Disability Services</td>
<td>Tate Erlinger, MD, MPH, Texas Department of State Health Services and George T. Roberts, Jr., FACHE, CEO, Northeast Texas Public Health District</td>
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<tr>
<td>Lisa Abate, PhD and Araceli Rey, RN, MPH Community Preparedness Section, Texas Department of State Health Services (1:15-1:45)</td>
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<td>David Zane, MS, and Tracy Haywood, BS Strategic Preparedness Team, Community Preparedness Section, Texas Department of State Health Services (1:45-2:15)</td>
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2:15-2:45 pm Break and Visit Exhibits and Poster/Educational Materials Displays

**2:45-3:45 pm**

<table>
<thead>
<tr>
<th>Concurrent Session 10</th>
<th>Concurrent Session 11</th>
<th>Concurrent Session 12</th>
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</thead>
<tbody>
<tr>
<td>OUTBREAK INVESTIGATIONS Chagas: Are We Missing Something?</td>
<td>The Impact of Aging and Alzheimer’s on Population Health</td>
<td>Community Health Education Programs that Work</td>
</tr>
<tr>
<td>Roger Sanchez, MPH, San Antonio Metropolitan Health District and Edward J. Wozniak, DVM, PhD, Texas Department of State Health Services (2:45-3:15)</td>
<td>James Simpkins, PhD, Professor of Pharmacology and Neuroscience, Graduate School of Biomedical Sciences and Thomas Fairchild, PhD, (not yet confirmed) Associate Professor of Health Management and Policy,</td>
<td>Dr. Jenny Lee (UNTHSC) The Good News Program (28 African-American Churches in Dallas area participating in a CVD prevention program.) She will tell us about that program and what it involves, how it is working, being evaluated.</td>
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<tr>
<td>Outbreaks</td>
<td></td>
<td>Dr. Heather Kitzman-Ulrich (UNTHSC)</td>
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</tbody>
</table>
The "Vickory is Active" project is a physical activity program aimed at a very diverse area of Dallas where 5 languages are spoken. There is also a community garden program that sprung up from this and the Good News program and Heather has an R03 aimed at preventing obesity in kids. She will give an overview of each.

4-5 pm

<table>
<thead>
<tr>
<th>Concurrent Session 13</th>
<th>Concurrent Session 14</th>
<th>Concurrent Session 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURVEILLANCE</td>
<td>Health Literacy</td>
<td>Impacting Community Health through Translational Research</td>
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<tr>
<td>Mortality and Causes of Death in the Seriously Mentally Ill of Texas</td>
<td>Michelle Malizia, Associate Director</td>
<td>Mark DeHaven, PhD, Professor of Social and Behavioral Science, Director, Texas Prevention Institute, School of Public Health</td>
</tr>
<tr>
<td>Robert J. Reynolds, School of Public Health, University of Texas Health Science Center at Houston (4-4:30) and Varicella in Texas, 2006-2010</td>
<td>NN/LM South Central Region (NN/LM SCR)</td>
<td>And Kathryn Cardarelli, PhD, Associate Professor of Epidemiology, School of Public Health</td>
</tr>
<tr>
<td>Lucille L. Palenapa, MS, Emerging and Acute Infectious Disease Branch, Texas Department of State Health Services (4:30-5)</td>
<td>Houston Academy of Medicine-Texas Medical Center (HAM-TMC) Library</td>
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5:30-7:30 pm

Reception & Awards Presentations (5:30-6:30 food and 6:30-7:30 awards presentations)

Day Three– March 23, 2012

9-10 am

<table>
<thead>
<tr>
<th>Concurrent Session 16</th>
<th>Concurrent Session 17</th>
<th>Concurrent Session 18</th>
</tr>
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<tbody>
<tr>
<td>Life is Better than Fiction: Reaching Policy-Makers with PHN Stories</td>
<td>Focus on Medical Special Needs (Past Experience and Best Practices)</td>
<td>Accreditation of Local Public Health: What It Means for Your Department</td>
</tr>
<tr>
<td>Lisa A. Campbell, DNP-PHN, RN, GNP-BC</td>
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<td>Matt Richardson, DrPH, Director, Amarillo Department of Public Health</td>
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<td>Lou Brewer, RN, MPH, Director, Tarrant County Public Health</td>
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10:15-11:15 am

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<thead>
<tr>
<th>Concurrent Session 19</th>
<th>Concurrent Session 20</th>
<th>Concurrent Session 21</th>
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<tbody>
<tr>
<td>Alpha Radiation in the Water Supply</td>
<td>Mass Fatality Plan and Mass Dispensing</td>
<td>Complementary and Alternative Medicine–Who is Contributing to Public Health?</td>
</tr>
<tr>
<td>Irina Cech, PhD, Professor (RET), The University of Texas Health Science Center at Houston (UTHealth)</td>
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<td>Will Evans, DC, PhD, MCHES, Texas Chiropractic College. (intro on CAM and National Health Interview Survey Results on Prevention of Chronic Disease)</td>
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<tr>
<td>Time</td>
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<tr>
<td>11:30 am-1:30 pm</td>
<td>Lunch and Closing Session</td>
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<td>Panel Discussion</td>
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<td></td>
<td>Eduardo Sanchez, M.D., Moderator</td>
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<td>US Surgeon General Richard Carmona (to be invited)</td>
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<tr>
<td>2-4 pm</td>
<td>2013 Program Planning Committee Meeting</td>
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<td></td>
<td>Incoming Executive Board Meeting (immediately following Program Planning</td>
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<td>Meeting)</td>
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Register Today

www.texaspha.org
The TPHA Public Health Presentations Committee Competition  
At TPHA’s 88th Annual Education Conference  
CALL FOR ABSTRACTS  
Public Health Posters, Research Papers & Education Materials Projects

The upcoming meeting offers presenters and participants a unique opportunity to promote TPHA’s emphasis on continuing education. Abstracts describing original research in a public health area for a paper or poster presentation or educational materials display are now being accepted. Submissions may include graduate student research projects, program evaluations or other original work. *Exhibits, descriptions of programs, advertising of products, etc. are not considered to be posters or public health education material.*

TPHA and affiliate members, local and regional health departments, hospitals, universities, and students are eligible to submit abstracts. **Entrant is not required to be a member of TPHA, but IS required to pay TPHA registration fees for the annual conference and you must attend the conference.** A **$200 award** and a **plaque** will be presented to the winner in each of the 3 categories. Winning abstracts will be published in *Texas Public Health Journal.*

If you are a **graduate** student in a School of Public Health or related health science program, you have an ADDITIONAL opportunity to compete for a **travel scholarship up to $400**. To compete, include a letter of endorsement from a faculty member (can be an email attachment) with your abstract and check the box for “wish to compete in student abstract competition” on the abstract form. If selected, you then will present your work at our annual meeting. Get forms at [www.texaspha.org](http://www.texaspha.org).

**Categories and rules of Competition:**

**NOTE:** An individual creation may only be entered once. Presenters may enter more than one paper or poster, provided each covers a different topic. Both a paper and a poster may be presented, provided that each covers a different topic.

1. **Public Health Education Materials:** Projects designed to educate the public on a public health topic. Some examples are: pamphlets, brochures, slide shows, videotapes, computer programs, etc. Tables will be provided to display your materials. Each presenter will have 4’ of space. Education Materials presenters must provide and be responsible for their own equipment (TV, VCR, laptop computers, etc.).

2. **Research Papers:** (Original research of an empirical nature, conceptual or methodological issues or innovative techniques in a public health area) Paper presentations will have a strictly enforced time limit of 15 minutes.

3. **Poster Presentations:** (Original research of an empirical nature, conceptual or methodological issues or innovative techniques in a public health area) Posters must present original work with a problem statement and results presented in poster form. Poster must be displayed on the 3 foot by 5 foot poster foam board on easel provided. Bring your push pins.

**Judging of all presentations is weighted most heavily on Evidence of public health contribution but is also judged on clarity, overall plan and organization of material, delivery of research paper, ability to answer questions and knowledge of topic.**

All Presentations (posters, research papers and education materials projects) are automatically eligible for the additional $100 “Members’ Choice” award. The winner of this award is chosen by majority vote of meeting attendees.

**DEADLINE** for submission of abstracts for all categories is December 31, 2011 and must be submitted in Microsoft Word format ONLY in Times New Roman 12 point font. **No exceptions.** Please contact P. Diana Brooks if you are not notified by February 17, 2012. **Email abstracts and submission forms to Txpha@aol.com AND abstractspdb@yahoo.com.** See page 38 for information on registering.

For more details about the competition, presenting at or attending the TPHA conference, visit [www.texaspha.org](http://www.texaspha.org).
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