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In Partnership with the People of Yakima County, the Public Health District Provides Prevention, Education, and Disease Control Services to Promote, Protect, and Enhance the Health and Safety of all.

YHD BULLETIN

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Local Public Health Indicators, Yakima County

The Washington State Department of Health (DOH) has developed a local public health indicators website, displaying 35 indicators that provide a sampling of health status, health behavior, and public health system data at the local level. Data acquisition dates vary from 2007 to 2010, depending on the specific item. Potential uses of the data include: (1) public health resource allocation and evaluation; (2) comparison of health status across jurisdictions and with the nation as a whole; and (3) integration with DOH's Public Health Standards (a distinct but related process aimed at ensuring that local public health agencies across the state meet essential capacity and performance measures).

The table on page 7 summarizes the data for Yakima County in comparison to Washington State and to the United States. Yakima County was better than state or national indicators with respect to immunizations, utilization of first-trimester prenatal care, low birth weight, behaviors related to alcohol and cigarette smoking, and air quality. Yakima County was on par with state and national indicators for items related to access to health care, adult health promotion behaviors, and correction of on-site sewage failures. Yakima County lags behind state or national indicators related to reproductive health (e.g., chlamydia and teen births), adult health insurance, poverty, childhood hospitalizations for unintentional injuries, diabetes, many preventive health markers (physical activity, obesity, colon cancer screening), teen depression, and life expectancy.

These findings should be familiar to frequent readers of the Bulletin, as many of these indicators have been addressed in past editions as conditions or risk factors associated with poor health outcomes in Yakima County. At least two caveats are warranted in interpreting and acting upon these data.

First, although the findings are presented here on the basis of better-than, same-as, or worse-than comparisons with the state and nation, such comparisons may not always suggest or warrant direct compensatory actions. Yakima's higher poverty rate is upstream from and lower life expectancy rates are downstream from evidence-based public health interventions more amenable to short-term improvements (e.g., influenza immunization and restricting teen access to alcohol and cigarettes). Here is a case where YHD might not directly address one or more poorly performing indicators (poverty, longevity) while adding efforts to further improve relatively well performing functions (immunizations, tobacco use prevention). Another poorly performing indicator, lack of health insurance coverage among adults, points out a local manifestation of a broader national public policy issue that local public health agencies are not in a position to meaningfully or sustainably address. Nevertheless, although not directly actionable by local public health, these types of indicators provide information to civil society about areas of need that may deserve community-based action or services at the local level, as well as which merit representation and emphasis in public policy development that occurs on a state and national level.

Second, these indicators are but one ingredient in a multi-factorial prioritization process for allocation of scarce local public health resources. In addition to absolute and comparative findings from objective health data such as these indicators, the following factors also play an important role in the prioritization process:

- statutory powers and duties assigned by the state legislature to the health officer and local Board of Health,
- rules established by the State Board of Health,
- individual severity and overall societal burden of morbidity associated with various

- conditions,
- varying availability of evidence-based technology and interventions for prevention and control, and
- economic implications of various conditions and their prevention or treatment.

As ongoing revenue shortfalls at the local, state, and national level continue to loom over the public sector, YHD’s Board and staff continue to account for these factors as they allocate diminishing resources for public health and attempt to sustain efforts to bring those resources to bear on the highest priority activities for the benefit of residents of Yakima County.

Further Reading and Resources

Washington State Department of Health. Local Public Health Indicators. <http://www.doh.wa.gov/hip/products/phi/overview.htm> (accessed 05 December 2011).

Washington State Legislature. RCW 70.05.060 Powers and duties of local board of health. <http://apps.leg.wa.gov/rcw/default.aspx?cite=70.05.060> (accessed 05 December 2011).

Washington State Legislature. RCW 70.05.070 Local health officer — Powers and duties. <http://apps.leg.wa.gov/rcw/default.aspx?cite=70.05.070> (accessed 05 December 2011).

Yakima Health Assessment, 1930

Moving from the preceding article, emphasizing health indicators of the present, we turn another page in the YHD centennial celebration to look back upon a 1930 health assessment sponsored by a local women’s service organization and a life insurance company. The preface of *A Review of Health Conditions and Needs in Yakima, Washington* urged one “to read [the report] and to give your support to any sound and responsible movement for improving conditions.” The succinct and well-written 12-page document provides an overview of the city history, its contemporary civic features, the organization and budget of the city-county health department (the FIRST such organization in the nation), local morbidity and mortality data, special services and programs, and recommendations for improvement.

In 1930, the population of Yakima was 22,100 and the assets of St. Elizabeth’s Hospital (now Yakima Regional Medical & Cardiac Center) were estimated at \$700,000 (about \$9 million in inflation-adjusted 2010 dollars). The County Health Unit employed 14 personnel and had a budget of \$41,480 (\$536,000 2010 dollars). A newly passed ordinance established compulsory examination for communicable diseases among all food handlers. Births outnumbered deaths by about 2-to-1 (i.e., 650-700 births, 350-400 deaths). Today the ratio is about the same (2.33; 4300 births, 1900 deaths). Annual crude mortality was

more than double what it is today (1700/100,000 vs. 725/100,000). Infant mortality was about 10 times its current magnitude (50-90 deaths per 1000 live births then vs. 5 per 1000 today).

Tuberculosis (TB), pneumonia, and diarrhea/enteritis were the leading causes of death compared to heart disease, cancer, and stroke today. About 75 cases of TB were reported annually (average 10-12 today), and most TB cases were transported to Spokane for sanitarium care. Other frequently reported communicable diseases included smallpox, scarlet fever, diphtheria, pertussis, typhoid fever, and measles.

Special programs existed for examination and care of poor children in schools, goiter prevention, children needing orthopedic procedures, and venereal (sexually transmitted) disease control. Dairy inspections and milk testing were routine, with 35% of distributed milk being pasteurized. A modern municipal clean water system collected water from underground sources in the Naches watershed near Oak Flat, ran it through a sand-and-gravel filter bed and stored it in a 12 million gallon underground concrete reservoir that was tested daily and provided water to 98% of city dwellings. Solid waste was burned by incineration at the city dump.

Recommendations made at the end of the report included expanding the infant welfare nurse from a half-time to a full-time position, establishing a sewage disposal plant to mitigate the impact upon Lower Valley residents of dumping of raw sewage into the Yakima River, increasing coverage with diphtheria vaccination, increasing the proportion of milk that is pasteurized, and improving reporting of contagious diseases and unsanitary conditions by physicians and residents.

Although the dates, figures, and details may have changed and outcomes are better today, we use the same basic principles now as then for controlling public health threats: site inspections, education and application of technology to mitigate environmental threats; surveillance, clinical services, and vaccines/therapeutics for control of contagious diseases; and early detection, education and referral for special needs of expectant mothers and young children.

To view the 1930 report in full go to http://yakimahealthdistrict.org/w/wp-content/uploads/2010/12/yhd_con.pdf.

Prostate Cancer Screening Guidelines

The United States Preventive Services Task Force’s (USPSTF) recent circulation of its draft prostate cancer screening (PCS) guidelines¹ and ensuing discussion of those and other PCS guidelines in a major medical journal,²⁻⁷ highlighted the limitations of routine prostate specific

antigen (PSA) testing in reducing prostate cancer mortality. More importantly, all recommending bodies and editorial discussants called upon primary care providers—initiators of the vast majority of PSA testing—to take a more active role in engaging their patient in making informed decisions about PCS.

“For two decades, primary care physicians have been expected to present a flawed screening test to patients, cloaking the flaws in an elaborate ritual of informed decision making. In turn, men have been expected to make sense of a confusing mix of hypothetical outcomes. Although the USPSTF recommendation is unlikely to end the PSA controversy, a document finally exists that should provide guidance to clinicians and policymakers.”⁵

Asymptomatic Prevalence, Reported Incidence and Mortality

Prostate cancer is a clinically heterogeneous disease. Autopsy studies have shown that approximately one third of men aged 40–60 years have histologically evident prostate cancer; the proportion increases to as high as three-fourths in men older than age 85 years. Most of these cases represent microscopic, well-differentiated lesions that are unlikely to be of clinical importance.¹

In the United States, prostate cancer is the most commonly diagnosed non-dermatologic cancer in men. After cancers of the lung and colon, it is the third most common cause of death due to cancer in men. Average age at diagnosis is 67 years. Among African Americans, incidence rates are about 60% higher and mortality rates are about 100% higher than among whites. Incidence is also higher in men with a first-degree relative diagnosed at age <65. In Yakima County, this translates into about 140-150 men diagnosed and 15-20 deaths annually. Annual incidence and mortality rates in Yakima County (136 and 18 per 100,000, respectively) are slightly below state and national figures (160 and 25 per 100,000, respectively).

Methods, Potential Benefits and Potential Risks of Prostate Cancer Screening

Digital rectal exam (DRE), PSA measurement in serum, and transrectal ultrasound are the available methods for PCS in asymptomatic men. However, recommending bodies focus on use of PSA and DRE. In addition, a risk assessment should include patient race and family history.

Theoretically, early detection and treatment of potentially curable prostate cancer might afford better chances of survival with localized disease. Yet, most prostate cancers are indolent and may never advance or progress to cause significant disease or death. Survival benefit from prostate cancer screening has not been demonstrated in rigorous trials. Both USPSTF and Cochrane Collaboration meta-

analyses of all eligible trials failed to find discernable benefits in terms of mortality.^{1,8} False negative results could delay the diagnosis of an aggressive tumor. False positive results may lead to increased anxiety and having to experience the discomfort and possible complications associated with biopsy (e.g., pain, hematospermia/hematuria, and infection). Treatment for prostate cancer can cause both short- and long-term side effects (e.g., pain, urinary incontinence, and impotence).

PSA can be obtained with a simple blood test and is widely available, affording PCS to men who might otherwise refuse DRE. Another potential benefit is the reassurance of being at low risk for prostate cancer among men with normal PSA results. However, both false positive and false negative results do occur resulting in considerable uncertainty in interpretation of results, especially in the region where results are indeterminate (e.g. 2.5-4.0ng/ml). Efforts to improve test performance by indexing PSA results in various ways (e.g., free, age-adjusted, velocity, density, slope, doubling time) have yielded no reliable correlation with outcomes. However, evidence does exist to support the practice of incorporating additional clinical information (e.g., DRE, transrectal ultrasound, prostate volume estimation) along with PSA testing to improve its predictive value. Patients with the same 4.0ng/ml PSA result but with divergent clinical findings have a biopsy-proven cancer risk that varies from 8% to 65%.⁶

Recommendations of Key Bodies

Recommendations of the American Urological Association, the American Cancer Society, and the USPSTF are summarized in the table at the bottom of page 4.

Despite the difference in details between the guidelines of recommending bodies, a great deal of agreement about PCS does exist. All bodies agree that, given the lack of conclusive evidence that screening can reduce mortality from prostate cancer, a clinician should not order the PSA test without first discussing with the patient the potential but uncertain benefits and the documented risks of prostate cancer screening and treatment. The decision to undergo PCS screening should be individualized, take into account the gaps in knowledge about benefit-risk ratio, and incorporate personal preferences, baseline health status, and life expectancy of the patient. If the decision to screen is made, there is overall agreement that while the PSA test is more sensitive than the DRE, the DRE adds worthwhile information to the PCS assessment. Although it is tempting to apply PCS screening more liberally to higher risk groups (e.g., African Americans, men with a family history of prostate cancer), the same evidence gaps and limitations that apply to PCS in general also apply to these groups, so most discussants on the matter shy away from promoting more aggressive approaches toward these groups.

Another issue addressed on the periphery of these recommendations is the economic implication of PCS. Applying data from the sole large scale study which did show some benefit to population-based screening (a 0.07% reduction in prostatic cancer deaths in the European screening trial), it has been estimated that over \$5 million dollars would need to be spent to prevent one death from prostate cancer.⁵ While the value of a life cannot be tagged with a price, the cost of saving healthy life years can be compared across interventions. PCS fares poorly in the contemporary context of competing for limited resources.

The PSA/PCS debate points out how yet another imperfect test can be misleading or even harmful when applied indiscriminately and interpreted in isolation. But it can also be quite helpful in the context of an overall risk assessment following informed decision making. In many cases, the appropriate choice for many men will be to not perform the test at all. Meanwhile, others who weigh the same benefits and risks differently are sure to pursue testing. While the UPSTF draft recommendations suggest that PCS not be addressed unless the patient asks, other legitimate bodies and discussants recommend more proactive approaches. Regardless of the column in the table that one favors, all primary care providers should become fluent in facilitating a patient-centered discussion about PCS to enable patients to make an informed choice about PCS screening and what lies beyond if the results are abnormal.

References

¹United States Preventive Services Task Force. Screening for Prostate Cancer: U.S. Preventive Services Task Force DRAFT Recommendation Statement. <http://www.uspreventiveservicestaskforce.org/draftrec3.htm> (accessed 05 December 2011).

²American Urological Association. Prostate-specific antigen best practice statement: 2009 update. Linthicum (MD): American Urological Association Education and Research, Inc.; 2009.

³Wolf AM, Wender RC, Etzioni RB, Thompson IM, D'Amico AV, Volk RJ, Brooks DD, Dash C, Guessous I, Andrews K, DeSantis C, Smith RA, American Cancer Society Prostate Cancer Advisory Committee. American Cancer Society guideline for the early detection of prostate cancer: update 2010. *CA Cancer J Clin* 2010 Mar-Apr;60(2):70-98.

⁴Hoffman RM. Screening for prostate cancer. *N Engl J Med* 2011; 365:2013-2019

⁵Brett AS, Ablin RJ. Prostate-Cancer Screening — What the U.S. Preventive Services Task Force Left Out. *N Engl J Med* 2011; 365:1949-1951

⁶Schröder FH. Stratifying Risk — The U.S. Preventive Services Task Force and Prostate-Cancer Screening. *N Engl J Med* 2011; 365:1953-1955

⁷McNaughton-Collins MF, Barry MJ. One Man at a Time — Resolving the PSA Controversy. *N Engl J Med* 2011; 365:1951-1953

⁸Ilic D, O'Connor D, et. al. Screening for Prostate Cancer. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.: CD004720. DOI: 10.1002/14651858.CD004720.pub2.

Decision Making Aids and Risk Assessment Tools

Centers for Disease Control and Prevention. Prostate Cancer Screening: A Decision Guide. Available in English and Spanish language with a special version for African Americans. http://www.cdc.gov/cancer/prostate/basic_info/screening.htm [scroll to bottom of page for downloads] (accessed 06 December 2011).

Prostate Cancer Research Foundation. <http://www.prostatecancer-riskcalculator.com/via.html>

Prostate Cancer Screening Guidelines Comparison

Recommendation	AUA ²	ACS ³	USPSTF ¹
Patient-centered decision making	Yes	Yes (with decision aids)	Yes (only if patient requests)
Age to begin offering screening	Average—40 High-risk—40	Average—50 High-risk—40-45	Not recommended
Discontinuation of screening	Life expectancy <10 years	Life expectancy <10 years	Not applicable
Method	PSA+DRE	PSA (+/- DRE)	Not applicable
Frequency	Annual (less if <50 y/o and low PSA [e.g., <0.6-0.7ng/ml])	Annual (biennial if PSA <2.5ng/ml)	Not applicable
Criteria for biopsy referral	Comprehensive risk assessment including age, family history, race/ethnicity, PSA results, other conditions	PSA ≥4.0ng/ml or abnormal DRE or individualized risk assessment if PSA borderline	Not applicable

AUA: American Urological Association
 ACS: American Cancer Society
 USPSTF: United States Preventive Services Task Force

Adapted from Hoffman RM. N Engl J Med 2011; 365:2013-2019

Forthcoming Retirement of Dennis Klukan, MSEPH, YHD Administrator

YHD Administrator, Dennis Klukan, recently announced his forthcoming retirement, effective February 29, 2012. YHD would like to take this opportunity to publicly salute Dennis, not only for his fourteen years of service to Yakima County, but for an entire career dedicated to public service.

A native of the Buckeye State, Dennis' professional life began as a fourth grade classroom teacher of 40 students at St. Michael's Elementary School in Independence, Ohio. He then went on to volunteer four years in the United States Navy as a staff member to the Commander of the Submarine Force of the Atlantic Fleet. Upon return to civilian life, Dennis attended the University of Toledo, earning a Bachelor of Science degree in social work and a Master of Science and Education in Public Health. Dennis worked his way through school, spending time as a personnel counselor for an Ohio-based staffing firm, a placement specialist for the Ohio Bureau of Services for the Blind, and the Director of Vocational Services for the Toledo Society of the Blind. After completing his graduate education, Dennis first went on to serve as the Director of Medical Social Services at Blanchard Valley Hospital in Findlay, Ohio.

Dennis' career as a public health official began three years later (now 30 years ago) as Commissioner of Public Health for the Kent City Department of Health, where he served for six years. He then spent three years as the Commissioner for the Medina County Department of Health. Greener pastures and bigger skies then brought Dennis west to Flathead County, Montana, where he served as Health Officer for 11 years. Finally, Dennis took one more giant leap west to take the YHD Administrator reigns from Gail Weaver in 1998. As Administrator, Dennis continued the transformation of YHD that began following its reorganization several years prior to his arrival and which has brought YHD to its current state as an efficient, effective, and respected population-based public health agency. Looking back on his career, Dennis says, "I feel that the greatest privilege in my life has been to serve in public health services for the past 30-plus years."

YHD is grateful to Dennis for the years of service he provided to the agency, to Yakima County, and to public health. His leadership, smile, warm greetings, and sense of humor will be missed, and we wish him and his family the best in the days, months and years that follow February 29, 2012. If you have the opportunity to do so, please express to Dennis your thoughts and memories of his days at YHD (dennis.klukan@co.yakima.wa.us).

STD Update for Clinicians Planned in 2012

A course designed for clinicians in the Yakima area, who diagnose and treat patients with sexually transmitted infections will be offered March 1, 2012 at the Yakima Convention Center. The training will offer both CME and CNE credits. The training is sponsored by the Seattle STD/HIV Prevention Training Center.

The Seattle STD/HIV Prevention Training Center (PTC) provides training to health care providers in Alaska, Idaho, Oregon and Washington on the prevention, diagnosis, management and treatment of sexually transmitted diseases.

Education and training programs are specifically designed for physicians, nurses, physician assistants, nurse practitioners, laboratorians, health educators and other health care professionals. Clinical and laboratory training programs include in-person lectures and didactic courses, hands-on clinical and laboratory experience, clinical consultation on all aspects of managing patient care and, Internet-based training and educational resources.

The Seattle PTC is one of eight regional training sites funded by the U.S. Centers for Disease Control and Prevention. <http://www.cdc.gov/>. In operation at the University of Washington <http://www.washington.edu/> since 1979, the Seattle PTC leads the way in providing world class STD/HIV training to health care providers in the Pacific Northwest. As a member of the National Network of STD/HIV Prevention Training Centers, <http://depts.washington.edu/nnpct/>, the Seattle PTC is affiliated with national and international programs involved in STD and HIV prevention, care and research. The Seattle PTC is associated with the Public Health-Seattle & King County <http://www.kingcounty.gov/healthservices/health.aspx> STD Clinic at Harborview Medical Center. Its teaching faculty are members of the University of Washington School of Medicine and personnel of PHSKC -- many are leaders in HIV and STD related research. A program of the UW Center for AIDS and STD <http://depts.washington.edu/cfas/>, the Seattle PTC also partners with health departments in Alaska, Idaho, Oregon and Washington to provide training and resources in each state.

A flyer with specific information on the training is included on page 8 of this Bulletin.



HAPPY HOLIDAYS!!!

FROM THE YAKIMA HEALTH DISTRICT

YAKIMA HEALTH DISTRICT

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<http://www.yakimapublichealth.org>



Dennis Klukan, MSEPH, Administrator
Christopher Spitters, MD, MPH, Health Officer
Devika Singh, MD, MPH Deputy Health Officer

Notifiable Condition <i>(includes confirmed and probable cases)</i>	Cases			Total Cases by Year	
	Jan- Nov	Jan- Nov	Jan- Nov	Total Cases by Year	Total Cases by Year
	2011	2010	2009	2010	2009
Campylobacteriosis	121	119	90	121	95
Chlamydia	1128	1020	1080	1111	1180
Cryptosporidiosis	1	4	2	4	3
Genital Herpes - Initial	71	46	53	51	57
Giardiasis	16	21	28	23	30
Gonorrhea	91	28	38	34	39
Hepatitis A acute	0	0	3	0	3
Hepatitis B acute	0	0	2	0	2
Hepatitis B chronic	7	4	8	4	9
Hepatitis C acute	0	1	1	1	1
Hepatitis C chronic	185	221	163	230	191
HIV/AIDS Cumulative Living	182	177	170	173	171
HIV/AIDS Deaths	4	5	5	6	5
HIV/AIDS New	12	11	17	11	17
Meningococcal	0	2	2	2	2
Pertussis	7	10	39	11	40
Salmonellosis	18	50	37	51	39
Shigellosis	9	2	6	2	7
STEC (enterohemorrhagic E. coli)	10	9	10	10	10
Syphilis - Primary and Secondary	8	6	2	6	2
Tuberculosis	6	9	6	9	7

**Notifiable
Conditions
Summary
Jan - Nov,
2011**

Yakima County Local Health Indicators, Update 2011

YAKIMA COUNTY <u>BETTER</u> THAN STATE OR NATIONAL FIGURES			
INDICATOR (with 95% confidence interval where appropriate)	YAKIMA COUNTY	WASHINGTON	UNITED STATES
Adult influenza vaccination (immunized in past 12 months, %)	39% (36-42)	38% (37-38)	36%
Child immunizations entered in Child Profile Registry (children 19-35 months with complete vaccination records in the registry, %)	51% (50-52)	42% (42-42)	N/A
First trimester prenatal care (%)	78% (76-80)	77% (77-78)	71%
Maternal cigarette smoking (%)	7% (7-8)	10% (10-10)	10%
Low birth weight (%)	5% (5-6)	5% (5-5)	8%
Teen cigarette smoking (%)	10% (9-11)	13% (11-14)	18%
Teen alcohol use (any use in past 30 days, %)	31% (29-33)	28% (26-30)	41%
Adult cigarette smoking (current smokers, %)	15% (13-18)	16 (15-16)	19%
Adult binge drinking (≥4-5 drinks in a single session in past 30 days, %)	13% (11-15)	16% (15-16)	16%
Hospitalization for falls in older adults (per 100,000 residents per year)	1620 (1514-1731)	1793 (1771-1815)	N/A
Days with clean air (meeting Dept. of Ecology 24-hour average clean air goal, %)	90% (87-93)	N/A	N/A
YAKIMA COUNTY <u>ABOUT THE SAME</u> AS STATE AND NATIONAL FIGURES			
INDICATOR (with 95% confidence interval where appropriate)	YAKIMA COUNTY	WASHINGTON	UNITED STATES
Adults with unmet medical need (in past 12 months due to cost, %)	16% (14-19)	13% (13-14)	15%
Adults with personal health care provider (%)	78% (75-81)	78% (77-78)	81%
Adult dental care (% in past year)	69% (64-73)	72% (71-73)	70%
Breast cancer screening (women ≥50 years with mammogram in past 2 years, %)	78% (72-82)	78% (77-79)	79%
Cervical cancer screening (women ≥21 years with pap smear in past 3 years, %)	76% (71-80)	76% (75-77)	79%
Children with health insurance (%)	92% (87-95)	95% (95-96)	N/A ³
Chlamydia infections treated (among reported cases in 15-24 year-old females, %)	97% (96-98)	97% (97-97)	N/A
Adult physical activity (regular moderate-to-vigorous physical activity, %)	60% (56-65)	62% (61-63)	58%
Adult fruit and vegetable consumption (≥5 servings per day, %)	23% (20-27)	26% (25-27)	25%
Adults with poor mental health (self report of ≥50% of days as poor, %)	10% (8-12)	10% (9-11)	10%
On-site sewage system (corrective action initiated within 2 weeks, %).	94% (88-97)	95% (94-95)	N/A
YAKIMA COUNTY <u>WORSE</u> THAN STATE OR NATIONAL FIGURES			
INDICATOR (with 95% confidence interval where appropriate)	YAKIMA COUNTY	WASHINGTON	UNITED STATES
Colorectal cancer screening (≥50 years undergoing screening, %)	64% (58-68)	72% (71-73)	65%
Adults with health insurance (%)	73% (69-76)	82% (82-83)	81%
Reported chlamydia infections (per 100,000 residents per year)	3648 (3451-3854)	2277 (2247-2308)	3209
Poverty (living at or below 100% of U.S. federal poverty level, %)	22% (19-25)	12% (12-13)	14%
Teen physical activity (≥60 minutes per day for ≥5 days in prior 7 days, %)	50% (47-53)	51% (47-55)	61%
Teen births (to women 15-19 years of age per 100,000 per year)	57 (53-62)	28 (28-29)	N/A
Teen overweight and obesity (≥85 th percentile weight-for-height among 10 th graders, %)	32% (30-35)	24% (22-27)	28%
Teen sadness or hopelessness (≥14 days in a row in past 12 months, %)	34% (32-35)	30% (28-31)	26%
Years of healthy life expected at age 20	46 (44-47)	51 (51-52)	48
Adult obesity (body mass index >30kg/m ² , %)	30% (27-33)	25% (25-26)	27%
Adults with diabetes (as told by a physician, %)	10% (8-11)	7% (7-7)	8%
Childhood hospitalizations for unintentional injury (per 100,000 children per year)	276 (249-305)	204 (199-209)	N/A
Inspected food establishments found to have fewer than 36 critical violation points (%)	88% (86-89)	95% (94-95)	N/A

Source: Washington State Department of Health. Local Public Health Indicators. <http://www.doh.wa.gov/hip/products/phi/overview.htm> (Accessed 05 December 2011).

The Seattle STD/HIV Prevention Training Center presents

March
1st
2012

STD Update for Clinicians

Yakima Convention Center

10 North 8th Street
Yakima, Washington 98901

8:30am-4:45pm

\$75

Seating is limited and pre-enrollment by February 21st is required.

Hotel rooms and dinner meals are not covered in the registration fee and are the participants' responsibility. Lunch and a Continental breakfast will be provided. Nearby free parking is available.

Please visit our website for online registration and payment information

www.seattlestdhivptc.org

(206) 685-9850
seaptc@u.washington.edu



Seattle
STD/HIV

PREVENTION TRAINING CENTER

This course is designed for clinicians in the Yakima area who diagnose and treat patients with sexually transmitted infections.

The STD Update course provides participants with training in the most recent advancements in the epidemiology, diagnosis, and management of viral and bacterial STDs.

- By the end of the course participants will be able to:
- Discuss the latest diagnostic and testing procedures for the infections covered.
- List the current recommended treatments for the sexually transmitted infections covered.

Continuing Medical & Nursing Education Credit Available

Continuing Medical Education: The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The University of Washington School of Medicine designates this live activity for a maximum of 6.5 AMA PRA Category 1 Credit(s)[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Continuing Nursing Education: Professionals who wish to receive a contact hour certificate must complete a CE registration form (provided at the course), all course activities, and an evaluation. A certificate for 6.5 contact hours will be awarded.

*The University of Washington School of Nursing is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

***Psychologists:** The UW School of Nursing qualifies as a Washington State CE program sponsor under WQAC 246-810-610.

***Social Workers and Counselors:** The UW School of Nursing qualifies as a Washington State CE program sponsor under WAC 246-924-240(1).

***Other Disciplines:** A certificate will be awarded for use in documenting completion of this offering.