Council of State and Territorial Epidemiologists
Position Statement

**03-ID-02**

**Committee:** **Infectious Disease**

**Title:** **State Food Safety Minimum Performance/Capacity Standards for Epidemiology and Surveillance**

**Statement of the Problem:**
In 1997, the CDC, FDA and USDA initiated the National Food Safety Initiative (NFSI) as an effort to decrease the incidence and risks of foodborne illness. The intent of the NFSI focuses on several components, one of which is to enhance the nation's surveillance and response capacity to outbreaks of foodborne illness. A long-standing goal of both CDC and CSTE has been to build state epidemiology and surveillance capacity to enhance the detection and prevention of foodborne illness. Currently, national public health systems do not have a measure of progress in place by which to assess the ability of state health departments to detect and prevent foodborne illness. In order to measure progress and as a measure for evaluation of financial support, baseline data are needed for state food safety programs. Since 2001, the CSTE Food Safety Standards Advisory Committee has been assessing foodborne illness surveillance and response capacity in state and territorial jurisdictions, and subsequently developing a set of minimum performance/capacity standards for state and local enteric/foodborne disease control programs. The proposed standards were published along with a 50-state survey in a September 2002 CSTE document entitled, National Assessment of Epidemiologic Capacity in Food Safety Programs: Findings and Recommendations.

**Position to be adopted:**
CSTE encourages the application of disease prevention and health promotion by supporting the use of effective public health surveillance and good epidemiologic practice through training, capacity building and advocating for resources. To assure that efforts appropriately targeted to the needs of state food safety epidemiology and surveillance programs, CSTE adopts the attached performance/capacity standards for food safety programs as developed by the CSTE Food Safety Standards Advisory Committee related to the following functions:

1. Epidemiologic Surveillance Capacity to Identify Sporadic and Outbreak Related Illnesses;
2. Capacity to Investigate and Respond to Outbreaks;
3. Public Health Infrastructure Necessary to Support Food Safety;
4. Legal Authority.

CSTE encourages CDC and FDA, as principal partners of state epidemiology and surveillance programs, to support state food safety programs by supporting these goals, making resources available and promoting initiatives addressing these standards.

**Background and justification:**
Beginning in 2000 and building on previous CDC/CSTE collaborations, CSTE received funding through its CDC/CSTE cooperative agreement to conduct a survey and develop standards for state food safety epidemiology and surveillance capacity in state food safety programs. These activities were conducted along with similarly funded projects with APHL and NEHA. State and territorial health agencies were asked to assess their enteric disease surveillance and epidemiologic response capacity and the capability for dealing with sporadic cases and outbreak of foodborne illness. The assessment was conduced with state and territorial epidemiologists as a web-based survey.

The CSTE Food Safety Advisory Committee, as a subset of the larger survey study group, was charged with developing performance/capacity standards based on a subset of questions from the CSTE Food Safety Epidemiologic Questionnaire. The Advisory Committee convened via five conference calls to develop the performance/capacity standards by consensus based on the

reported capacity level of food safety programs received from the survey and on the anecdotal expertise and experience of the committee. In September 2002, CSTE published the results of its 50-state survey of epidemiology and surveillance capacity of state food safety programs along with a proposal for standards. However, it was felt that in order to be most effective and representative, these standards required approval by the full membership and support by federal partners.

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**STATE FOOD SAFETY PROGRAM MINIMUM PERFORMANCE/CAPACITY STANDARDS FOR EPIDEMIOLOGY AND SURVEILLANCE**

**Function 1: Epidemiologic Surveillance Capacity to Identify Sporadic and Outbreak Related Illnesses**

- Food safety programs should keep records of enteric illness complaints from the general public (whether at the state and/or county level).
- Epidemiology offices should have the capability to receive in electronic form information from laboratory results and to maintain a database of such information.
- A database of laboratory confirmed and probable/presumptive cases of enteric illnesses should be maintained.
- Either for outbreak investigations or for sporadic enteric illnesses, food safety programs should have the capacity to complete the following tasks:
    - Enter data
    - Review for consistency and completeness
    - Compare reports to a standardized case definition

  If needed, additional capacity can be obtained via surge capacity (surge capacity-the ability to obtain additional staff when needed from another area program, office or department). Epidemiologic surge capacity to respond to outbreaks, natural emergencies or bioterrorist events, should be identified and secured in advance.
- Food safety programs should have a standard complaint form that includes a core set of questions common to all jurisdictions.

**Function 2: Capacity to Investigate and Respond to Outbreaks**

**Leadership**

- Food safety programs should have an appointed outbreak team to respond to foodborne illness investigations. The team (s) should include members representing environmental, epidemiology and laboratory or other related fields as needed.
- Every jurisdiction should have a dedicated enteric/foodborne disease epidemiologist. Smaller jurisdictions where an entire full time equivalent is not justified should identify a staff member as the point of contact. At least a Master-level education with specific training and education and/or practical experience in foodborne disease epidemiology is recommended.

**Case Ascertainment**

- Written case definitions are required for syndromic and outbreak investigations. When possible laboratory confirmation should be part of the definition.
- Food safety programs should have the capacity to conduct active case surveillance as needed within their state in a timely and complete manner.
- Food safety programs should have broadcast fax capability especially with key partners. Key partners may include, hospital emergency rooms, physicians, hospital infection control specialist (s), other departments within the state, and other state health departments.

**Data Collection and Management**

- Food safety programs should have a standardized, non-pathogen specific questionnaire that can be modified for an outbreak investigation.

- Food safety programs should have the capacity to investigate all identified foodborne outbreaks in a timely and complete manner.

**Traceback**

- Food safety programs should be able to conduct traceback investigations of items implicated. The epidemiology program and environmental health program should participate or initiate early tracing of initial (common) exposure sources as dictated by local jurisdictional status. The state food safety program outbreak investigation team should conduct tracebacks with appropriate leadership appointed as required by the particular investigation. For example, if the investigation relates to a restaurant, the team leader may be a part of the environmental health program with the laboratory and epidemiology members as support.
- During an outbreak investigation, epidemiologist (s) may or may not routinely accompany environmental health specialist because each circumstance is different but should always be available.

**Function 3:** **Public Health Infrastructure necessary to support food safety**

- State food safety programs or when appropriate county or city jurisdictions should have the capability to receive electronic reports from their public health laboratories, respectively, all public health laboratories should have the capability to send electronic reports to all state food safety programs.
- Food safety programs should have the capability to electronically access environmental health inspection reports. In order to access the reports electronically, the reports must exist electronically. It is recommended that responsible programs within state health departments take steps towards developing an electronically accessible format available to all state enteric/foodborne disease epidemiology programs.
- Epidemiologists within food safety program should receive basic training in food facility environmental inspections; in turn, all state environmental health specialists should receive basic training in epidemiology. Training will allow both groups the ability to mutually understand one another's role as well as terminology.

**Function 4:** **Legal Authority**

- A regulation or statute that specifically requires the submission of certain enteric isolates to the public health laboratory should exist at all state food safety programs. This is very important in linking isolates from different jurisdictions.
- Training in legal issues (including chain of custody) regarding foodborne investigations should exist for epidemiologists as well as environmental health specialists. Both epidemiologists and environmental health specialists need to have some level of understanding of legal issues, especially regarding the release of information. A statute or regulation that addresses the release of individual facility information from routine inspections or outbreaks should exist at food safety programs.
- Food safety programs should develop a working relationship with their state health officer through their State Epidemiologist, which may lead to a more rapid modification of the list of reportable diseases.
- Food safety programs should have the authority to share information related to foodborne outbreaks (as long as the information does not constitute a breach in medical confidentiality) with federal agencies, e.g. USDA, FDA, EPA, and CDC. Overall, an increase in communication or information sharing should be an effort of both state and federal entities.