

Northwest PUBLIC HEALTH

Letters to the Editor

Don't leave out VISTA

I read with great interest the article "Public Health Informatics Transforms the Notifiable Condition System" [Summer 2001]. However I was dismayed to see that the list of component projects in WEDSS left out VISTA-PH, a tool that public health entities have been using routinely for at least five years.

VISTA helps public health staff conduct standard statistical analyses and generate reports. In my Department, as in many others, we use VISTA routinely to follow disease trends, compare subpopulations and geographic entities, and make policy recommendations.

I believe you overlooked this important component of currently practiced public health informatics. In reading the article I began to question the support and commitment of the Washington State Department of Health to the VISTA project.

*Sherri McDonald, Deputy Director
Thurston County Public Health & Social Services*

Jac Davies replies

VISTA-PH has been a resounding success in assisting local health jurisdictions in the areas you mentioned. It is a marvelously detailed tool for conducting statistical analyses and generating reports that can be used in many ways.

VISTA-PH was not mentioned in the article for a couple of reasons. The article focused on the notifiable conditions surveillance system. WEDSS is simply a series of software and infrastructure solutions, focused on disease surveillance, that are being planned and designed together in a systematic fashion. WEDSS is also not a complete list of all possible statistical or data tools or programs for all public health practitioners. Many other tools and data analysis solutions for public health practitioners were not mentioned as well (including PRAMS, CHILD Profile, CHARS, and others). All of these viable and valuable tools for use by public health practitioners, including VISTA-PH, will continue to be supported by DOH.

Inclusion not just cultural competency

I'd like to compliment Betty Bekemeier on a fine feature about workforce development [Summer 2001]. She notes that public health advocates must "communicate and work in coalition with groups of diverse ethnic and religious backgrounds." That is true-but it is not enough.

The article focuses on training for the existing workforce, and within that context I applaud Ms. Bekemeier for including cultural competency. But readers should keep in mind that it is not enough to work with diverse groups; we must include those groups in our ranks.

A May report by the Washington State Board of Health documents the link between eliminating health disparities and diversifying the health workforce. Washington has a serious shortage of people of color in several health care professions-doctors, nurse practitioners, physician assistants, registered nurses, and practical nurses. The shortage is even more severe when you consider the disease burden of racial and

ethnic minorities. Though we lack data on the composition of much of the health workforce, the Board believes diversity is inadequate in other segments. It also believes improved diversity in all segments-including public health-will help eliminate health disparities.

The Board is asking professional associations to enumerate the racial and ethnic compositions of their memberships and to convene a panel to coordinate workforce diversity efforts. It has included the Washington Association of Local Public Health Officials in this request.

I would hope that the six states participating in the Northwest Regional Network for Public Health Workforce Development take a careful look at race and ethnicity as part of their workforce assessments, and that workforce development planning recognizes that cultural competency training alone is not enough. The public health workforce, to be truly effective, needs to reflect the populations it serves.

*Linda Lake, Chair
Washington State Board of Health*

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