Table of Contents 2006 - 2007

Financial Statements & Auditors Reports

INDEPENDENT AUDITOR'S REPORT

Executive Committee
Council of State and Territorial Epidemiologists, Inc.
Atlanta, Georgia

We have audited the accompanying statement of financial position of the Council of State and Territorial Epidemiologists, Inc. (a nonprofit organization) as of September 30, 2007 and the related statements of activities, functional expenses and cash flows for the year then ended. These financial statements are the responsibility of the Organization's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and Government Auditing Standards, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes, examining on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Council of State and Territorial Epidemiologists, Inc. as of September 30, 2007 and the changes in net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with Government Auditing Standards, we have also issued our report dated November 30, 2007, on our consideration of Council of State and Territorial Epidemiologists, Inc. internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. That report is an integral part of an audit performed in accordance with Government auditing standards and should be read in conjunction with this report in considering the results of our audit.

Our audit was performed of the purpose of forming an opinion of the basic financial statements of Council of State and Territorial Epidemiologists, Inc. taken as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by U.S. Office of Management and Budget Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations," and is not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is fairly stated, in all material respects, in relation to the basic financial statements taken as a whole.

November 30, 2007
Atlanta, Georgia

Financial Statements & Auditors Reports

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC
STATEMENT OF FINANCIAL POSITION
SEPTEMBER 30, 2007

ASSETS

CURRENT ASSETS	
Cash and Cash Equivalents	$ 97,579
Certificates of Deposit	484,074
Accounts Receivable	5,849
Grants Receivable	132,826
Accrued Interest Receivable	6,270
Prepaid Expenses	307,361
TOTAL CURRENT ASSETS	1,033,959
PROPERTY AND EQUIPMENT	
Computers and Software	89,961
Furniture and Equipment	58,888
Less: Accumulated Depreciation	(72,586)
TOTAL PROPERTY AND EQUIPMENT	76,263
OTHER ASSETS	
Deposits	3,153
TOTAL ASSETS	$1,113,375

LIABILITIES AND NET ASSETS

CURRENT LIABILITIES	
Accounts Payable	$ 407,016
Accrued Expenses	195,297
TOTAL CURRENT LIABILITIES	602,313
NET ASSETS	
Unrestricted	502,771
Temporarily Restricted	8,291
Permanently Restricted	0
TOTAL NET ASSETS	511,062
TOTAL LIABILITIES AND NET ASSETS	$1,113,375

See Accompanying Notes to Financial Statements

Financial Statements & Auditors Reports

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
STATEMENT OF ACTIVITIES
YEAR ENDED SEPTEMBER 30, 2007

UNRESTRICTED NET ASSETS:	
Revenues and Other Support	
Memberships	$ 96,345
Annual Meeting	407,195
Interest Income	25,078
Gain on Disposal of Asset	1,175
Miscellaneous	522
	530,315
Restrictions Satisfied by Payments	4,714,664
TOTAL UNRESTRICTED SUPPORT AND RECLASSIFICATIONS	5,244,979
Expenses	
Program Services	4,714,664
General Supporting Expenses	480,251
Total Expenses	5,194,915
INCREASE IN UNRESTRICTED NET ASSETS	50,064
TEMPORARILOY RESTRICTED NET ASSETS	
Support from Grants	4,722,955
Net Assets Released from Restrictions	(4,714,664)
INCREEASE IN TEMPORARILY RESTRICTED NET ASSETS	8,291
INCREASE IN NET ASSETS	58,355
NET ASSETS, BEGINNING OF YEAR	452,706
NET ASSETS, END OF YEAR	$511,061

See Accompanying Notes to Financial Statements

Financial Statements & Auditors Reports

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
STATEMENT OF CASH FLOWS
YEAR ENDED SEPTEMBER 30, 2007

CASH FLOW FROM OPERATING ACTIVITIES	
Change in Net Assets	$58,355
Adjustment to Reconcile Change in Net Assets to Net Cash Provided by Operating Activities:	
Depreciation	12,016
Disposal of Fixed Assets	(1,175)
(Increase) Decrease in Operating Assets:	
Grant Funds Receivable	71,574
Accounts Receivable	(607)
Accrued Interest Receivable	(4,573)
Prepaid Expenses	(270,157)
Increase (Decrease) in Operating Liabilities:	
Bank Overdrafts	(53,895)
Accounts Payable	379,720
Accrued Expenses	(51,742)
NET CASH PROVIDED BY OPERATING ACTIVITIES	139,516
CASH FLOWS FROM INVESTING ACTIVITIES	
Purchase of Certificates of Deposit	(248,889)
Purchase of Property and Equipment	(60,885)
Sales of Property and Equipment	1,175
NET CASH (USED) BY INVESTING ACTIVITIES	(308,599)
NET DECREASE IN CASH AND CASH EQUIVALENTS	(169,083
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	266,662
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 97,579
NON CASH TRANSACTIONS	
Abandonment of fully Depreciated Fixed Assets	$ 71,396
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION	
Cash paid During the Year For:	
Interest	0
Income Taxes	0

See Accompanying Notes to Financial Statements

Financial Statements & Auditors Reports

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
STATEMENT OF FUNCTIONAL EXPENSES
YEAR ENDED SEPTEMBER 30, 2007

	PROGRAM SERVICES						
	BIRTH DEFECTS	CRONIC DISEASE	ENVIRONMENTAL	INFECTIOUS DUSEASE	INJURY	NATIONAL OFFICE	TERROR
Conference	$0	$0	$0	$0	$0	$0	$0
Consultants	0	0	0	318,932	0	176,276	0
Contracts	0	0	0	17,500	0	0	0
Depreciation	208	1,631	526	5,515	266	2,268	8
Fringe	746	6,520	7,091	45,598	1,719	107,783	414
General and Administrative	18,292	124,441	47,387	469,243	21,543	205,684	786
Other	15	2,782	35,990	776,649	1,984	108,929	495
Personnel	4,025	30,032	30,088	166,792	6,415	344,587	1,710
Postage and Delivery	38	223	107	2,444	0	2,131	0
Printing and Reproduction	0	0	0	25	0	1,533	0
Staff Travel	0	1,162	3,546	21,951	1,399	21,710	0
Supplies	0	0	157	1,498	0	5,239	0
Telephone	0	0	203	3,468	0	1,650	0
Trainee Expenses	66,396	538,389	102,245	554,779	81,696	2,915	0
Total Expenses	$89,720	$705,180	$227,341	$2,384,395	$115,023	$980,706	$3,414

	PROGRAM SERVICES						
	CDC FOUNDATION	OCCUPATIONAL CAPACITY	OCCUPATIONAL CONFERENCE	RWJF LEGAL	UNIVERSITY OF MICHIGAN	NON FEDERAL	TOTAL EXPENSES
Conference	$0	$0	$0	$0	$0	$205,059	$205,059
Consultants	0	0	0	70,000	4,038	26,125	595,370
Contracts	0	0	0	0	0	35,000	52,500
Depreciation	1	200	102	166	13	1,111	12,016
Fringe	0	7,320	188	43	0	2,311	179,734
General and Administrative	130	19,836	0	1,763	617	115,992	1,025,714
Other	462	22,534	43,359	0	0	23,730	1,016,929
Personnel	0	28,638	578	0	0	36,456	649,321
Postage and Delivery	0	0	54	0	530	301	5,828
Printing and Reproduction	0	0	0	0	0	26,880	28,438
Staff Travel	0	6,679	0	0	305	4,716	61,468
Supplies	0	236	20	0	197	2,570	9,918
Telephone	0	879	0	0	0	0	6,200
Trainee Expenses	0	0	0	0	0	0	1,346,421
Total Expenses	$593	$86,321	$44,301	$71,972	$5,699	$480,251	$5,194,915

Financial Statements & Auditors Reports

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
NOTES TO FINANCIAL STATEMENTS
YEAR ENDED SEPTEMBER 30, 2007

1. **Organization and Nature of Activities.** The Council of State and Territorial Epidemiologists, Inc. (CSTE) (a nonprofit organization) is organized to promote effective public health, promote epidemiology practice, and facilitate effective epidemiology training in state and territorial health agencies. As a professional association of public health epidemiologists, CSTE and governmental agencies such as Centers for Disease Control and Prevention, Federal Drug Administration, and Environmental Protection Agency work cooperatively on capacity surveys, surveillance, and epidemiology best practices, and disease reporting requirements. These activities are initiated by CSTE, but of mutual interest to government public health partners. CSTE also provides many technical and scientific consultancies each year to support the public health efforts of such organizations as Centers for Disease Control and Prevention, The Association of State and Territorial Health Officials, National Association of County and City Health Officials, Association of Public Health Laboratories, and Institute of Medicine.

   CSTE also supports general membership service activities through non-federal resources. One of the primary activities is the employment of a consultant whose main responsibility is to report activities occurring within the federal government which may impact public health. Non-federal resources are provided by individuals, states, and other territories who are members of the council.

   The significant accounting policies followed are described below to enhance the usefulness of the financial statements to the reader.

2. **Summary of Significant Accounting Policies**

   Functional Allocation of Expenses. The costs of the various programs and other activities have been summarized on a functional basis in the Statement of Functional Expenses. Accordingly, certain costs have been allocated among the programs and supporting services benefitted.

   Cooperative Agreements. The Organization receives the majority of its revenue in the form of cooperative agreements from the Public Health Service, Centers for Disease Control, a division of the U. S. Department of Health and Human Services. The Organization has various cooperative agreements authorized in the amount of $4,700,329 for the year ended September 30, 2007. For the year ended September 30, 2007 the Organization received disbursements on these agreements in the amount of $4,636,400.

   Cash and Cash Equivalents: Cash and cash equivalents consist of short-term, highly liquid investments which are readily convertible into cash within ninety (90) days of purchase.

   Property and Equipment: Property and equipment are recorded at cost and all property and equipment purchased greater than $5,000 is capitalized. Repairs and maintenance costs are expensed as incurred. Depreciation is provided on the straight line balance method of depreciation over the estimated useful life of the related asset. The estimated useful life if the assets range from five to seven years.

   Estimates: The preparation of financial statements in accordance with generally accepted accounting principles generally accepted in the United States of America require management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

   Income Taxes: The organization is exempt from income taxes under Section 501 (c)(06) of the Internal Revenue Code. Accordingly, no income taxes have been considered in the accompanying financial statements.

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
NOTES TO FINANCIAL STATEMENTS
YEAR ENDED SEPTEMBER 30, 2007

3. **Noncancelable Lease Commitments:** The Organization leases its offices and certain equipment under leases that are considered operating leases. Total rent expense was $143,890 for the year ended September 30, 2007. Future minimum lease payments under these noncancelable operating leases as of September 30, 2007 are as follows:

Year Ended September 30,	
2008	$120,672
2009	135,857
2010	132,571
2011	134,382
2012	137,568
Thereafter	11,016
	$672,066

4. **Profit Sharing Plan:** The Organization has a 401(k) profit sharing plan covering substantially all employees. The Organization's contribution to the plan is 6% of each participant's earnings. The Organization's total contribution for the year ended September 30, 2007 was $49,283.

5. **Concentration of Credit Risk:** The Organization maintains in a single financial institution certain cash balances which at time may exceed federally insured limits. Management works hard to avoid exceeding the federally insured limit. The Organization has not experienced any losses in such accounts.

   Approximately ninety (90%) of the Organization's support was from federal governmental grant assistance for the year ended September 30, 2007.

6. **Effect of Current Economic Conditions on Grants:** CSTE depends primarily on grants for its revenue. The ability of grantors to continue giving amounts comparable with prior years may be dependent upon current and future overall economic conditions. The Organization's ability to continue its programs, and the extent to which such programs continue are dependent on the above factors. In addition, grants require fulfillment of certain conditions as set forth in the grant agreement. Failure to fulfill the conditions could result in the revoking of funds by the grantor. However, management deems this contingency unlikely, since by accepting the grant and its terms, the Organization has agreed to fulfill its obligation pursuant to the provisions of the grant.

Financial Statements & Auditors Reports

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
SCHEDULE OF FEDERAL AWARDS
YEAR ENDED SEPTEMBER 30, 2007

Fed Grantor/Pass-through Grantor Prog Title/Reference#	Federal CFDA Number	Agency or Pass-thru Amount	Program or Award Amount	Federal Disbursements Expenditures
U.S. Dept. of Health & Human Services- Center for Disease Control & Prevention. Development of State Level Surveillance Systems and Epidemiology Training Programs				
U60/ccu007277-15-8	93.283	N/A	$5,495,688	$4,586,900
U.S. Dept. of Health & Human Services Center for Disease Control & Prevention State based Occupational Health based Surveillance Meeting.				
IR 13 OH008565-02	93.262	N/A	$38,800	$22,893
IR 13 OH008565-03	93.262	N/A	39,600	—
U.S. Dept. of Health & Human Services Center for Disease Control & Prevention State based Occupational Capacity.				
IR 25 OH008802-01	93.262	N/A	$100,000	$77,387
IR 25 OH008802-02	93.262	N/A	$100,000	$13,148

The accompanying schedule of federal expenditures of federal awards includes the federal activity of CSTE and is presented on the accrual basis of accounting. The information in this schedule is presented in accordance with the requirements of OMB Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations." Therefore, some amounts presented in this schedule may differ from amounts presented in, or used in the preparation of, the basic financial statements.

See Accompanying Notes to Financial Statements

Financial Statements & Auditors Reports

REPORT ON COMPLIANCE AND ON INTERNAL CONTROL OVER FINANCIAL REPORTING BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH GOVERNMENT AUDITING STANDARDS

Executive Committee
Council of State and Territorial Epidemiologists, Inc.
Atlanta, Georgia

We have audited the financial statements of Council of State and Territorial Epidemiologists, Inc. (a nonprofit organization) as of and for the year ended September 30, 2007, and have issued our report thereon dated November 30, 2007. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States.

Compliance

As part of obtaining reasonable assurance about whether Council of State and Territorial Epidemiologists, Inc. financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grants, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under Government Auditing Standards.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered Council of State and Territorial Epidemiologists, Inc.'s internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control over financial reporting. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be material weaknesses.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We noted no matters involving the internal control over financial reporting and its operation that we consider to be material weaknesses.

This report is intended for the information of the audit committee, management, and federal awarding agencies and pass-through entities. However, this report is a matter of public record and its distribution is not limited.

November 30, 2007
Atlanta, Georgia

Financial Statements & Auditors Reports

REPORT ON COMPLIANCE WITH REQUIREMENTS APPLICABLE TO EACH MAJOR PROGRAM AND ON INTERNAL CONTROL OVER COMPLIANCE IN ACCORDANCE WITH OMB CIRCULAR A-133

Executive Committee
Council of State and Territorial Epidemiologists, Inc.

Compliance

We have audited the compliance of the Council of State and Territorial Epidemiologists, Inc. (CSTE) (a nonprofit organization) with the types of compliance requirements described in the "U.S. Office of Management and Budget (OMB) Circular A-133 Compliance Supplement" that are applicable to each of its major federal programs for the year ended September 30, 2007. CSTE's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs. Compliance with the requirements of laws, regulations, contracts, and grants applicable to each of its major federal programs is the responsibility of CSTE's management. Our responsibility is to express an opinion on CSTE's compliance based on our audit.

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States; and OMB Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations." Those standards and OMB Circular A-133 require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about CSTE's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Our audit does not provide a legal determination of CSTE's compliance with those requirements.

In our opinion, CSTE complied, in all material respects, with the requirements referred to above that are applicable to each of its major federal programs for the year ended September 30, 2007.

Internal Control Over Compliance

The management of CSTE is responsible for establishing and maintaining effective internal control over compliance with the requirements of laws, regulations, contracts, and grants applicable to federal programs. In planning and performing our audit, we considered CSTE's internal control over compliance with requirements that could have a direct and material effect on a major federal program in order to determine our auditing procedures for the purpose of expressing our opinion on compliance and to test and report on internal control over compliance in accordance with OMB Circular A-133.

Our consideration of the internal control over compliance would not necessarily disclose all matters in the internal control that might be material weaknesses. A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that noncompliance with applicable requirements of laws, regulations, contracts, and grants that would be material in relation to a major federal program being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We noted no matters involving the internal control over compliance and its operation that we consider to be material weaknesses.

**REPORT ON COMPLIANCE WITH REQUIREMENTS
APPLICABLE TO EACH MAJOR PROGRAM AND ON INTERNAL CONTROL
OVER COMPLIANCE IN ACCORDANCE WITH OMB CIRCULAR A-133**

This report is intended for the information of the audit committee, management, and federal awarding agencies and pass-through entities. However, this report is a matter of public record and its distribution is not limited.

November 30, 2007
Atlanta, Georgia

Financial Statements & Auditors Reports

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
YEAR ENDED SEPTEMBER 30, 2007

SUMMARY OF AUDIT RESULTS

1. The auditor's report expresses an unqualified opinion on the financial statements of Council of State and Territorial Epidemiologists, Inc.
2. No material weaknesses or reportable conditions were identified during the audit of the financial statements.
3. No instances of noncompliance material to the financial statements of Council of State and Territorial Epidemiologists, Inc. were disclosed during the audit.
4. No material weaknesses or reportable conditions were identified during the audit of the major federal awards programs.
5. The auditors report on compliance for the major federal award programs for Council of State and Territorial Epidemiologists, Inc. expresses an unqualified opinion.
6. The programs tested as major programs included:
   Development of state level surveillance systems and epidemiology training programs. CFDA number 93.283.
7. The threshold for distinguishing Types A and B programs was $300,000.
8. Council of State and Territorial Epidemiologists, Inc. qualified as a high risk auditee because of the size of the grant.

FINDINGS-FINANCIAL STATEMENTS AUDIT

None

FINDINGS AND QUESTIONED COSTS-MAJOR FEDERAL AWARD PROGRAMS AUDIT

None

2007 Jonathan Mann Memorial Lecturer

JAMES S. MARKS, M.D., M.P.H.

James S. Marks, M.D., M.P.H., is the senior vice president and director of the Health Group. He is responsible for the overall planning, budgeting, staffing, management and evaluation of all program and administrative activities of the RWJF Health Group.

Before joining the Foundation in December 2004, Marks had served as the acting director of the Centers for Disease Control and Prevention's (CDC) Coordinating Center for Health Information and Service. From 1995 until May 2004, he was director of the CDC's National Center for Chronic Disease Prevention and Health Promotion. Throughout his career at the CDC, he developed and advanced systematic ways to address the nation's growing epidemic of obesity, reduce tobacco use, and prevent diseases such as cancer, heart disease and diabetes. In addition, Marks has served on the National Advisory Committee for The Robert Wood Johnson Foundation's Health and Society Scholars program.

Marks has received numerous federal, state, and private awards, including the U.S. Public Health Service Distinguished Service Award, the Surgeon General's Award for Distinguished Service, the Association of State and Territorial Chronic Disease Directors' Award for Excellence, the American Cancer Society's Distinguished Service Award, and the National Arthritis Foundation's Special Award of Appreciation. He has published extensively in the areas of maternal and child health, health promotion and chronic disease prevention, and has served on many government and nonprofit boards and committees devoted to improving public health.

Marks received an M.D. from the State University of New York at Buffalo. He trained as a pediatrician at the University of California at San Francisco, and was a Robert Wood Johnson Clinical Scholar at Yale University, where he received his M.P.H.

2007 Annual Conference Summary

Council of State and Territorial Epidemiologist
2007 Annual Conference Summary

Theme: Eliminating Health Disparities: Data to Action

Location: Atlantic City, New Jersey
Sheraton Atlanta City Convention Center Hotel

Dates: June 24-28, 2007

Groups: Council of State and Territorial Epidemiologists
The National Association of State Public Health Veterinarians

Total Attendees: 1000

Program Summary:

Workshops	CSTE Pre-Conference Workshop- Environmental Health tracking
	CSTE Pre-Conference Workshop- Epi-X
	CSTE Pre-Conference Workshop- HIV/AIDS Surveillance Coordinators
	CSTE Pre-Conference Workshop-NASPHV
	CSTE Pre-Conference Workshop- Occupational Health
	CSTE Pre-Conference OutbreakNet
	CSTE Pre-Conference PHIN
	CSTE Pre-Conference Substance Abuse
Day One	Epidemiology to Address Racial, Ethnic and Other Disparities in Health
Day Two	Stopping Disease at the Border
Day Three	Changing Forces in Public Health Surveillance

Planning Committee:

Eddy Bresnitz	Committee Chair
Mark Baptiste	Chronic/MCH/Oral Health Chair
Jay Butler	Infectious Disease Committee
Beverly Christner	Staff
Shundra Clinton	Staff
Jerald Fagliano	Environmental Committee Lead
Jerry Gibson	Infectious Disease Committee
Chris Hahn	Infectious Disease Committee Co-Chair
Kathy Hempstead	Chronic and Injury Committees
Jo Hofmann	Infectious Disease Committee
David Johnson	Environmental/Occupational/Injury Chair
Melvin Kohn	Injury Committee Lead
Dorothy Kozlowski	CME Coordinator

Council of State and Territorial Epidemiologist
2007 Annual Conference Summary

Planning Committee (continued):

Lakota Kruse	Chronic Committee
Michael Landen	Cross-Cutting Committee Lead
Jennifer Lemmings	Staff
Ellen Mangione	Infectious Disease Committee Chair
Bela Matyas	Infectious Disease Committee
Jose Montero	Infectious Disease Committee
Amy Patel	Staff
Lakesha Robinson	Staff
C. Mack Sewell	CSTE Past President
Perry Smith	Cross-Cutting Committee Lead
Faye Sorhage	NASPHV Representative
Christina Tan	Cross-Cutting Committee Lead
David Valiante	Occupational Health Committee Lead
Tanja Walker	Staff
Molly Wray	Staff

2007 Business Meeting Minutes

Council of State and Territorial Epidemiologist
2007 Business Meeting Minutes
Thursday, June 28, 2007

Roll Call

Present: Alabama, Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

Absent: American Samoa, Arkansas, Delaware, Federated States of Micronesia, Guam, Hawaii, Indiana, Maine, Montana, North Dakota, Northern Mariana Island, Rhode Island, Utah, Virgin Island, and Wyoming.

The roll call of the States and Territories was conducted by Patrick McConnon, Executive Director.

Robert Harrison called the meeting to order at 8:10am.

Secretary-Treasurer Report

Perry Smith presented the financial statements to the membership. The report was based on the audited financial statements from September 29, 2005 to September 30, 2006, conducted by the independent auditor Conn and Company from Atlanta, Georgia. The report included no material weaknesses and no reportable conditions were identified. No instances of noncompliance material to the financial statements were disclosed, and CSTE qualified as a low risk auditee.

A motion to accept the financial statements for the period September 29, 2005 to September 30, 2006, was accepted from the floor and seconded. The membership voted to accept the financial statements as record.

Business Meeting Minutes

Minutes from the 2006 Business meeting were reviewed. A motion to accept the 2006 Anaheim, California, Business Meeting minutes was brought from the floor, and seconded by the membership. A vote was taken, and the 2006 Business Meeting Minutes were approved.

Review of Voting Rights

Each state or territory shall be able to vote for as many candidates as there are positions to be filled. Only one vote per state or territory shall be allowed. A majority vote of the voting shall be required to elect. If no candidate received a

Majority vote on the first ballot, the candidate for the office-in question receiving the smallest number of votes shall be dropped after each ballot in succession until a majority vote is obtained.

Discussion and Vote

- Several technical edits to the CSTE BY-Laws were proposed and accepted by the membership.
- Proposed change to the CSTE By-Laws on Article V
  - The proposed changes were accepted by the CSTE membership.

2007 Business Meeting Minutes

Council of State and Territorial Epidemiologist
2007 Business Meeting Minutes
Thursday, June 28, 2007

Executive Committee Elections

Perry Smith called for the election of open positions on the Executive Committee. The appointed tellers were Patty Quinlisk, MarySue Shulin, and Janet Mohle.

Ballots were distributed by the tellers for each open position. The ballots were distributed to each state representative.

Perry Smith called for membership to vote for the **President-Elect position**. The names on the ballot were Perry Smith and Melvin Kohn. There was a call for additional nominations from the floor. With no nomination from the floor, a motion was called to close the nomination, and seconded. **Perry Smith** was elected to the President Elect position.

Perry Smith called for membership to mark ballots for the **Environmental/Occupational/Injury position**. The names placed on the ballot were Richard Kreutzer, Jon Roesler and Martha Stanbury. With no nomination from the floor, a motion was called to close the nomination, and seconded. **Martha Stanbury** was elected to the Environmental/ Occupational/Injury position.

Perry Smith called for membership to mark ballots for **Chronic Disease/MCH/Oral Health position**. The names placed on the ballots were John Horan, and Youjie Huang. With no nomination from the floor, a motion was called to close the nomination, and seconded. **John Horan** was elected to the Chronic Disease/MCH/Oral Health position.

Perry Smith called for the membership to mark ballots for **Infectious Disease Chair**. The name placed on the ballots was Gail Hansen and Bob Rolf. Bob Rolf withdrew his nomination. There was a call for nominations from the floor. With no nominations from the floor, a motion was called to close the nomination, and seconded. **Gail Hansen** was elected to the Infectious Disease position.

Perry Smith called for the membership to mark ballots for the 3 years **At-Large Position**. The names placed on the ballot were Michael Landen, Tom Safranek and Richard Kreutzer. With no nominations from the floor, a motion was called to close the nomination, and second. **Michael Landen** was elected to the 3 year At-Large position.

Perry Smith called for membership to mark ballots for the 2-year **At-Large Position**. The names placed on the ballots were Richard Kreutzer and Tom Safranek. With no nominations from the floor, a motion was called to close the nomination, and seconded. **Tom Safranek** was elected to the 2-year At-Large position.

Perry Smith called for membership to vote for the **Secretary-Treasurer position** The position was left vacant following Perry Smith election to the President Elect position. Nomination from the floor was Melvin Kohn. **Melvin Kohn** was elected to the Secretary Treasurer position.

2007 Business Meeting Minutes

Council of State and Territorial Epidemiologist
2007 Business Meeting Minutes
Thursday, June 28, 2007

Position Statements

Prior to the Business Meeting, the CSTE members had discussed each position statement in committee and proposed a consent calendar to the CSTE membership. The consent calendar represented position statements about which the membership had no concerns as written.

The CSTE members voted to pass the 2007 Position Statement consent calendar

07-ID-01	National Reporting for Novel Influenza A Virus Infections
07-ID-03	Revision of the Surveillance Case Definition for Ehrlichiosis
07-ID-04	Revision of the Surveillance Case Definition for Q fever
07-ID-05	Revision of the Surveillance Case Definition for Rocky Mountain Spotted fever
07-ID-06	Events that May Constitute a Public Health Emergency of International Concern
07-ID-08	Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas
07-ID-09	Heterosexual HIV Transmission Classification
07-ID-10	Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age <18 months
07-ID-12	National Reporting of Neonatal Herpes
07-ID-13	Revision of the Surveillance Case Definition for Coccidioidomycosis
07-EH-01	Support for Continuity of Environmental Public Health Indicators Development
07-EH-02	Occupational and Environmental Risks of Nanotechnology
07-EH-03	Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance
07-OH-01	Occupational and Environmental Risks of Nanotechnology
07-INJ-01	Improving External Cause Coding in Hospital Discharge Data
07-CD-01	State-level Chronic Disease Epidemiology Capacity

Position Statements that were discussed and approved by vote at the Business Meeting:

07-EC-01	Research to study and disseminate evidence of effective community health assessments
07-ID-11	Revised National Surveillance Case Definition for Lyme Disease

Position Statements that were discussed amended and approved by vote at the Business meeting:

07-EC -02	CSTE official list of Nationally Notifiable Conditions
07-EC-03	Support and reinstatement of funding for CDC's Outbreak Management System
07-ID-02	Revision of the Surveillance Case Definition for Mumps
07-ID-07	Enhancing Disease Control for Cruise Ship Travel

2007 Business Meeting Minutes

Council of State and Territorial Epidemiologist
2007 Business Meeting Minutes
Thursday, June 28, 2007

2008 Annual Conference

The next CSTE Annual Meeting will take place in Denver, Colorado.

New Business:

- Executive Committee will follow up with the Lead Industry Abstract. This abstract will not be posted.
- Suggestions for consideration for the 2008 Annual Conference
  - Time management for the moderators.
  - Provide more discussion time in the Plenaries.
  - Accept more posters and add more time for posters presentations.
  - Additional discussion time is needed for breakout sessions.
- Patty Quinlisk would like to volunteer for the 2008 planning Committee.
- Membership has requested that CSTE have strategic meeting this year before the 2008 Executive Committee Meeting to discuss the issues related to the CSTE organization. The subgroups identified for the meeting: Executive Committee, Past President, lead consultants and local health representative.

Adjournment:

The meeting adjourned as President Robert Harrison handed the gavel to President Eddy Bresnitz.

2007 Pumphandle Award Winner

James Hadler, M.D., M.P.H.

This year's recipient of the Pumphandle Award, Dr. James Hadler, understands first hand the challenges that experts in the field of public health have in "feeling like a real doctor," and he believes that addressing this is a key component of continuing to attract talented people to the field.

After receiving his medical degree, Hadler spent two and a half years working for the Centers for Disease Control's Tuberculosis Control Division, first with the Navajo Area Indian Health Service in Arizona, and then with a joint CDC-World Health Organization survey in Western Samoa and American Samoa in the South Pacific.

"In the course of my medical training, I had become interested in internal medicine, and in particular, infectious disease," Hadler said. "I very much enjoyed running the TB control program on the Navaho reservation, and working on the medical and statistical information. But I still wanted to finish that 'real doctor' feeling." So over the next several years, he completed his internal medicine residency in Waterbury, Connecticut as well as an infectious disease fellowship and preventive medicine residency at Yale University School of Medicine.

Luckily for public health and CSTE, during this time Hadler also had the opportunity to serve as a medical epidemiology consultant for the Connecticut State Department of Health Services. "The state couldn't fill the position full time, so it was a one-day-a-week job," said Hadler. "But along with my work with the TB Control Division, it was definitely one of my formative experiences in public health."

In 1984, Connecticut was able to fill the position, and Hadler has served as state epidemiologist and director of the Infectious Diseases Division ever since. In 1994, he also took on the responsibilities of director of the Connecticut Emerging Infectious Diseases Program (EIP), one of nine federally-funded special population-based EIPs in the country.

In his work with the state of Connecticut and as an assistant professor (University of Connecticut) and associate professor (Yale University) of medicine, Hadler continues to see the challenge of getting people interested in public health, for many of the same reasons he had years ago. "For one thing, Individual patient care is enjoyable," he said. "Most people don't see the excitement in using data from others to look at the stats and help people on a large scale." Other issues include what he calls, "answering to friends and family" – who think if you don't see patients, you must not be a real doctor. "Once people understand public health, they find the work attractive on the public health side, but it's important that we continue to think about how to get people to really try public health as a career," he continued. "Without actual public health experience, it's difficult to get a real feel for it."

Hadler believes that one thing epidemiologists can do is share their experiences to show others what the field is really about. "It's not all charts and numbers, either. One of the most exciting things now is figuring out the potential use of new technologies," he said. "How can we use these technologies to help us take new approaches and really benefit the public?"

He also cites the increase in resources and domain as a draw to bring quality people into public health. "There has been a huge infusion of resources and people since I started as a state epi in 1984. There is now a different level and aspect to the job – more planning, more issues, more scrutiny," he said. "It's a challenge to deal with."

Other challenges include new and emerging infectious diseases, currently diminishing funding in relation to the surge of funding after 9/11, and national public health preparedness. "I see public health continuing to be a demanding field because of these and other issues," said Hadler. "These are challenging but very interesting times to be in public health."

Executive Committee 2006 – 2007

President
Robert Harrison, MD, MPH
California Department of Health Services
1515 Clay Street
Suite. 1901
Oakland, CA 94612
510/622-4404 Phone
510/821-9934 Fax
robert.harrison@ucsf.edu
Term expiration 2007

Vice President
C. Mack Sewell, DrPH, MS
State Epidemiologist
New Mexico Department of Health Office of Epidemiology
1190 St. Francis Drive, RoomN-1350 Santa Fe, NM 87502
505/476-3568 Phone
505/827-0013 Fax
macks@doh.state.nm.us
Term expiration 2007

President Elect
Eddy Bresnitz, MD, MS
NJ Department of Health and Senior Services
3635 Quakerbridge Road
Trenton, NJ 08625
609/588-7463 Phone
609/584-5088 Fax
Eddy.bresnitz@doh.state.nj.us
Term expiration 2007

Secretary –Treasurer
Perry Smith, MD
State Epidemiologist
New York State Department of Health
Empire State Plaza
Corning Tower, Room 503 ESP
Albany, NY 12237
518/474-1055
518/473-2301
pfs01@health.state.ny.us
Term expiration 2008

Environmental /Occupational/Injurv Epidemiology
David Johnson, MD, MS
Florida Department of Health
4052 Bald Cypress Way
Bin A-08
Tallahassee, FL 32399
850/245-4115 Phone
850/922-8473 Fax
David_johnson@doh.state.fl.us
Term expiration 2009

Chronic Disease/MCH/Oral Health Epidemiology
Mark Baptiste, PhD
New York State Department of Health
Empire State Plaza Corning Tower
Room 515
Albany, NY 12237
518/474-0512 Phone
518/474-2853 Fax
msb02@health.state.ny.us
Term expiration 2007

Infectious Disease Epidemiology
Ellen Mangione, MD, MPH
Colorado Department of Public Health and Environment
Director, Division of Disease Control and Environmental Epidemiology
4300 Cherry Creek Drive South, A3
Denver, CO 80246-1530
303/692-2613 phone
303/758-9051 fax
ellen.mangione@state.co.us
Term expiration 2008

Executive Committee 2006 – 2007

Members At-Large

Melvin Kohn, MD, MPH
Oregon Department of Human Services
800 NE Oregon Street
Suite 730
Portland, OR 97232
503/731-4023 Phone
503/731-4082 Fax
Melvin.a.kohn@state.or.us
Term expiration 2007

Allen S. Craig, MD
Tennessee Department of Health
Cordell Hull Building
425 5th Avenue North
4th Floor
Nashville, TN 37247
615/741-7247 Phone
615/741-3857 Fax
Allen.craig@state.tn us
Term expiration 2008

Jo Hofmann, MD
Washington State Department of Health
State Epidemiologist for Communicable Disease
1610 NE 150 Street MS K 17-19
Shoreline, WA 98155
206/418-5510
206/418-5515
jo.hofmann@doh.wa.gov
Term expiration 2009

Executive Director

Patrick J. McConnon
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard
Suite. 303
Atlanta, GA 30341-4015
770/458-3811 Phone
770/458-8516 Fax
pmcconnon@cste.org
No Term expiration

2007 Ballot and Results

2007 Election of PRESIDENT– ELECT

_____ **Melvin Kohn, MD, MPH**
State Epidemiologist, Oregon

__X__ **Perry Smith, MD**
State Epidemiologist, New York

\2007 Election of AT-LARGE POSITION (Three Year Term)

__X__ **Michael Landen, MD, MPH**
Deputy State Epidemiologist, New Mexico

_____ **Tom Safranek, MD**
State Epidemiologist, Nebraska

_____ _____

_____ _____

2007 Election of AT-LARGE POSITION (Two Year Term)

__X__ **Tom Safranek, MD**
State Epidemiologist, Nebraska

_____ _____

2007 Election of ENVIRONMENTAL / OCCUPATIONAL / INJURY CHAIR (Two Year Term)

_____ **Rick Kreutzer, MD**
Chief Environmental Health Investigations Branch, California

_____ **Jon Roesler, MS**
Epidemiologist Supervisor, Minnesota

___X__ **Martha Stanbury, MSPH**
Section Manager in the Division of Environmental Health, Michigan

_____ _____

2007 Ballot and Results

2007 Election of INFECTIOUS DISEASE CHAIR (One Year Term)

__X__ **Gail Hansen, DVM, MPH**
State Epidemiologist, Kansas

_____ **Robert Rolfs, MD**
State Epidemiologist, Utah

_____ _____

2007 Election of CHRONIC DISEASE/MCH/ORAL HEALTH CHAIR (Three Year Term)

__X__ **John Horan, MD, MPH**
Chronic Disease, Injury and Environmental Epidemiology Section Chief, Georgia

_____ **Youjie Huang, MD, MPH, DrPH**
Chronic Disease Epidemiologist, Florida

_____ _____

2007 Election of SECRETARY-TREASURER (One Year Term)

__X__ **Melvin Kohn, MD, MPH**
State Epidemiologist, Oregon

_____ _____

_____ _____

CSTE Staff September 2006 – 2007

Beverly Christner
Director of Operations
Employed since March 1999

Stephen Clay
Webmaster
Employed since October 2004

Shundra Clinton
Member Services Coordinator
Employed since July 2000

Lisa Dwyer
Associate Research Analyst
Employed since June 2007

Kevin Gibbs
Applications Programmer
Employed since October 2003

Tarajee Curry
Administrative Assistant
Employed since August 2003

Jennifer Lemmings
Associate Research Analyst
Employed since January 2004

Patrick McConnon
Executive Director
Employed since August 2002

Lakesha Robinson
Program Director
Employed since January 2001

Erin Simms
Associate Research Analyst
Employed since October 2007

MarySue Shulin
Business Manger
Employed since December 2002

Molly Wray
Workforce and Fellowship Coordinator
Employed since July 2006

State Dues as of June 20, 2007

	Paid	Unpaid
Alabama	✔	
Alaska	✔	
American Samoa		✔
Arizona	✔	
Arkansas	✔	
California	✔	
Colorado	✔	
Connecticut	✔	
Delaware	✔	
District of Columbia	✔	
Federated States of Micronesia		✔
Florida	✔	
Georgia	✔	
Guam		✔
Hawaii	✔	
Idaho	✔	
Illinois	✔	
Indiana	✔	
Iowa	✔	
Kansas	✔	
Kentucky	✔	
Louisiana	✔	
Maine	✔	
Maryland	✔	
Massachusetts	✔	
Michigan	✔	
Minnesota	✔	
Mississippi	✔	

	Paid	Unpaid
Missouri	✔	
Montana	✔	
Nebraska	✔	
Nevada	✔	
New Hampshire	✔	
New Jersey	✔	
New Mexico	✔	
New York	✔	
North Carolina	✔	
North Dakota	✔	
Northern Mariana Island		✔
Ohio	✔	
Oklahoma	✔	
Oregon	✔	
Pennsylvania	✔	
Puerto Rico		✔
Rhode Island	✔	
South Carolina	✔	
South Dakota	✔	
Tennessee	✔	
Texas	✔	
Utah	✔	
Vermont	✔	
Virgin Islands		✔
Virginia	✔	
Washington	✔	
West Virginia	✔	
Wisconsin	✔	
Wyoming	✔	

2007 Position Statements

07-CD-01

Committee: Chronic Disease

Title: State-level Chronic Disease Epidemiology Capacity

Statement of the Problem:

CSTE has long recognized that chronic diseases are leading causes of morbidity and mortality in the US. Epidemiology, as the basic science of public health, is essential for the detection, control and prevention of chronic disease morbidity and mortality. A 1992 CSTE position statement (1) called for increased chronic disease epidemiology capacity at the state level. A strategic plan (2), released in 2000, laid out goals for coordination of chronic disease epidemiology across categorical programs. A number of advances in Chronic Disease Epidemiology (CDE) Capacity have occurred since that time:

- A Capacity Building Workgroup has been established including representatives from CSTE, CDC/NCCDPHP, APHA, ACPM, ASTHO and NACDD.
- A report on *Essential Functions of Chronic Disease Epidemiology in State Health Departments* (3) was released in 2004, highlighting issues of work force, access to data, data analysis/interpretation, data dissemination, and outreach/partnership. This report and follow up article (4) defined the minimum recommended CDE work force as follows:
  - At least one senior chronic disease epidemiologist, defined as follows: doctoral degree with at least 5 years of experience in chronic disease epidemiology or masters degree with at least 10 years of experience in chronic disease epidemiology.
  - At least one chronic disease epidemiologist who is responsible for coordinating/integrating chronic disease epidemiology activities across categorical programs.
  - Five or more full-time chronic disease epidemiologists, at least one of who has a doctoral degree (progress toward this staffing level should be incremental in states that have fewer than four full-time CDE).
- *A National Assessment of Epidemiologic Capacity in Chronic Disease* (5) showed some improvement in CDE capacity. The percentage of states with at least one doctoral-level chronic disease epidemiologist has increased to 92% (5).

However, the goal of having a minimum recommended CDE work force of trained and experience epidemiologists in each state (5) has not yet been met.

- 43% of states still have fewer than five chronic disease epidemiologists
- 43% states do not have a "senior-level" chronic disease epidemiologist.

Statement of the desired action(s) to be taken:

CSTE will work with CDC, ASTHO, NACDD, and other partner organizations to support states in their efforts to recruit and retain adequate numbers of trained and experienced chronic disease epidemiologists to carry out the functions described in the *Essential Functions of Chronic Disease Epidemiology in State Health Departments* (3). States should be encouraged to deploy chronic disease epidemiologists in ways consistent with state chronic disease priorities and in an organizational structure that maximizes their ability to coordinate activities with chronic disease program staff and ensures coordination among chronic disease epidemiologists. This support should allow maximum flexibility for states to address their own chronic disease needs and respect state and local organizational structure.

Specific steps to achieve these outcomes should include the following:

- CDC shall encourage as many states as possible to achieve the recommended minimum CDE workforce through 1) language in cooperative agreements that explicitly encourages hiring of CDEs; and 2) mechanisms and opportunities that give states greater flexibility in using categorical funding, including resources from multiple grants, to support these positions. Project officers from categorical CDC programs should be included in this coordination process.
- ASTHO and its affiliates (e.g., NACDD and CSTE) will work for and with states to take advantage of the funding flexibility and other resources to ensure hiring of needed CDEs.
- CSTE should disseminate standards for and strongly encourage the development of competency-based Epidemiology Job series in state personnel systems.
- CSTE and partners shall continue the work of the CDE capacity building work group to assist states in meeting the capacity targets set in the 2004 *National Assessment of Epidemiologic Capacity in Chronic Disease* (5).

2007 Position Statements

(continued)
07-CD-01

Committee: Chronic Disease

Title: State-level Chronic Disease Epidemiology Capacity

- CSTE, in partnership with CDC, NACDD and ASTHO, should develop a list of capacity indicators that correspond to the capacity domains described in the 2004 CSTE chronic disease epidemiology capacity survey (i.e., workforce, access to data and consultants, data analysis/interpretation, dissemination, and outreach/partnership) (5)
- CSTE should develop and conduct an on-line rapid assessment tool to measure these indicators in each state approximately once every two years. A profile including the state/territory's results of this rapid assessment and nationwide averages should be sent to CSTE Chronic Disease Epidemiology Point of Contact in each state/territory so that each can compare its current capacity with aggregate data from other states.
- ASTHO will use the results of the state profiles to advocate for the development of Chronic Disease Epidemiology capacity in its annual consultations with the DHHS Secretary.

Public Health Impact:
The rationale for hiring a senior chronic disease epidemiologist early in the capacity building process includes the following: a) integrating chronic disease epidemiology activities across categorical programs requires insights that can be gained only through experience and b) experience is often required to help write grant applications that will secure the funds needed to hire additional epidemiology staff and then to mentor the new junior staff. Support of chronic disease epidemiology functions will enhance the ability of states to prioritize, plan, implement and evaluate evidence-based interventions. This will prevent development of and reduce suffering from chronic diseases and associated disparities.

References

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2007 Position Statements

(continued)
07-CD-01

Committee: Chronic Disease

Title: State-level Chronic Disease Epidemiology Capacity

Coordination:

Agencies for Response:

(1) Julie L. Gerberding, Director
Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta GA 30333
(404) 639-7000
jvg2@cdc.gov

(2) Paul Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officials (ASTHO)
1275 K Street NW Suite 800
Washington, DC 20005

Agencies for Information:

(1) Mr. John Robitscher
Executive Director
National Association of Chronic Disease Directors
2872 Woodcock Boulevard, Suite 220
jrobitscher@chronicdisease.org
(770) 458-7400

Submitting Author:

Sarah Lyon-Callo, MS
Chronic Disease Epidemiology Manager
Michigan Department of Community Health
201 Townsend, PO Box 30195
Lansing, MI 48909
(517) 335-9315
lyoncallos@michigan.gov

Co-Author:

Dr. Mark S. Baptiste, PhD
Director, Division of Chronic Disease Prevention and Adult Health
New York State Department of Health
Empire State Plaza
Corning Tower Building., Room 515
Albany, NY 12237-0675
518-474-0512
msb02@health.state.ny.us

2007 Position Statements

07-EC-01

Committee: CSTE Executive Committee

Title: Research to study and disseminate evidence of effective community health assessments

Statement of the Problem:

The Future of Public Health, the landmark 1988 Institute of Medicine (IOM) report identified assessment as one of three core public health functions that every public health agency should perform.[1] While this statement has been widely accepted in the public health community, there is little published literature on evaluations of community health assessments.[2]

Statement of the desired action(s) to be taken:

1. The CDC should identify an office within the organization that can oversee research on, and evaluation of community health assessments and health impact assessment.
2. CSTE encourages the allocation of sufficient financial and human resources at federal, state and local levels to set up a workgroup in collaboration with professional organizations including, but not limited to, APHA, Association of State and Territorial Health Officials (ASTHO), Council of State and Territorial Epidemiologists (CSTE), National Association of County and City Health Officials (NACCHO) to develop a plan and recommendations for developing an evidence-base of effective community health assessment practices. Among the questions this workgroup should study are:
   - What are the criteria for good research to identify what makes a community health assessment lead to public health action?
   - What factors influence effectiveness of community health assessments?
   - What measures can be used to track effectiveness of community health assessments?
   - What are factors that need to be in place to evaluate community health assessment practice consistent with standards used by the Task Force on Community Preventive Services[3] in the health sector and the Campbell Collaboration[4] in the educational, social and behavioral sectors?
   - What changes in policy will make it feasible to study community health assessment practice?
   - What aspect of community health assessment practice (e.g. methods of data dissemination, community involvement frameworks) should take priority?
   - What methodologies and evaluation frameworks can be used to study community health assessment practice?
   - What are the specific roles of assessment practitioners at the federal, state and local levels in community health assessment practice research?
   - What are the technical, training and resource needs for evaluating community health assessment practice?
3. The CDC should organize an Action Learning Lab in partnership with selected states to study evaluation of community health assessments, for example, as is done in the maternal child health field.[5]

Public Health Impact:

Communities conduct health assessments to inform a community health improvement process and justify or advocate for services and programs. Hence, the performance of a community health assessment and its effectiveness is measured by changes in public health planning and policy decisions, and their impact on health outcomes. Community Health Assessment (CHA) is a core public health function. A CHA is the first step in planning and policy development, or in assessing the impact of a changed policy. It occurs across all programs including chronic disease, environmental health, social, educational, public health preparedness, and health care access.

2007 Position Statements

(continued)
07-EC-01

Committee: CSTE Executive Committee

Title: Research to study and disseminate evidence of effective community health assessments

A Governmental Accountability Office (GAO) Report[6] of 29 comprehensive key indicator systems showed evidence of positive effects in four areas. The comprehensive key indicator systems enhanced collaboration to address public issues, provided tools to encourage progress, helped inform decision-making and improve research, and increased public knowledge about key economic, environmental, social and cultural issues. The GAO report acknowledges that the various community influences on decision-making made it difficult to attribute all the positive change only to the indicator system. While the GAO report focused on larger systems, it provides lessons and directions for CHA research.

There are also a number of tools such as the National Public Health Performance Standards Survey[7], and the Turning Point Performance Management Model[8] that assist with measuring the performance of the public health system including assessment. A number of published studies point towards collaboration, leadership, how the CHA is developed and presented, and available resources as influencing the quality and ability of communities to conduct CHAs.[9,10,11]

How a CHA is conducted and implemented impacts policy and health status outcomes. While logic models support the use of CHA for data-based decision-making with community involvement, it would be very helpful to have concrete evidence of effectiveness. If crosscutting research into evaluation of community heath is not conducted, communities will continue to use the different frameworks recommended, but not know of components with proven results or that are critical for public health action. If there are mistakes, or missed opportunities, learning occurs only within program silos, rather than across systems. CHA research is basic public health science. As in any basic science, understanding how to achieve optimal effectiveness, and developing a feedback loop will have far-reaching implications on areas such as chronic disease, public health preparedness, health care access, and reducing disparities.

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2007 Position Statements

(continued)
07-EC-01

Committee: CSTE Executive Committee

Title: Research to study and disseminate evidence of effective community health assessments

References:

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2007 Position Statements

(continued)
07-EC-01

Committee: CSTE Executive Committee

Title: Research to study and disseminate evidence of effective community health assessments

Coordination:

Agencies for Response:

(1) Julie Gerberding, MD
Director
Centers for Disease Control and Prevention (CDC)
1600 Clifton Park NE
Mailstop D-14
Atlanta, GA 30333
404-639-7000
julie.gerberding@cdc.hhs.gov

Agencies for Information:

None

Submitting Author:

(1) Michael Landen, M.D., M.P.H.
Deputy State Epidemiologist
New Mexico Department of Health
1190 St. Francis Drive, Suite N1320
Sante Fe, NM 87502
505-476-3575
Michael.Landen@state.nm.us

Co-Authors:

(1) Annie Gjelsvik, PhD
Epidemiologist, Diabetes Prevention and Control Program
Rhode Island Department of Health
3 Capitol Hill, Room 103
Cannon Building
Providence, RI 02908-5097
401-222-5119
Annie.Gjelsvik@health.ri.gov

(2) Cate Bohn
Community Health Information Specialist
New York State Department of Health
750 Corning Tower, ESP
Albany, NY 12237
518-473-3713
cmb20@health.state.ny.us

2007 Position Statements

07-EC-02

Committee: Executive

Title: CSTE official list of Nationally Notifiable Conditions

Statement of the Problem:
The federal American Health Information Community (AHIC) Biosurveillance Workgroup (now retitled Population Health & Clinical Care Connections Workgroup) was charged with developing recommendations "to implement the informational tools and business operation to support realtime nationwide public health event monitoring and rapid response management". In early 2007, the workgroup and AHIC adopted case-reporting recommendations which included:

- *Recommendation 2.0* By April 30, 2007, CSTE, in collaboration with CDC, should define an on-going process to be used in establishing a common list of nationally notifiable conditions to be reported to all levels of public health and their associated standardized case definitions including the data elements to be reported.
- *Recommendation 2.1* By August 1, 2007, CSTE, in collaboration with CDC, should provide to HHS the common list of nationally notifiable conditions and the first set of case definitions including the list of common and disease specific data elements to be reported. Subsequent sets of case definitions will be delivered on a scheduled basis as defined by the process resulting from Recommendation 2.0 above.

The National Notifiable Diseases Surveillance System is described by CDC as follows (http://www.cdc.gov/epo/dphsi/nndsshis.htm):

- In 1878, Congress authorized the U.S. Marine Hospital Service (i.e., the forerunner of the Public Health Service [PHS]) to collect morbidity reports regarding cholera, smallpox, plague, and yellow fever from U.S. consuls overseas; this information was to be used for instituting quarantine measures to prevent the introduction and spread of these diseases into the United States. In 1879, a specific Congressional appropriation was made for the collection and publication of reports of these notifiable diseases. The authority for weekly reporting and publication of these reports was expanded by Congress in 1893 to include data from states and municipal authorities. To increase the uniformity of the data, Congress enacted a law in 1902 directing the Surgeon General to provide forms for the collection and compilation of data and for the publication of reports at the national level. In 1912, state and territorial health authorities--in conjunction with PHS--recommended immediate telegraphic reporting of five infectious diseases and the monthly reporting, by letter, of 10 additional diseases. The first annual summary of The Notifiable Diseases in 1912 included reports of 10 diseases from 19 states, the District of Columbia, and Hawaii. By 1928, all states, the District of Columbia, Hawaii, and Puerto Rico were participating in national reporting of 29 specified diseases. At their annual meeting in 1950, the State and Territorial Health Officers authorized a conference of state and territorial epidemiologists whose purpose was to determine which diseases should be reported to PHS. In 1961, CDC assumed responsibility for the collection and publication of data concerning nationally notifiable diseases.
- The list of nationally notifiable diseases is revised periodically. For example, a disease may be added to the list as a new pathogen emerges, or a disease may be deleted as its incidence declines. Public health officials at state health departments and CDC continue to collaborate in determining which diseases should be nationally notifiable; CSTE, with input from CDC, makes recommendations annually for additions and deletions to the list of nationally notifiable diseases. However, reporting of nationally notifiable diseases to CDC by the states is voluntary. Reporting is currently mandated (i.e., by state legislation or regulation) only at the state level. The list of diseases that are considered notifiable, therefore, varies slightly by state.

In October 1990, in collaboration with CSTE, CDC published Case Definitions for Public Health Surveillance, which, for the first time, provided uniform criteria for reporting cases, and included infectious diseases and non-infectious conditions. This report was revised in 1997 and published as Case Definitions for Infectious Conditions Under Public Health Surveillance. The CDC NNDSS program currently maintains a list of "Nationally Notifiable Infectious Diseases" (http://www.cdc.gov/epo/dphsi/phs/infdis.htm), although the collection of case definitions includes archived non-infectious conditions (http://www.cdc.gov/epo/dphsi/casedef/case_definitions.htm).

2007 Position Statements

(continued)
07-EC-02

Committee: Executive

Title: CSTE official list of Nationally Notifiable Conditions

In 2001, CSTE adopted the position statement "Standardizing the structure of public health case definitions for diseases and conditions placed under the National Public Health Surveillance System (NPHSS)."

CSTE has surveyed state epidemiologists on reporting requirements periodically, roughly every other year in the current decade. In order to aid production of its weekly tables in MMWR and the annual publication Summary of notifiable diseases, NNDSS has conducted annual surveys of reporting requirements. In November 2007, CSTE and CDC plan to initiate a joint annual survey.

In 2006, CSTE and CDC began planning for the next generation of information systems for reporting requirements, the Notifiable Conditions Knowledge-base (NC-Kb), which will "provide a central, up-to-date listing of reportable Public Health conditions by jurisdiction". NC-Kb will be an authoritative real-time centralized listing of all reportable conditions in each reporting jurisdiction, for healthcare providers, laboratories, hospitals, and other entities that require this information. Manufacturers of administrative software systems for physician offices could use information in the centralized repository to automate case-reporting to states, when a diagnosis of a reportable condition is made. NC-Kb information could also be used by healthcare and laboratory information systems to facilitate automated case-reporting to public health. The NC-Kb will be accessible through webpage query, as are the current CSTE survey results, and also available for machine-to-machine automated data exchange. We anticipate that the information in the NCKb will be maintained using CDC resources for security and for back-up of the data, and that the established procedures will enable modification access limited to authorized state health agency staff.

In announcing in December 2006 that the U.S. would adopt the new WHO International Health Regulations, DHHS Secretary Leavitt stated that the nation "accepted the IHRs with the reservation that it will implement them in line with U.S. principles of federalism." This explicit statement reiterates the principles which have served as a foundation for the state-federal relationship responsible for the existing National Notifiable Diseases Surveillance System.

An official list of nationally-notifiable conditions must achieve a balance between two contradictory objectives:

- to include conditions which are currently explicitly included under existing state law/regulation in all jurisdictions
- to include all conditions which have been recommended to be nationally notifiable by CSTE, regardless of whether they are currently explicitly included under existing state law/regulation in every jurisdiction.

A list which meets only the former objective will be shorter, while a list which meets only the latter objective will be longer. State and territorial laws and regulations often do not include explicit mention of certain specific low-incidence conditions on the rationale that their rules include "rare diseases of public health importance", or similar language. In this circumstance, traditional reporters (clinicians. labs, hospitals) are expected to report because the rules mandate such reporting. However, with the development of electronic automated case-reporting capacity, a list of notifiable conditions which omits some conditions can result in under-reporting. Conversely, a more comprehensive list of notifiable conditions can result in over-reporting in some jurisdictions: sending of case reports to public health authorities in the absence of legal authority for the sender to do so (e.g., a violation of HIPAA). Further, in some jurisdictions, certain specific high-incidence conditions are omitted from the list of notifiable conditions because the governmental health agency lacks the resources to conduct individual case investigations. In that circumstance, a more comprehensive list of notifiable conditions could result in over-reporting in some jurisdictions that would result in a flood of case reports which the agency would find difficult to manage. In addition, the more comprehensive list of notifiable conditions includes some conditions of special regional significance, which are not a substantial problem equally in all regions.

2007 Position Statements

(continued)
07-EC-02

Committee: Executive

Title: CSTE official list of Nationally Notifiable Conditions

Statement of the desired action(s) to be taken:

CSTE requests:

1. The assistance of CDC in establishing and maintaining the CSTE official list of Nationally Notifiable Conditions.
2. That CDC, in collaboration with CSTE, develop, implement and maintain notifiable conditions standardized reporting definitions which comply with the AHIC recommendations for standardization to support "automated case reporting from electronic health records or other clinical care information systems" and have been adopted by CSTE. At a minimum, this is expected to include common and disease-specific reportable data elements, regardless of whether data elements are specified in the relevant CSTE position statement.
3. That CDC continue its valuable collaboration with CSTE on development and implementation of the joint CDC-CSTE Notifiable Conditions Knowledge-base (NC-Kb), which will be the authoritative real-time centralized listing of all notifiable conditions in each reporting jurisdiction. NC-Kb should also document reporting definitions and disease-specific data elements. The NCKb should be accessible through webpage query, and also available for machine-to-machine automated data exchange. The information in the NC-Kb should be maintained securely by CDC, with modification access limited to authorized state health agency staff. CSTE will establish a mechanism for identification of the specific authorized individuals for each jurisdiction.
4. That the CDC National Notifiable Diseases Surveillance System (NNDSS) implement CSTE position statements which call for national surveillance of specified non-infectious conditions using case ascertainment conducted by the sending of individual case data to the state health agency by clinicians, laboratories or hospital facilities. This includes maintaining case definitions for these non-infectious conditions on the existing CDC case definition website. Implementation steps for listing all Nationally Notifiable Conditions can be accomplished by either establishment of a new list of Nationally Notifiable Non-Infectious Conditions, or by modification of the existing list of Nationally Notifiable Infectious Diseases to become a unified list of Nationally Notifiable Conditions. The latter option would mirror the list of Nationally Notifiable Conditions maintained by CSTE.

Public Health Impact:

This establishment and maintenance of the CSTE official list of Nationally Notifiable Conditions, along with standardized reporting definitions, will help CSTE and CDC partners to achieve more complete and timely reporting of potential notifiable condition cases through expanded use of automated electronic case reporting. Public health not only has a responsibility to keep laboratories, hospitals, and healthcare providers serving the population of one state informed of their reporting requirements, public health also has a responsibility to keep laboratories and hospitals serving the needs of multiple states informed of those states' reporting requirements.

2007 Position Statements

(continued)
07-EC-02

Committee: Executive

Title: CSTE official list of Nationally Notifiable Conditions

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Coordination:

Agencies for Response:

Julie Gerberding, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Road NE M/S D14
Atlanta, GA 30333
404-639-7000
jyg2@cdc.gov

Agencies for Information:

Scott Becker
Executive Director
Association of Public Health Laboratories
8515 Georgia Avenue, Suite 700
Silver Spring, MD 20910
Telephone: 240-485-2745 ext 201
Fax: 240-485-2700
sbecker@aphl.org

Paul Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officers
2231 Crystal Drive Suite 450
Arlington, VA 22202
Phone: (202) 371-9090
Fax: (571) 527-3189
pjarris@astho.org

2007 Position Statements

(continued)
07-EC-02

Committee: Executive

Title: CSTE official list of Nationally Notifiable Conditions

Agencies for Information:

Patrick Libby
National Association of County and City Health Officials
440 First Street , N.W.
Washington, DC 20001
(202) 942-4224

Submitting Author:

Steven Macdonald
Surveillance Epidemiologist
Washington State Department of Health
Office of Epidemiology
PO Box 47812
Olympia WA 98504
360-236-4253
steven.macdonald@doh.wa.gov

2007 Position Statements

07-EC-03

Committee: Executive

Title: Support and reinstatement of funding for CDC's Outbreak Management System

Statement of the Problem:
Public health preparedness and response to natural and intentional infectious disease outbreaks require that State and local public health staff have electronic data management tools available that support triage of suspected cases, case management, tracking of patients and their contacts, and rapid compilation and analysis of these data. It is critical to efficiently collect and manage exposure data for cases and contacts, track multiple laboratory and/or environmental specimens associated with those patients, follow contacts, issue and track isolation and quarantine orders, and manage the workflow required for these activities. Many state and local health departments do not currently have an adequate data management tool to efficiently handle large or complex outbreaks and may not be able to provide timely information to decision-makers when needed. The 2003 outbreak of SARS, as well as the anthrax attacks of 2001, illustrate the overwhelming necessity and importance of such a tool. The absence of robust data management software systems was cited by multiple after action reports produced in Canada following the Toronto outbreak of SARS as one of the primary impediments to outbreak control.

The Outbreak Management System (OMS) developed by CDC is an example of a system that has the potential to meet these needs. It was developed with the intention of providing it at no cost to prospective users in public health. CDC OMS has multiple unique features including:

- suitability and flexibility for epidemiologic investigations,
- ability to support and facilitate workflow,
- robust case and contact management and follow-up,
- ability to link cases and contacts to multiple potential exposures or other objects in the database such as places, or vehicles,
- ability to link and track relationships between entities in order to describe social networks and patterns amongst communities during outbreaks,
- use of standard PHIN-compliant core vocabulary, which will support investigations across jurisdictions, and messaging between database systems, such as surveillance databases and laboratory databases (a critical feature), combined with
- support for user-defined vocabulary and supplemental question sets
- flexibility and capacity to allow the user to reuse and edit existing question sets,
- support of multiple versions of questionnaires,
- ease of data analysis and export,
- capacity for multiple users to access and use the system simultaneously.

The current Beta version of OMS (1.2) is a tool that was developed by CDC with the active input of state and local health department epidemiology professionals. Version 1.2 has benefited from lessons learned during local public health outbreak investigations and reflects the needs of ground level epidemiology in addition to more global assets. It is currently fully deployed in at least two jurisdictions (Tennessee and Houston, Texas) and is in the process of being deployed or evaluated by several more. OMS 1.2 has proved to be a usable tool both in the field as well as in two recent pandemic influenza exercises conducted at CDC. However, without the capacity to exchange messages with other databases, particularly with surveillance and laboratory databases, its usefulness is limited. Critical features were planned for the next version (1.3), including the ability to send and receive XML and HL7 messages.

CDC cooperative agreements for emergency preparedness for bioterrorism and pandemic influenza expressly require the recipients to develop PHIN compliant electronic software systems for managing data during outbreaks, both to ensure that health departments are prepared for public health emergencies, and so that data can be reported, managed and exchanged efficiently with partners at the state, local and federal levels.

CDC announced in September 2006 that it was pausing the development of OMS while it was conducting an evaluation of the system. A beta version of OMS 1.2 was released in early 2007 to a small number of jurisdictions; CDC has not been able to provide training or support for OMS 1.2.

2007 Position Statements

(continued)
07-EC-03

Committee: Executive

Title: Support and reinstatement of funding for CDC's Outbreak Management System

CSTE, at the request of CDC, has conducted a needs assessment for a data-management system such as OMS. This was completed in February 2007, and the report was distributed to CDC staff (NCPHI and COTPER) on March 20, 2007. Fifty out of 50 States and 6 out of 11 large urban areas responded. The full report can be accessed on:
http://www.cste.org/pdffiles/2007/CSTEOMSassessmentreport20070320final.pdf

The findings were as follows:

- Most jurisdictions do not currently feel prepared to manage data of complex outbreaks.
- States and local health departments stated that it is very important to have a system such as CDC's OMS.
- Many jurisdictions have not developed an in-house solution and had been planning to evaluate/ implement CDC-OMS 1.2.
- There is strong interest in CDC-OMS as a possible solution, but many jurisdictions have limited exposure to the most recent version and expressed concerns over whether the application will continue to be developed and supported to meet the outbreak management needs of state and local health departments.
- States and local public health jurisdictions want an outbreak management system to be able to exchange messages with surveillance and laboratory systems.
- Strong interest was expressed in having an outbreak management system developed as a web-based and client-server application.

The OMS development team that had been extremely responsive to the needs of CSTE members has now been disbanded and assigned to other duties. This is of tremendous concern to CSTE because of the inevitable loss of momentum and institutional knowledge, which will be difficult if not impossible to recapture regardless of the outcome of the evaluation. CSTE strongly urges CDC not to waste the tremendous amount of work and thought that has gone into OMS. Building a comparable and viable outbreak management system would be virtually impossible for individual state and local health departments. Developing a viable tool in the private sector or customizing an already existing tool would also require substantial input and investment by state, local and federal users of such a system. The need for such a system is urgent; public health has to be ready to respond.

Statement of the desired action(s) to be taken:

1. CSTE requests that CDC immediately provide ongoing funding for the development of OMS, including the messaging component while an evaluation is taking place, to prevent further loss of OMS development team staff and loss of institutional knowledge and momentum.
2. CDC reinstate support for OMS version 1.2 for training, deployment, and help desk and reconvene the OMS working group.
3. Prioritization of future enhancements of OMS should include feedback from experience of OMS 1.2 in the field and from the OMS working group.
4. Messaging and other specific high value enhancements should be prioritized for completion in the next version.
5. If funding for the messaging component is not provided, CDC should provide the source code for OMS to States and Territorial health departments, so that a consortium of State and Territorial health departments can collaboratively work on developing the messaging component or other necessary enhancements.
6. CDC should investigate the options to provide source code to States and Territorial health departments that need access to the source code for the purpose of integrating with other electronic surveillance systems.

2007 Position Statements

(continued)
07-EC-03

Committee: Executive

Title: Support and reinstatement of funding for CDC's Outbreak Management System

Public Health Impact:

Adoption of these recommendations will:

1. Improve state and local preparedness for large scale outbreaks of infectious disease or environmental public health emergencies.
2. Increase the ability of public health staff to respond efficiently and effectively to outbreaks to minimize morbidity, mortality and economic impact.
3. Make more efficient use of public funding for development of outbreak management software.
4. Support the capacity for public health agencies to share and exchange critical public health data during large or multijurisdictional outbreaks.
5. Complete a critical component of the PHIN.

Coordination:

Agencies for Response:

(1) Julie Gerberding, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Road NE M/S D14
Atlanta, GA 30333
404-639-7000

Agencies for Information:

(1) Scott J. Becker, MS
Executive Director
Association of Public Health Laboratories
8515 Georgia Avenue
Suite 700
Silver Spring, MD 20910
Telephone: 240-485-2745 ext 201
Fax: 240-485-2700: sbecker@aphl.org

(2) Paul E. Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officials
2231 Crystal Drive Suite 450
Arlington, VA 22202
Phone: (202) 371-9090
Fax: (571) 527-3189
pjarris@astho.org

2007 Position Statements

(continued)
07-EC-03

Committee: Executive

Title: Support and reinstatement of funding for CDC's Outbreak Management System

Agencies for Information:

(3) Pat Libbey
National Association of City and County Health Officials
1100 17th Street, NW, Second Floor
Washington, DC 20036
Fax: (202) 783-1583

(4) American Health Information Community (AHIC)
US Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitting Author:

(1) Marion Angelika Kainer MD, MPH
Medical Epidemiologist
Tennessee Department of Health
425 5th Avenue North
Cordell Hull Building
Nashville, TN 37243
615 741 7247
marion.kainer@state.tn.us

Co-Author:

(1) Annie Fine, MD
Medical Epidemiologist
Bureau of Communicable Disease
New York City Department of Health and Mental Hygiene
125 Worth St.
CN 22A
New York, NY 10013
212-788-4388
afine@health.nyc.gov

2007 Position Statements

07-EH-01

Committee: Occupational/Environmental Health

Title: Support for Continuity of Environmental Public Health Indicators Development

Statement of the Problem:
The Council of State and Territorial Epidemiologists (CSTE) and the National Center for Environmental Health (NCEH) of the Centers for Disease Control and Prevention (CDC), have a common interest in enhancing environmental public health surveillance capacity nationally and among state health departments using standardized, systematic methods that produce useful results. This was expressed in the 2001 CSTE position statement, 01-ENV-01 "Development of Environmental Public Health Indicators." Subsequently, several state and national environmental health agencies, including the NCEH Environmental Public Health Tracking (EPHT) Program of CDC, have recognized the value of developing indicators that can represent data on important environmental public health issues such as air and water pollution, asthma, the built environment, and climate change for stakeholders. Developing workable indicators requires several steps including pilot testing.

The U.S. Environmental Protection Agency (EPA) has a rich collection of data through its extensive history of environmental monitoring facilitated by individual state programs. Through many avenues, the EPA is strengthening its role in protecting ecosystems which directly and indirectly benefit human health. The EPA provides broad access to national and state-specific environmental measures and has several different indicator initiatives including the EPA 'Report on the Environment' and "America's Children and the Environment." These indicators are primarily focused at the national level. Efforts to enhance environmental surveillance and indicator development at the state level are needed.

CSTE serves as the primary body for collaborative efforts to increase state-level public health surveillance and indicator development. CSTE has been working on development of the National Public Health Surveillance System, which includes non-infectious disease indicators from injury, occupational, chronic disease and environmental health. The need for technical direction and best practices for characterizing environmental public health is common among all states. The degree of resource availability and technical skill for developing measures for environmental public health varies throughout the US. To that end, CSTE has the opportunity and the organizational capacity to positively affect Environmental Public Health Indicators (EPHI0 on a broad scale. CDC, in the interest of standardizing systematic methods throughout the nation, can benefit from additional contributions toward development and pilot testing of indictors.

The State Environmental Health Indicators Collaborative (SEHIC) has made important strides in development and testing of environmental public health indicators relevant for states. Cooperation among states, CSTE, CDC and EPA have been sought to leverage this existing collaboration model to increase topics covered by SEHIC and to accelerate indicator product development, testing and deployment on a national scale as part of the CDC/CSTE cooperative agreement. To date SEHIC partners have developed templates and "how-to-guides" outlining indicators and measures related to (1) air quality, (2) asthma and (3) drinking water. Piloting of these indicators has been performed among SEHIC participating states. Additional efforts are underway to address climate change and the built environment.

Statement of the desired actions to be taken:
Twelve of the states participating in the State Environmental Health Indicators Collaborative met March 2007 with the following recommendations:

1. The SEHIC should be continued in order to promote a systematic approach to indicator development and to provide a venue for developing environmental public health indicators useful to all states.
2. Support for the continuation of the SEHIC is best provided by CSTE as an administrative and professional entity with its demonstrated success in managing resources and collaborative projects impacting public health, and more specifically, indicator development.
3. CDC has similar interests in developing environmental public health indicators through its Environmental Public Health Tracking (EPHT) program. The EPHT scope, however, is limited to those entities specifically selected to participate in its program. The CDC long-term goal is to institutionalize a comprehensive Tracking Network, presumably to include data from all states, regardless of funding for EPHT. CDC should support the continuing of the SEHIC and CSTE to extend capacity for indicators that can contribute to the agency's EPHT project as well as provide technical support to every state.

2007 Position Statements

(continued)
07-EH-01

Committee: Occupational/Environmental Health

Title: Support for Continuity of Environmental Public Health Indicators Development

4. The EPA and the United States Geological Survey (USGS) can provide data and facilitate the acquisition and analysis of environmental data critical in the development of environmental public health indicators. These agencies are vital partners in the SEHIC and, as such, working relationships with the EPA and USGS should continue. Involvement of state environmental agencies will also enhance the process.
5. Evaluation of the SEHIC should be conducted to assure the partnerships are functioning effectively and products are meeting the needs of the respective entities.

Public Health Impact:
SEHIC membership is extended to all states. Representatives of state environmental health agencies, health and environmental data stewards, as well as universities, federal agencies and federal environmental data stewards (CDC, EPA, USGS) are invited to participate. The comprehensive and voluntary nature of this effort clears the way for innovation, exploration and expansion beyond traditional mechanisms of federal and state initiatives. The nature of the SEHIC organizational flexibility can decrease time for identification, development and pilot testing of indicators. The result of this collaboration is broader participation, technical skill development, intellectual and professional sharing and growth. Additionally, relationships among the contributors lead to mentoring, resource sharing, and better quality of environmental health capacity for public service.

Coordination:

Agencies for Response:

(1) Julie Gerberding, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Road MS D14
Atlanta, GA 30329
404-639-7000
julie.gerberding@cdc.hhs.gov

(2) Stephen L. Johnson
Administrator
Environmental Protection Agency
USEPA Headquarters Ariel Rios Building
1200 Pennsylvania Avenue, N. W.
Mail Code: 1101A
Washington, DC 20460
202-564-4700
johnson.stephen@epa.gov

Agencies for Information

(1) Paul E. Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officials
2231 Crystal Drive Suite 450
Arlington, VA 22202
Phone: (202) 371-9090
Fax: (571) 527-3189
pjarris@astho.org

2007 Position Statements

(continued)
07-EH-01

Committee: Occupational/Environmental Health

Title: Support for Continuity of Environmental Public Health Indicators Development

(2) Pat Libbey
National Association of City and County Officials (NACCHO)
1100 17th Street, NW, Second Floor
Washington, DC 20036
(202) 783-5550
plibbey@naccho.org

(3) Nelson Fabian
Executive Director
National Environmental Health Association
720 S. Colorado Blvd.
Suite 1000-N
Denver, CO 80246-1926
(303) 756-9090
Nfabian@neha.org

Submitting Author:
(1) Lesa Roberts, MPH, BSN, RN
Environmental Health Officer
Divisions of Health & Environment
Kansas Department of Health & Environment
1000 SW Jackson, Suite 310
Topeka, KS 66612
(785) 296-2501
LesaRoberts@kdhe.state.ks.us

Co-Author:

(1) Kristen Malecki, PhD, MPH
Epidemiologist
Wisconsin Department of Health and Family Services
Division of Public Health
Bureau of Environmental and Occupational Health
1 West Wilson, Rm 150
Madison, WI 53717
(608) 267-3830
maleckm@dhfs.state.wi.us

2007 Position Statements

07-EH-02

Committee: Occupational/Environmental

Title: Occupational and Environmental Risks of Nanotechnology

Statement of the Problem:

In general terms, nanotechnology covers "engineered structures, devices and systems that have a length scale of 1 – 100 nanometers. At these length scales, materials begin to exhibit unique properties that affect physical, chemical and biological behavior." (1) Nanotechnology is already used for a wide variety of products such as paints, sunscreen and cosmetics, sports equipment, stain-free clothing and automobile parts and equipment. Currently, over 200 products are on the market. (2)

By 2015, the economic impact of nanotechnology world-wide is expected to be over $1 trillion. (1) Research and development is particularly significant in the fields of electronics, optoelectronics, magnetic applications, medical imaging, drug delivery, and cosmetics. The National Nanotechnology Initiative, the federal government's coordinating body for nanotechnology R & D, has spent approximately $1 billion per year since 2001. (3) Only about 4% of that amount has been dedicated to studying the potential health and environmental effects of nanomaterials in the last 3 years. (3) This seems inadequate given that an estimated 2 million workers are exposed to nanometer particles on a regular basis. Researchers and other interested parties have recommended that federal funding be greatly increased. Annual funding for the EPA's Particulate Matter Research Program was authorized at approximately $100 million.

The health, safety and environmental effects of nanomaterials are poorly understood. The size, surface area, reactivity and other unique characteristics of such substances raise concern that their effects on biological systems may be different than the effects posed by their conventional counterparts. Recent research suggests that nano-sized materials can penetrate deep into the lungs (4), reach the brain via the olfactory nerves (5), penetrate the skin (6), and cause oxidative damage (7). Studies on fish suggest that at least one form of nanoparticles can cause significant damage to the brain (7). Another concern is the potential explosiveness of nanomaterials. The potential for dusts of many chemicals to explode is well known, and particle size and surface area play a role in their explosiveness, yet no studies have been published examining this hazard for nanoparticles.

There are many uncertainties regarding the health, safety and environmental effects of nanotechnology; however, our limited knowledge of its potential harm is cause for concern. The Royal Society of Great Britain, among others, has therefore called for the application of the "precautionary principle" (8): taking measures to prevent harm even when threats to human health or the environment are not fully established. Several government agencies and organizations are in the process of establishing guidelines for the control of nanotechnology, including the National Institute for Occupational Safety and Health, the U.S. Environmental Protection Agency, American Society for Testing and Materials (ASTM) International and the International Standards Organization. However, enforceable standards have not been promulgated to protect workers, the general public or the environment.

Statement of the desired action(s) to be taken:

CSTE shall request Congress and the appropriate federal agencies to significantly increase the level of funding for research on the health, safety and environmental impacts of nanotechnology.

In the meantime, using the precautionary principle, CSTE shall:

- Request the U.S. Environmental Protection Agency to establish a national registry of companies that manufacture or use nanoparticles, and make that registry publicly available.
- Request the U.S. Environmental Protection Agency to require the submission of "Premanufacture Notices" by manufacturers of nanomaterials, in accordance with the Toxic Substances Control Act, and to insist on a thorough characterization of potential health and environmental risks of these materials.
- Request the U.S. Food and Drug Administration to require the labeling of products containing nanoparticles that are aerosolized or applied to the skin, listing the contents, intended use and proper handling of the product.

2007 Position Statements

(continued)
07-EH-02

Committee: Occupational/Environmental

Title: Occupational and Environmental Risks of Nanotechnology

- Request the Occupational Safety and Health Administration and the Environmental Protection Agency to promulgate standards for the protection of workers, the general public and the environment against known or suspected harmful effects of nanoparticles.

Public Health Impact:
Increased availability of information to the public on the uses of nanotechnology;
- Identification of the producers and industrial users of nanomaterials;
- Increased funds to support a necessary research program on the health and environmental
- impacts of nanotechnology;
- Increased government oversight of the nanotechnology industry;
- Increased understanding of the health, safety and environmental effects of nanoparticles;
- Increased protection of workers, consumers, the general public and the environment from the adverse effects of nanotechnology.

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Coordination

Agencies for Response:

(1) Stephen Johnson
Administrator
U.S. Environmental Protection Agency
Ariel Rios Building
1200 Pennsylvania Avenue, N.W.
Washington, DC 20460
202-564-4700
johnson.stephen@epa.gov

(continued)
07-EH-02

Committee: Occupational/Environmental

Title: Occupational and Environmental Risks of Nanotechnology

2) Edwin Foulke, Jr.
Assistant Secretary of Labor
Occupational Safety & Health Administration
200 Constitution Avenue, NW
Washington, DC 20210
202-693-1999

(3) Andrew von Eschenbach, M.D
Commissioner
Food and Drug Administration
5600 Fishers Lane
Rockville MD 20857
301-827-2410
andrew.voneschenbach@fda.hhs.gov

Agencies for Information:

(1) Jennifer Sass, Ph.D.
Staff Scientist
Natural Resources Defense Council
40 West 20th Street
New York, NY 10011
(212) 727-2700
jsass@nrdc.org

(2) John Howard, M.D., M.P.H., J.D., LL.M.
Director
National Institute for Occupational Safety and Health
Hubert H. Humphrey Bldg, Room 715H
200 Independence Ave., SW
Washington, DC 20201
(202) 401-6997

(3) Georges C. Benjamin, MD, FACP
Executive Director
American Public Health Association
800 I Street, NW
Washington, DC 20001
Telephone Number 202-777-2742
georges.benjamin@apha.org

2007 Position Statements

(continued)
07-EH-02

Committee: Occupational/Environmental

Title: Occupational and Environmental Risks of Nanotechnology

Submitting Author:

(1) Richard Rabin
Coordinator, Lead Registry
Massachusetts Department of Labor
1001 Watertown St.
Newton, MA 02465
617-969-7177
rick.rabin@state.ma.us

Co-Author:
(1) Richard Kreutzer, MD
Chief
Environmental Health Investigations Branch, CA Department of Health Services
850 Marina Bay Parkway, bldg. P, 3rd floor
Richmond, CA 94804
510-620-3620
RKreutze@dhs.ca.gov

2007 Position Statements

07-EH-03

Committee: Environmental Health

Title: Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance

Statement of the Problem:
The Carbon Monoxide Surveillance Workgroup (CO-SWG) was formed in 2005 under the national Environmental Public Health Tracking (EPHT) grant, though its members include nongrantee state epidemiologists as well as clinicians interested in improving the surveillance and recognition of carbon monoxide poisoning. In the process of developing and testing nationally consistent measures for carbon monoxide (CO) poisoning and exposure, the CO-SWG has evaluated the Surveillance Case Definition for Acute Carbon Monoxide Poisoning adopted by CSTE in 1998. Several proposed revisions were identified:

First, the COSWG proposes the addition of three ICD-9 external cause of injury E-codes to the suspected case definition for administrative data sets. These are for 1) accidental, 2) intentional, and 3) unknown cause of poisoning by unspecified gases or vapors (E.869.9, E952.9, and E962.9, respectively). Although these were not included in the 1998 position statement, they are consistent with the suspected case definition for administrative data, which calls for E-codes when CO exposure is plausible, though not exclusively mentioned.

Second, the 1998 case classification for confirmed CO poisoning (Clinicians/Medical Examiners/Coroners notification systems) specifies either 1) laboratory confirmation of an elevated carboxyhemoglobin (COHb) level from a blood specimen or 2) environmental monitoring data suggesting a source of CO exposure. Since 1998 there have been advances in biomedical instrumentation for pulse oximetry, allowing COHb levels to be measured quickly and noninvasively. While traditional pulse oximeters use two wavelengths of light to measure oxygen saturation, a new device approved by the FDA (Rad-57 Pulse CO-Oximeter, Masimo Inc) uses eight wavelengths to measure not only oxygen saturation, but also carboxyhemoglobin and methemoglobin levels. One validity study found that the Rad-57 pulse CO-oximeter measured COHb levels below 15% with strong precision (2.2% uncertainty) relative to laboratory COoximetry of blood specimens drawn concurrently (1). Another recent study documented the utility of pulse CO-oximetry in emergency room triage, where three unsuspected cases of CO toxicity were identified over twelve days using the Rad-57 and confirmed with blood samples (2). The CDC is presently funding a multi-state study to further test the sensitivity and specificity of pulse CO-oximetry in the emergency room setting (3). Given the favorable nature of these early findings, the CO-SWG recommends that pulse CO-oximetry be added to (1) of the case classification as indicated below; until further study results are available, it is not recommended as sufficient criteria alone in the absence of signs and symptoms of CO poisoning.

Third, since the 1998 position statement was adopted, several states have evaluated and demonstrated the utility of monitoring local Poison Control Center (PCC) data in their surveillance of acute carbon monoxide poisoning. Nationally, the CDC and American Association of Poison Control Centers (AAPCC) conduct routine surveillance of local PCC data to detect potential public health emergencies such as biological or chemical events (4). However, because identifying data and case notes are removed from local PCC data prior to submission to the national database, local PCC partnerships can provide increased case details for investigation and analysis. In New York City, the health code was updated in 2004 to specify CO poisoning as an immediately reportable condition, where the NYC PCC receives reports from healthcare providers and rapidly notifies the fire department for follow-up investigation in order to prevent secondary cases at the incident site (5). In Florida, the state Department of Health has partnered with their regional PCC since 2003 to monitor exposure reports during hurricane season, identifying CO and hydrocarbon fuel poisonings related to generator use, and using these data to tailor public health safety advisories before, during, and after hurricane landfall (6). More generally, PCC data provide the added value of identifying exposures and poisoning cases that may not otherwise be captured in emergency department or hospitalization datasets, such as when the case experienced a health effect but did not seek medical treatment. Two state-based evaluations (Connecticut (7), Wisconsin (8)) found minimal overlap between PCC cases and patients treated in emergency rooms or hospitalized for CO poisoning.

The CO-SWG proposes the addition of a Probable case classification for PCC data, for cases recorded as having exposure to CO that involved a health effect of at least a minor nature. By definition, the coding practices set forth by the AAPCC specify that the selection of a health effect implies that the case's symptoms were most likely attributable to his/her exposure, in the judgment of the PCC specialist based on the history provided by the case or the caller. Some case records may have additional details in the notes indicating a confirmed environmental sample for CO or an elevated carboxyhemoglobin level. These cases should be elevated to Confirmed status as delineated in the recommended actions below.

2007 Position Statements

(continued)
07-EH-03

Committee: Environmental Health

Title: Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance

Statement of the desired action(s) to be taken:
The COSWG proposes the following changes to the 1998 case definition for acute CO poisoning:

Surveillance Case Definition for Acute Carbon Monoxide Poisoning
Type of surveillance: Outcome

Clinical Description
There is no consistent constellation of signs and symptoms resulting from acute carbon monoxide poisoning, nor are there any pathognomonic clinical signs or symptoms which would unequivocally indicate a case of acute carbon monoxide poisoning. The clinical presentation of acute carbon monoxide (CO) poisoning varies not only with the duration and magnitude of exposure, but also between individuals with the same degree of exposure and/or same venous carboxyhemoglobin (COHb) level.

Clinical signs and symptoms of acute carbon monoxide poisoning that are commonly reported to health care professionals include, but are not limited to: headache, nausea, lethargy (or fatigue), weakness, abdominal discomfort/pain, confusion, and dizziness.

Other signs and symptoms reported include: visual disturbances including blurred vision, numbness and tingling, ataxia, irritability, agitation, chest pain, dyspnea (shortness of breath) on exertion, palpitations, seizures, and loss of consciousness.

Clinical Case Definition

There is no clinical case definition for acute carbon monoxide poisoning. There are no pathognomonic clinical signs or symptoms that would unequivocally indicate a case of acute carbon monoxide poisoning (without confirmation of an elevated carboxyhemoglobin level. See Clinical Description and Laboratory Criteria for Diagnosis.

Laboratory Criteria for Diagnosis

A blood specimen with an elevated carboxyhemoglobin (COHb) concentration, as determined by a validated method (e.g., photometric, gas chromatography). Elevated levels of carboxyhemoglobin should be interpreted in light of endogenous production, patient smoking status, and exposures to second hand smoke (1).

Case Classification
Confirmed:

Notification Systems:
Clinicians/Medical Examiners/Coroners: (1) A report of a patient with signs and symptoms consistent with acute carbon monoxide poisoning and a confirmed elevated COHb level, as determined by either a blood specimen (See Laboratory Criteria for Diagnosis) or pulse COoximetry, OR; (2) a report of a patient with signs and symptoms consistent with acute carbon monoxide poisoning (in the absence of clinical or laboratory confirmation of an elevated COHb level), with supplementary evidence in the form of environmental monitoring data suggesting exposure from a specific poisoning source.

- OR -

Laboratories: A report of a blood specimen (in the absence of clinical and environmental laboratory data) with a carboxyhemoglobin level that is equal to or greater than a volume fraction of 0.12, ie. 12%. [Note: This level was selected to identify those people whose COHb levels are likely to cause clinically apparent adverse health effects, while attempting to minimize the number of chronic smokers reported as acutely poisoned (1) (see comment section).]

2007 Position Statements

(continued)
07-EH-03

Committee: Environmental Health

Title: Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance

Administrative Data:

ICD-9 Coded Data: (1) A record in which the Nature of Injury code N-986 "Toxic effect of CO" is listed, OR; (2) a record in which an External Cause of Injury code (E-code), indicating exposure to carbon monoxide (exclusively) is listed, ie. E868.3, E868.8, E868.9, E952.1, or E982.1.

-OR-

ICD- 10 Coded Data: A record in which T58, Toxic Effect of Carbon Monoxide, is listed

-OR-

ICD-10-CM (under development) coded data: A record in which T58, Toxic Effect of Carbon Monoxide, is listed

-OR-

Poison Control Center (PCC) Data: (1) A record of a case with “exposure” recorded as the type of call, when the exposure substance was carbon monoxide, AND a minor, moderate, or major medical effect or death was reported AND an elevated carboxyhemoglobin level was indicated in the case notes; OR (2) A record of a case with “exposure” recorded as the type of call, when the exposure substance was carbon monoxide, AND a minor, moderate, or major medical effect or death was reported AND a positive environmental sample for CO was indicated in the case notes.

Probable Case:

Notification Systems:
Clinicians/Medical Examiners/Coroners: In the absence of clinical and environmental monitoring data: (1) A report of a patient with signs and symptoms consistent with acute carbon monoxide poisoning and the same history of environmental exposure as that of a confirmed case, OR, (2) a report of a patient with signs and symptoms consistent with acute carbon monoxide poisoning and history of smoke inhalation secondary to conflagration.

-OR-

Laboratories: A report of a blood specimen with a carboxyhemoglobin level that is equal to or greater than a volume fraction of 0.09, i.e. 9% and less than a volume fraction of 0.12, i.e. 12% (9<COHb%<12).

Administrative Data:
ICD-9 Coded Data: A record in which an E-code indicating acute carbon monoxide poisoning inferred from motor vehicle exhaust gas exposure is listed, ie. E868.2, E952.0, or E982.0.

-OR-

Hyperbaric Treatment Facilities: A report of a patient who has an exposure history consistent with carbon monoxide, and has received hyperbaric treatment for acute carbon monoxide poisoning, regardless of carboxyhemoglobin concentration reported, and regardless of the presence or absence of symptoms.

-OR-

2007 Position Statements

(continued)
07-EH-03

Committee: Environmental Health

Title: Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance

Poison Control Center (PCC) Data: A record of a case with "exposure" recorded as the type of call, when the exposure substance was carbon monoxide, AND a minor, moderate, or major medical outcome or death was reported.

Suspected Case:

Notification Systems:
Clinicians/Medical Examiners/Coroners: A report of a patient with signs and symptoms consistent with acute carbon monoxide poisoning and a history of present illness consistent with exposure to carbon monoxide.

Administrative Data:

ICD-9 Coded Data: In the absence of an N-986 code: (1) a record in which an E-code that mentions CO exposure is listed (E818.0-.9, E825.0-.9, E844.0-.9, E867, E868.0, E868.1, E890.2, E891.2), (2) a record in which an E-Code where carbon monoxide exposure is plausible is listed (E838.0-.9, E869.9, E951.0, E951.1, E951.8, E952.9, E962.2, E962.9, E968.0, E981.0, E981.1, E981.8, E988.1).

-OR-

ICD-10 Coded Data: In the absence of T58 code, a record in which a code that mentions CO exposure, is listed (X47, X67, Y17). [Note: The June 2003 draft of ICD-10-CM omits these codes.]

-OR-

Worker's Compensation Data: A report of a person with carbon monoxide poisoning documented in the record.

The descriptions provided for identifying cases of acute carbon monoxide poisoning utilize a variety of sources of data that one may use or integrate into a surveillance system. These are commonly available data that may be consistently utilized by all states. Additional state specific databases may have greater detail and professional discretion is encouraged when using alternative or supplemental databases. These definitions should be updated as the clinical, diagnostic, and epidemiologic state-of-the-art evolves and as new data sources become available.

Since the 1998 position statement was adopted, several states have evaluated and demonstrated the utility of monitoring local Poison Control Center (PCC) data in their surveillance of acute carbon monoxide poisoning. Nationally, the CDC and American Association of Poison Control Centers (AAPCC) conduct routine surveillance of local PCC data to detect potential public health emergencies such as biological or chemical events; however, because identifying data and case notes are removed from local PCC data prior to submission to the national database, local PCC partnerships can provide increased case details for investigation and analysis.

The 2007 CO-SWG proposes the addition of a probable case classification for PCC data, for cases recorded as having exposure to CO that involved a health effect of at least a minor nature. By definition, the coding practices set forth by the AAPCC specify that the selection of a health effect implies that the case's symptoms were most likely attributable to his/her exposure, in the judgment of the PCC specialist based on the history provided by the case or the caller. Some case records may have additional details in the notes indicating a confirmed environmental sample for CO or an elevated carboxyhemoglobin level. These cases should be elevated to confirmed status as delineated in the recommended actions.

The case descriptions provided are designed to ascertain cases of acute carbon monoxide poisoning regardless of the source of the exposure. Information on the history of the poisoning incident and the suspected exposure sources should be reviewed for targeting prevention efforts/interventions (see comments on persons with occupational exposure).

(continued)
07-EH-03

Committee: Environmental Health

Title: Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance

The surveillance case definitions for acute carbon monoxide poisoning have been formulated to address the general population. There are several sub-populations which may be more or less susceptible to the adverse health effects of carbon monoxide intoxication, due to pre-disposing environmental and physiologic conditions (see below). Separate surveillance case definitions for sub-populations have not been formulated at this time as it is unclear from the published peerreviewed literature whether these groups suffer more extreme outcomes from poisoning at lower levels of exposure and/or lower levels of carboxyhemoglobin saturation. In addition it is unclear whether the reporting sources would be able to consistently differentiate these sub-populations based on the information currently available in their databases.

The following sub-populations have been identified in the literature as having special concerns with respect to acute carbon monoxide poisoning:

1. Persons Exposed to Tobacco Smoke: Active and passive exposure to tobacco smoke elevates carboxyhemoglobin levels as a result of inhalation of combustion by-products. Data from the National Health and Nutrition Evaluation Survey, II , 1976-80, revealed that self reported current smokers showed larger variability in COHb levels along with a relative insensitivity of this group to incremental changes in the environmental burden of CO when compared with the never smoking group. NHANES, II also reported that approximately 95.9% of the current smokers had a concentration of COHb less than or equal to 9% (1).
2. Children: It is known that children have a higher minute ventilation per unit body weight than adults and that children have been reported to be more susceptible to the acute adverse health effects from exposure to CO. It is acknowledged that while children may accumulate COHb faster than adults, it is unclear whether they experience more severe outcomes at lower levels of COHb saturation, therefore a unique surveillance case definition has not been formulated at this time.
3. Fetal Exposure/Pregnancy: It is known that fetal blood has a higher affinity for CO than does adult hemoglobin and this is an important distinction considered by the clinician when treating the pregnant patient. It is unclear, at this time whether a unique surveillance case definition for this subgroup based on maternal COHb levels is necessary for reporting purposes.
4. Persons Living at Altitude: It is known that persons living at altitude experience faster loading of COHb as result of a leftward shift of the oxygen-hemoglobin dissociation curve. It is unclear whether persons at altitude experience more severe outcomes at lower levels of COHb saturation, therefore, a unique surveillance case definition for this sub-group has not been formulated at this time.
5. Persons with Pre-morbid Conditions: It is known that sub-populations with conditions of low oxygen saturation (e.g.; chronic obstructive pulmonary disease) and conditions with decreased oxygen delivery to the tissues (e.g.; ischemic heart disease) experience adverse health effects with increased COHb levels. It is unclear whether these sub-groups experience more severe outcomes at lower levels of COHb saturation, therefore, unique surveillance case definitions for these sub-populations have not been formulated at this time.
6. Persons with Occupational Exposure: Occupational exposure to carbon monoxide is not uncommon. The outcomes from acute CO poisoning at work are no different than then consequences of other sources of exposure. It is important to gather information on potential occupational exposures as this information is important for preventing future poisonings.

(continued)
07-EH-03

Committee: Environmental Health

Title: Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance

Public Health Impact:
It is anticipated that these revisions will increase the sensitivity of the CSTE case definition for acute carbon monoxide poisoning surveillance. No change in specificity is expected. Ultimately, the public health impact should be increased recognition of the full spectrum and burden of CO poisoning, to the extent that pulse CO-oximetry becomes more widely adopted as a standard of care in emergency room triage. Likewise, the impact of these changes will increase as more states and territories adopt and maintain CO poisoning as a reportable condition.

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Coordination:

Agencies for Response:

(1) Julie Gerberding, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Road MS D14
Atlanta, GA 30329
404-639-7000
julie.gerberding@cdc.hhs.gov

(2) John Howard, MD, MPH, JD, LLM, Director
National Institute of Occupational Safety and Health (NIOSH)
200 Independence Ave, SW
Room 715H
Washington, DC 20201
202-401-6997

2007 Position Statements

(continued)
07-EH-03

Committee: Environmental Health

Title: Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance

(3) Alvin Bronstein, MD, Acting Associate Director of Surveillance
American Association of Poison Control Centers (AAPCC)
Rocky Mountain Poison and Drug Center
777 Bannock St, Mail Code 0180
Denver, CO 80204-4508
303-739-1100
al.bronstein@rmpdc.org

Agencies for Information:

(1) Dr. John G. Lyon, Director
The U.S. Environmental Protection Agency (EPA)
Ariel Rios Building
1200 Pennsylvania Ave, NW
Washington, DC 20460
202-272-0167

(2) Nelson Fabian, MS, Executive Director
The National Environmental Health Association (NEHA)
720 S. Colorado Blvd.
Suite 1000-N
Denver, CO 80246-1926
303-756-9090
staff@neha.org

Submitting Authors:

(1) Katie Wheeler, MPH, Research Scientist/Epidemiologist
New York City Department of Health and Mental Hygiene
253 Broadway, Room 603
Mailbox CN34C
New York, NY 10007
212-676-2940
kwheeler@health.nyc.gov

2007 Position Statements

(continued)
07-EH-03

Committee: Environmental Health

Title: Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance

Co-Author:

(1) Allison Stock, PhD, MPH, LCDR, US Public Health Service
National Center for Environmental Health (NCEH)
Air Pollution and Respiratory Health Branch
1600 Clifton Road, MS E-17
Atlanta, GA 30333
404-498-1034
astock@cdc.gov

(2) Judith Graber, MPH, Epidemiologist, Project Coordinator
Consultant for Maine Center for Disease Control
judith.graber@gmail.com

2007 Acute Carbon Monoxide Poisoning Case Definition Workgroup also includes:

J. Rex Astles, PhD
CDC, Division for Laboratory Systems

Jane McCammon
Double Angel Foundation
Formerly with: National Institute of Occupational Safety and Health

Neil B. Hampson, MD
Virginia Mason Medical Center, WA

Patricia Miskell, MPH
Brian Toal, MSPH
Connecticut Department of Health

Andrew Smith, SM, ScD
Maine Center for Disease Control

Steven Macdonald, PhD, MPH
Washington State Department of Health

2007 Position Statements

07-ID-01

Committee: Infectious Disease

Title: National reporting for initial detections of novel influenza A viruses

Statement of the Problem:
Human infections with novel influenza A viruses that can be transmitted from person to person may signal the beginning of an influenza pandemic. Rapid detection and reporting of human infections with novel influenza A viruses – viruses against which there is little to no pre-existing immunity – will facilitate prompt detection and characterization of influenza A viruses with pandemic potential and accelerate the implementation of effective public health responses.

Statement of the desired action(s) to be taken:
Add detection of infections and illnesses with novel influenza A viruses to the list of nationally notifiable infectious diseases reportable to the National Notifiable Diseases Surveillance System (NNDSS).

Goals of Surveillance:
1) Rapidly identify and report infections and illnesses among humans with novel influenza A viruses to the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO); 2) ensure prompt confirmation of human novel influenza A virus infections; and 3) facilitate early initiation of appropriate public health responses.

This position statement does not address the goals and methods of surveillance that will be needed during an influenza pandemic. When a state or territory determines that the transmission of a novel strain of influenza in the general population has become efficient and sustained, this new pandemic influenza strain will no longer be considered novel for the purposes of surveillance. Based on experience with seasonal influenza surveillance, notification of individual influenza cases is unlikely to be either practical or the best use of surveillance resources during this phase of a pandemic (e.g., during World Health Organization Phase 6)). Once widespread community transmission has been established, it is anticipated that other approaches will be used to track the pandemic and guide the public health response (e.g. reporting of aggregate numbers of influenza-related hospitalizations, tracking of rates of influenza-like illness, and tracking of pneumonia and influenza mortality).

Methods for Surveillance:
Case finding is conducted through standard clinician reporting and laboratory testing and reporting methods in use at public health laboratories.

State and territorial epidemiologists in conjunction with public health laboratories will report to CDC all human infections with influenza A viruses that are different from currently circulating human influenza H1 and H3 viruses. These viruses include those that are subtyped as nonhuman in origin and those that are unsubtypable with standard methods and reagents. Core surveillance data will be reported to NNDSS through the National Electronic Telecommunications.

System for Surveillance (NETSS) or the National Electronic Disease Surveillance System (NEDSS), as per state protocol. Submission of specimens from health department laboratories to CDC's influenza laboratory for confirmation and full characterization is a parallel component.

Case Definition narrative:
Clinical presentation: Illness compatible with influenza virus infection.

Laboratory evidence: A specimen from a human that is reverse transcriptase polymerase chain reaction (RT-PCR)- or culture-positive for influenza A and tests negative for currently circulating human H1 and H3 subtypes. (For example, any specimen that is RT-PCR-positive for influenza A and H5 in testing performed by a public health laboratory would meet these criteria).

2007 Position Statements

(continued)
07-ID-01

Committee: Infectious Disease

Title: National reporting for initial detections of novel influenza A viruses

Case Definition tables:
Suggested codes for case ascertainment
To be developed for this condition, which depends upon laboratory diagnosis by a public health laboratory

Detailed definitions for case classification
Confirmed case: A case of human infection with a novel influenza A virus detected by a public health laboratory that has been laboratory confirmed by CDC.

Probable case: A case of human infection with a novel influenza A virus detected by a public health laboratory or a case that meets the clinical criteria and is epidemiologically linked to a confirmed case, and for which laboratory confirmation by CDC's influenza laboratory was either not done or was inconclusive.

Suspected case: (1) A case of human infection with a novel influenza A virus detected by a public health laboratory, and for which laboratory confirmation by CDC is pending; or (2) A case that meets the clinical criteria and is epidemiologically linked to a confirmed case, and for which laboratory testing for influenza is pending.

Period of Surveillance:
Ongoing, beginning in January 2007

Background and Justification:
On December 13, 2006, the United States formally accepted the revision of the International Health Regulations, referred to as IHR (2005) (http://www.hhs.gov/news/press/2006pres/20061213.html). This international legal instrument governs the roles of the WHO and its member countries in identifying and responding to and sharing information about public health emergencies of international concern (http://www.who.int/csr/ihr/IHRWHA58_3-en.pdf). The updated rules are designed to prevent and protect against the international spread of diseases, while minimizing interference with world travel and trade. The revised regulations add human infections with new influenza strains to the list of conditions that Member States must immediately report to WHO. An outbreak of infections with a new influenza A virus that demonstrates human-to-human transmission could signal the beginning of the next pandemic. Robust epidemiologic and laboratory surveillance systems are required for a coordinated public health response to infections with a novel influenza virus subtype. Early detection of an influenza virus with pandemic potential will permit identification of viral characteristics (e.g., genetic sequence, antiviral susceptibility, and virulence) that will affect clinical management and public health response measures. It should also facilitate development of virus-specific vaccine and testing strategies.

All state public health laboratories have the capacity to test respiratory specimens for influenza viruses with sensitive and specific assays that can detect human and non-human influenza A viruses. They also have the capacity to subtype currently circulating human influenza A H1, H3, and avian H5 (Asian lineage) viruses. The detection or confirmation by a state public health laboratory of an influenza A virus that is unsubtypable with standard methods (e.g., realtime RT-PCR assays for human influenza A(H3) or (H1) viruses), or a nonhuman influenza virus (e.g., H5) from a human specimen, could be the initial identification of a virus with pandemic potential. Novel strains detected by tests performed by non-public health laboratories using assays not validated by CDC should be immediately reported to the state health department and the state public health laboratory for confirmatory testing.

2007 Position Statements

(continued)
07-ID-01

Committee: Infectious Disease

Title: National reporting for initial detections of novel influenza A viruses

Prompt notification of CDC by a state epidemiologist in conjunction with the public health laboratory will permit rapid confirmation of results and reporting to WHO, and aid prompt viral characterization and the development of virus-specific diagnostic tests. Based on experience with seasonal influenza surveillance, notification of individual influenza cases is unlikely to be practical, useful, or the best use of surveillance resources during the pandemic phase. Once widespread community transmission has been established, it is anticipated that other approaches will be used to track the pandemic and guide the public health response (e.g. reporting of aggregate numbers of influenza-related hospitalizations, tracking of rates of influenza-like illness, and tracking of pneumonia and influenza mortality).

References:

CSTE. National reporting for novel influenza A virus infections -- 2007 Interim Position Statement dated January 5, 2007.

CDC response letter dated March 22, 2007.

Coordination

Agencies for Response:

Julie L. Gerberding, MD
Director
US Centers for Disease Control and Prevention
600 Clifton Road
Atlanta, GA 30333
404-639-7000
jyg2@cdc.gov

Agency for Information:

(1) Scott J. Becker, MS
Executive Director
Association of Public Health Laboratories
8515 Georgia Avenue
Suite 700
Silver Spring, MD 20910
Telephone: 240-485-2745 ext 201
Fax: 240-485-2700
sbecker@aphl.org

(2) Paul E. Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officials
2231 Crystal Drive Suite 450
Arlington, VA 22202
Phone: (202) 371-9090
Fax: (571) 527-3189

2007 Position Statements

(continued)
07-ID-01

Committee: Infectious Disease

Title: National reporting for initial detections of novel influenza A viruses

Submitting Author:

(1) Matthew L. Cartter, MD, MPH
Epidemiology Program Coordinator
Connecticut Department of Public Health
410 Capitol Ave.
MS# 11EPI
P.O. Box 340308
Hartford, CT 06134-0308
Phone: (860) 509-7994
Fax: (860) 509-7910
matt.cartter@ct.gov

2007 Position Statements

07-ID-02

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

Statement of the Problem:
In 2006, the U.S. experienced the largest mumps outbreak in twenty years. Using the current CSTE mumps definition and classifications, states had difficulty in trying to quantify, classify, and report possible mumps cases. Due to this difficulty, there was inconsistency among states when applying the case classifications which resulted in an inability to assess the actual impact of disease. Additionally, problems with laboratory confirmation were identified during this outbreak. In light of the new information obtained during the outbreak, it became apparent that the case definition and classifications needed to be updated. The current case definition and classifications do not include acute mumps complications, suspected case definition or newer laboratory tests. In addition, the CSTE case classification of import status for measles, rubella and congenital rubella syndrome approved in 2006 is being applied to the mumps classification for import status.

Changes were made to the case definition, laboratory criteria and case classifications. For the case definition, a clinical description was added to include cases that may present with only complications. Changes to the laboratory criteria included the addition of detection of mumps nucleic acid. PCR testing is now available in several states. Due to the problems with the serologic testing, a more specific criterion for IgG testing was added.

For case classification, several changes were made. A suspect case classification was added so states have a category to use for cases that may not meet the probable or confirmed definition but that likely will once the case investigation is complete. For both probable and confirmed, the clinical symptoms include clinical case definition or acute complications consistent with mumps disease as noted in the clinical description. For confirmed case definition, symptoms are now required in addition to laboratory confirmation or epidemiological linkage to a confirmed or probable case. The previous confirmed case classification did not require symptoms with laboratory confirmation. When state health departments were evaluating mumps cases in 2006, there was debate as to the reliability of the serologic tests for immunoglobulin M that vary by manufacturer and by availability in each state. The sensitivity and specificity of mumps serologic test kits varies greatly and there is no current standardization for all state public health laboratories.

Studies suggest that serum IgM may be negative in up to 50-60% of acute serum samples among individuals who have been previously immunized. Thus, a case in a vaccinated person cannot not be ruled out on the basis of a negative IgM1 For this reason, clinical symptoms consistent with mumps disease are now suggested for meeting the confirmed case classification.

The proposed definition was expanded by adding a clinical description to capture the clinica complications, but the definitions for case classification were made specific to increase the reliability of reporting true mumps cases. With mumps, it is essential that in the future states are able to readily identify cases using a uniform case definition sensitive enough to detect true cases and specific enough to rule cases attributable to other causes.

[1]http://www.cdc.gov/nip/diseases/mumps/faqs-lab-test-infect.htm

Statement of the desired action(s) to be taken:
The following modified case definition, case classifications and case classification of import status will be implemented for mumps:

Clinical case definition:
- An illness with acute onset of unilateral or bilateral tender, self-limited swelling of the parotid and\ or other salivary gland(s), lasting at least 2 days, and without other apparent cause.

Clinically Compatible Illness:
Infection with mumps virus may present as aseptic meningitis, encephalitis, hearing loss, orchitis, oophoritis, parotitis or other salivary gland swelling, mastitis or pancreatitis.

2007 Position Statements

(continued)
07-ID-02

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

Laboratory criteria

- Isolation of mumps virus from clinical specimen, or
- Detection of mumps nucleic acid (e.g., standard or real time RT-PCR assays), or
- Detection of mumps IgM antibody, or
- Demonstration of specific mumps antibody response in absence of recent vaccination, either a four-fold increase in IgG titer as measured by quantitative assays, or a seroconversion from negative to positive using a standard serologic assay of paired acute and convalescent serum specimens.

Case classification

Suspected: A case with clinically compatible illness or meets the clinical case definition without laboratory testing, or a case with laboratory tests suggestive of mumps without clinical information.

Probable: A case that meets the clinical case definition without laboratory confirmation and is epidemiologically linked to a clinically compatible case.

Confirmed: A case that 1. meets the clinical case definition or has clinically compatible illness, and 2. is either laboratory confirmed or is epidemiologically linked to a confirmed case.

Comment: With previous contact with mumps virus either through vaccination (particularly with 2 doses) or natural infection, serum mumps IgM test results may be negative; IgG test results may be positive at initial blood draw and viral detection in RT-PCR or culture may have low yield. Therefore, mumps cases should not be ruled out by negative laboratory results. Serologic tests should be interpreted with caution, as false positive and false negative results are possible with IgM tests.

Case Classification for Import Status

Internationally imported case: An internationally imported case is defined as a case in which mumps results from exposure to mumps virus outside the United States as evidenced by at least some of the exposure period (12–25 days before onset of parotitis or other mumps-associated complications) occurring outside the United States and the onset of parotitis or other mumpsassociated complications within 25 days of entering the United States and no known exposure to mumps in the U.S. during that time. All other cases are considered U.S.-acquired cases.

U.S.-acquired case: A U.S.-acquired case is defined as a case in which the patient had not been outside the United States during the 25 days before onset of parotitis or other mumps-associated complications or was known to have been exposed to mumps within the United States.

U.S.-acquired cases are subclassified into four mutually exclusive groups:

Import-linked case: Any case in a chain of transmission that is epidemiologically linked to an internationally imported case. Imported-virus case: A case for which an epidemiologic link to an internationally imported case was not identified but for which viral genetic evidence indicates an imported mumps genotype, i.e., a genotype that is not occurring within the United States in a pattern indicative of endemic transmission. An endemic genotype is the genotype of any mumps virus that occurs in an endemic chain of transmission (i.e., lasting ≥12 months). Any genotype that is found repeatedly in U.S.-acquired cases should be thoroughly investigated as a potential endemic genotype, especially if the cases are closely related in time or location.

(continued)
07-ID-02

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

Endemic case: A case for which epidemiological or virological evidence indicates an endemic chain of transmission. Endemic transmission is defined as a chain of mumps virus transmission continuous for ≥12 months within the United States. Unknown source case: A case for which an epidemiological or virological link to importation or to endemic transmission within the U.S. cannot be established after a thorough investigation. These cases must be carefully assessed epidemiologically to assure that they do not represent a sustained U.S.-acquired chain of transmission or an endemic chain of transmission within the U.S.

Note: Internationally imported, import-linked, and imported-virus cases are considered collectively to be import-associated cases.

Comment: Currently, there is insufficient information to determine whether any mumps strains are endemic to the United States or to distinguish endemic from non-endemic strains.

Note: States may also choose to classify cases as "out-of-state-imported" when imported from another state in the United States. For national reporting, however, cases will be classified as either internationally imported or U.S.-acquired.

Public Health Impact:
The changes in the case definition and classifications of mumps will provide states a mechanism to report mumps consistently, using newer laboratory methods available and atypical clinical presentations. Consistent application of criteria and reporting will facilitate a clearer understanding of the current epidemiology of mumps. The addition of the importation status will allow identification of the origin of cases that are brought into the country.

(continued)
07-ID-02

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

Coordination:

Agencies for Response:

(1) Julie L. Gerberding, M.D.
Director
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, Georgia 30333
404-639-7000
jyg2@cdc.gov

Agencies for Information:

(1) Paul Jarris, M.D., MBA
Executive Director
Association of State and Territorial Health Officers
2231 Crystal Drive Suite 450
Arlington, VA 22202
Phone: (202) 371-9090
Fax: (571) 527-3189
pjarris@astho.org

(2) Scott Becker, MS
Executive Director
Association of Public Health Laboratories
8515 Georgia Avenue, Suite 700
Silver Spring, Maryland 20910
240-485-2745
scott.becker@aphl.org

Submitting Author:

(1) Patricia Quinlisk, M.D., MPH
Medical Director / State Epidemiologist
Iowa Department of Public Health
321 East 12th Street
Des Moines, Iowa 50319
515 281-4941
pquinlis@idph.state.ia.us

2007 Position Statements

07-ID-03

Committee: Infectious Disease

Title: Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)

Statement of the Problem:
The purpose of the recommended revisions to the case definitions of Ehrlichiosis, a tick-borne rickettsial disease under public health surveillance, is to update taxonomic changes in the pathogens, clarify misleading or poorly defined laboratory statements, and to improve case classification for reporting.

Statement of the desired action to be taken:
Revise the national surveillance case definition for Ehrlichiosis.

Goals of Surveillance:
The improved case definition will provide the tools to help establish the burden of disease due to this pathogen. This will provide a greater understanding of this disease among physicians, nurses, and public health professionals and allow for appropriate prevention messages to the public.

Methods for Surveillance:
Case finding is conducted through clinician and laboratory reporting. Core surveillance data will be reported to the National Notifiable Disease Surveillance System (NNDSS) through the National Electronic Telecommunications System for Surveillance (NETSS) or the National Electronic Disease Surveillance System (NEDSS), as per state protocol.

Case definition:
Clinical presentation
A tick-borne illness characterized by acute onset of fever and one or more of the following symptoms or signs: headache, myalgia, malaise, anemia, leukopenia, thrombocytopenia, or elevated hepatic transaminases. Nausea, vomiting, or rash may be present in some cases. Intracytoplasmic bacterial aggregates (morulae) may be visible in the leukocytes of some patients. There are at least three species of bacteria, all intracellular, responsible for ehrlichiosis/anaplasmosis in the United States: *Ehrlichia chaffeensis*, found primarily in monocytes, and *Anaplasma phagocytophilum and Ehrlichia ewingii*, found primarily in granulocytes. The clinical signs of disease that result from infection with these agents are similar, and the range distributions of the agents overlap, so testing for one or more species may be indicated. Serologic cross-reactions may occur among tests for these etiologic agents.

Four sub-categories of confirmed or probable ehrlichiosis/anaplasmosis should be reported: 1) human ehrlichiosis caused by *Ehrlichia chaffeensis*, 2) human ehrlichiosis caused by *E. ewingii*, 3) human anaplasmosis caused by *Anaplasma phagocytophilum*, or 4) human ehrlichiosis/anaplasmosis - undetermined. Cases reported in the fourth sub-category can only be reported as “probable” because the cases are only weakly supported by ambiguous laboratory test results.

Clinical evidence:
Any reported fever and one or more of the following: headache, myalgia, anemia, leucopenia, thromobocytopenia, or any hepatic transaminase elevation.

2007 Position Statements

(continued)
07-ID-03

Committee: Infectious Disease

Title: Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)

Laboratory evidence:
For the purposes of surveillance.

1) Ehrlichia chaffeensis infection (formerly included in the category Human Monocytic Ehrlichiosis [HME]):

Laboratory confirmed:
- Serological evidence of a fourfold change in immunoglobulin G (IgG)-specific antibody titer to E. chaffeensis antigen by indirect immunofluorescence assay (IFA) between paired serum samples (one taken in first week of illness and a second 2-4 weeks later), or
- Detection of E. chaffeensis DNA in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay, or
- Demonstration of ehrlichial antigen in a biopsy/autopsy sample by immunohistochemical methods, or
- Isolation of E. chaffeensis from a clinical specimen in cell culture.

Laboratory supportive:
- Serological evidence of elevated IgG or IgM antibody reactive with E. chaffeensis antigen by IFA, enzyme-linked immunosorbent assay (ELISA), dot-ELISA, or assays in other formats (CDC uses an IFA IgG cutoff of >1:64 and does not use IgM test results independently as diagnostic support criteria.), or
- Identification of morulae in the cytoplasm of monocytes or macrophages by microscopic examination.

2) *Ehrlichia ewingii* infection (formerly included in the category Ehrlichiosis [unspecified, or other agent]):

Laboratory confirmed:
- Because the organism has never been cultured, antigens are not available. Thus, Ehrlichia ewingii infections may only be diagnosed by molecular detection methods: E. ewingii DNA detected in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay.

3) *Anaplasma phagocytophilum* infection (formerly included in the category Human Granulocytic Ehrlichiosis [HGE]):

Laboratory confirmed:
- Serological evidence of a fourfold change in IgG-specific antibody titer to *A. phagocytophilum* antigen by indirect immunofluorescence assay (IFA) in paired serum samples (one taken in first week of illness and a second 2-4 weeks later), or
- Detection of *A. phagocytophilum* DNA in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay, or
- Demonstration of anaplasmal antigen in a biopsy/autopsy sample by immunohistochemical methods, or
- Isolation of *A. phagocytophilum* from a clinical specimen in cell culture.

Laboratory supportive:
- Serological evidence of elevated IgG or IgM antibody reactive with A. phagocytophilum antigen by IFA, enzyme-linked immunosorbent Assay (ELISA), dot-ELISA, or assays in other formats (CDC uses an IFA IgG cutoff of >1:64 and does not use IgM test results independently as diagnostic support criteria.), or
- Identification of morulae in the cytoplasm of neutrophils or eosinophils by microscopic examination.

(continued)
07-ID-03

Committee: Infectious Disease

Title: Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)

4) Human ehrlichiosis/anaplasmosis – undetermined:
   • See case classification

Note: Problem cases for which sera demonstrate elevated antibody IFA responses to more than a single infectious agent are usually resolvable by comparing the levels of the antibody responses, the greater antibody response generally being that directed at the actual agent involved. Tests of additional sera and further evaluation via the use of PCR, IHC, and isolation via cell culture may be needed for further clarification. Cases involving persons infected with more than a single etiologic agent, while possible, are extremely rare and every effort should be undertaken to resolve cases that appear as such (equivalent IFA antibody titers) via other explanations.

Current commercially available ELISA tests are not quantitative, cannot be used to evaluate changes in antibody titer, and hence are not useful for serological confirmation. Furthermore, IgM tests are not always specific and the IgM response may be persistent. Therefore, IgM tests are not strongly supported for use in serodiagnosis of acute disease.

Exposure:
Exposure is defined as having been in potential tick habitats within the past 14 days before onset of symptoms. A history of a tick bite is not required.

Case definition tables:

Suggested codes for case ascertainment

To be developed.

Detailed definitions for case classification
Confirmed: A clinically compatible case (meets clinical evidence criteria) that is laboratory confirmed.

Probable: A clinically compatible case (meets clinical evidence criteria) that has supportive laboratory results. For ehrlichiosis/anaplasmosis – an undetermined case can only be classified as probable. This occurs when a case has compatible clinical criteria with laboratory evidence to support ehrlichia/anaplasma infection, but not with sufficient clarity to definitively place it in one of the categories previously described. This may include the identification of morulae in white cells by microscopic examination in the absence of other supportive laboratory results.

Suspect: A case with laboratory evidence of past or present infection but no clinical information available (e.g. a laboratory report).

Period of surveillance:
Ongoing. This revision of the surveillance case definition will be effective January 1, 2008.

Data sharing/release and print criteria:
States and territories will send CDC case data for all confirmed and probable cases. Final printed counts published in MMWR by CDC will distinguish between confirmed and probable cases. Provisional case report data will not be used until verification procedures are completed. Suspect cases will be excluded from final printed counts published by CDC.

2007 Position Statements

(continued)
07-ID-03

Committee: Infectious Disease

Title: Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)

Background and Justification:
The case definition for human ehrlichiosis was last updated in 2000. In that revision, cases could be subcategorized into three possible categories: 1) human ehrlichiosis due to *Ehrlichia chaffeensis*, 2) human ehrlichiosis due to *Ehrlichia phagocytophila*, or 3) human ehrlichiosis, undetermined (which was designed to include both cases without clear laboratory support for etiology at species-level and those cases due to the newly recognized *Ehrlichia ewingii*). However, in 1999, a major taxonomic revision of the genera comprising this group of pathogens was published. With gradual acceptance by the public health community, these changes in classification caused problems in nomenclature of the diseases and in loss of clarity in reporting. It became difficult to determine which category a particular case should be placed into due to these taxonomic changes. For example, the agent causing what was inappropriately named, *Ehrlichia phagocytophila*, was moved to the genus *Anaplasma*. The new name, *Anaplasma phagocytophilum*, thus was no longer an ehrlichiosis (infection by an *Ehrlichia spp.*) and had nomenclaturally become *anaplasmosis* (for which there was no category). *Ehrlichia ewingii* infections were originally expected to be categorized as *Ehrlichiosis*, undetermined or other, yet now could be correctly classified as another agent responsible for human granulocytic ehrlichiosis.

The current revision is designed to update the taxonomic changes and to clarify some of the wording used for the associated laboratory descriptions. It is proposed that the title of the category include Anaplasmosis to reflect the taxonomic issues with this disease grouping. However, this revision is not intended to create a separate new notifiable disease category as *Anaplasma phagocytophilum* already existed as a subcategory (as *Ehrlichia phagocytophila*), induces similar clinical manifestations, has similar epidemiologic features, and is often suspected and tested with at least one of the other species in this category. The traditional colloquial names would be avoided as they were never unique for that species (considering other infections by *Ehrlichia* globally) and caused confusion. The ehrlichiosis undetermined category would be utilized only to report those cases supported by laboratory tests that demonstrate elevated antibodies to more than one ehrlichial/anaplasmal antigen.

References:

- 2000 Case Definition
- 1998 Case Definition
- 1996 Case Definition
- Dumler JS. Barbet AF. Bekker CP. Dasch GA. Palmer GH. Ray SC. Rikihisa Y. Rurangirwa FR. 2001. Reorganization of genera in the families Rickettsiaceae and Anaplasmataceae in the order Rickettsiales: unification of some species of Ehrlichia with *Anaplasma, Cowdria* with *Ehrlichia* and *Ehrlichia* with *Neorickettsia*, descriptions of six new species combinations and designation of Ehrlichia equi and 'HGE agent' as subjective synonyms of *Ehrlichia phagocytophila*. International Journal of Systematic & Evolutionary Microbiology. 51(Pt 6):2145-2165. Medline UI: 11760958

(continued)
07-ID-03

Committee: Infectious Disease

Title: Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)

Coordination:

Agencies for Response:

(1) Julie L. Gerberding, MD
Director
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30333
404-639-7000
jyg2@cdc.gov

Agencies for Information:

(1) Robert F. Massung, PhD, Chief
Rickettsial Zoonoses Branch (RZB)
Division of Viral and Rickettsial Diseases (DVRD)
National Center for Zoonotic, Vector-borne, and Enteric Diseases (NCZVED)
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-13
Atlanta, GA 30333
Telephone: (404) 639-1082
Email: rfm2@cdc.gov

Submitting Authors:

(1) Jeffrey Engel, MD
NC State Epidemiologist
Division of Public Health
N.C. Department of Health and Human Services
1902 Mail Service Center
Raleigh, NC 27699-1902
Tel: (919) 715-7394
Fax: (919) 218-3384
Email: jeffrey.engel@ncmail.net

(2) Kristy Bradley, DVM, MPH
OK State Public Health Veterinarian/Acting State Epidemiologist
Oklahoma State Department of Health
Communicable Disease Division
1000 NE 10th St
Oklahoma City, OK 73117-1299
Tel: (405) 271-4060
Fax: (405) 271-6680
Email: kristyb@health.ok.gov

2007 Position Statements

(continued)
07-ID-03

Committee: Infectious Disease

Title: Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)

Co-Authors:

(1) David Swerdlow, MD
Team Leader
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-13
Atlanta, GA 30333
Telephone: (404) 639-1329
Email: dls3@cdc.gov

(2) William Nicholson, PhD
Research Microbiologist
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-13
Atlanta, GA 30333
Telephone: (404) 639-1095
Email: wan6@cdc.gov

(3) Alicia Anderson, DVM, MPH
Epidemiologist
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-4499
Email: aha5@cdc.gov

(4) Marta Guerra DVM, PhD
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-3951
Email: hcg4@cdc.gov

(5) Marina Eremeeva MD, PhD
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-4612
Email: mge6@cdc.gov

(6) Gregory Dasch, PhD

2007 Position Statements

(continued)
07-ID-03

Committee: Infectious Disease

Title: Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)

(6) Gregory Dasch, PhD
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-4140
Email: ged4@cdc.gov

(7) John Krebs, MS
Public Health Scientist
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-1079
Email: jok2@cdc.gov

2007 Position Statements

07-ID-04

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

Statement of the Problem:
The purpose of the recommended revisions to the surveillance case definition of Q fever, a disease under public health surveillance, is to clarify misleading or poorly defined laboratory statements, and to improve case classification for reporting.

Goals of surveillance:
The improved case definition will provide the tools to help establish the burden of disease due to this pathogen. This will provide a greater understanding of this disease among physicians, nurses, and public health professionals and allow for appropriate prevention messages to the public.

Methods for surveillance:
Case finding is conducted through clinician and laboratory reporting. Core surveillance data will be reported to the National Notifiable Disease Surveillance System (NNDSS) through the National Electronic Telecommunications System for Surveillance (NETSS) or the National Electronic Disease Surveillance System (NEDSS), as per state protocol.

Case Definition:
Clinical presentation:
Acute infection: Acute fever usually accompanied by rigors, myalgia, malaise, and a severe retrobulbar headache. Fatigue, night-sweats, dyspnea, confusion, nausea, diarrhea, abdominal pain, vomiting, non-productive cough, and chest pain have also been reported. Severe disease can include acute hepatitis, atypical pneumonia with abnormal radiograph, and meningoencephalitis. Pregnant women are at risk for fetal death and abortion. Clinical laboratory findings may include elevated liver enzyme levels, leukocytosis, and thrombocytopenia. Asymptomatic infections may also occur.

Note: Serologic profiles of pregnant women infected with acute Q fever during gestation may progress frequently and rapidly to those characteristic of chronic infection.

Chronic infection: Infection that persists for more than 6 months. Potentially fatal endocarditis may evolve months to years after acute infection, particularly in persons with underlying valvular disease. Infections of aneurysms and vascular prostheses have been reported.

Immunocompromised individuals are particularly susceptible. Rare cases of chronic hepatitis without endocarditis, osteomyelitis, osteoarthritis, and pneumonitis have been described.

Clinical evidence:

Acute Q fever: Acute fever and one or more of the following: rigors, severe retrobulbar headache, acute hepatitis, pneumonia, or elevated liver enzyme levels.

Chronic Q fever: Newly recognized, culture-negative endocarditis, particularly in a patient with previous valvulopathy or compromised immune system, suspected infection of a vascular aneurysm or vascular prosthesis, or chronic hepatitis, osteomyelitis, osteoarthritis, or pneumonitis in the absence of other known etiology.

2007 Position Statements

(continued)
07-ID-04

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

1. Acute Q fever

   Laboratory evidence:

   Laboratory confirmed:
   - Serological evidence of a fourfold change in immunoglobulin G (IgG)-specific antibody titer to *C. burnetii* phase II antigen by indirect immunofluorescence assay (IFA) between paired serum samples,(CDC suggests one taken during the first week of illness and a second 3-6 weeks later, antibody titers to phase I antigen may be elevated or rise as well) or
   - Detection of *C. burnetii* DNA in a clinical specimen via amplification of a specific target by polymerase chain reaction (PCR) assay, or
   - Demonstration of *C. burnetii* antigen in a clinical specimen by immunohistochemical methods (IHC), or
   - Isolation of C. *burnetii* from a clinical specimen by culture.

   Laboratory supportive:
   - Has a single supportive IFA IgG titer of ≥1:128 to phase II antigen (phase I titers may be elevated as well).
   - Has serologic evidence of elevated IgG or IgM antibody reactive with C. *burnetii* antigen by enzyme-linked immunosorbent assay (ELISA), dot-ELISA, or latex agglutination.

1. Chronic Q fever

   Laboratory evidence:

   Laboratory confirmed:
   - Serological evidence of IgG antibody to C. *burnetii* phase I antigen ≥ 1:800 by IFA (while phase II IgG titer will be elevated as well; phase I titer is higher than the phase II titer), or
   - Detection of *C. burnetii* DNA in a clinical specimen via amplification of a specific target by PCR assay, or
   - Demonstration of *C. burnetii* antigen in a clinical specimen by IHC, or
   - Isolation of *C. burnetii* from a clinical specimen by culture.

   Laboratory supportive:
   - Has an antibody titer to *C. burnetii* phase I IgG antigen ≥1:128 and < 1:800 by IFA.

Note: Samples from suspected chronic patients should be evaluated for IgG titers to both phase I and phase II antigens. Current commercially available ELISA tests (which test only for phase 2) are not quantitative, cannot be used to evaluate changes in antibody titer, and hence are not useful for serological confirmation. IgM tests are not strongly supported for use in serodiagnosis of acute disease, as the response may not be specific for the agent (resulting in false positives) and the IgM response may be persistent. Complement fixation (CF) tests and other older test methods are neither readily available nor commonly used. For acute testing, CDC uses in-house IFA IgG testing (cutoff of≥1:128), preferring simultaneous testing of paired specimens, and does not use IgM results for routine diagnostic testing.

Serologic test results must be interpreted with caution, because baseline antibodies acquired as a result of historical exposure to Q fever may exist, especially in rural and farming areas.

(continued)
07-ID-04

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

Exposure:

Exposure is usually via aerosol, is broadly interpreted, and may be unknown (especially for chronic infection), but often includes the presence of goats, sheep, or other livestock, especially during periods of parturition. Direct contact with animals is not required, and variable incubation periods may be dose dependent.

Case definition tables:

Suggested codes for case ascertainment

To be developed.

Detailed definitions for case classification:

Confirmed acute Q Fever: .A laboratory confirmed case that either meets clinical case criteria or is epidemiologically linked to a lab confirmed case.

Probable acute Q Fever: A clinically compatible case of acute illness (meets clinical evidence criteria for acute Q fever illness) that has laboratory supportive results for past or present acute disease (antibody to Phase II antigen) but is not laboratory confirmed.

Confirmed chronic Q Fever: A clinically compatible case of chronic illness (meets clinical evidence criteria for chronic Q fever) that is laboratory confirmed for chronic infection.

Probable chronic Q Fever: A clinically compatible case of chronic illness (meets clinical evidence criteria for chronic Q fever) that has laboratory supportive results for past or present chronic infection (antibody to Phase I antigen).

Period of surveillance:

Ongoing. This revision of the surveillance case definition will be effective January 1, 2008.

Background and Justification:
The case definition for Q fever was first developed and posted in 1999 and has not been subsequently modified. While the Laboratory Resource Network (LRN) has assays and protocols for *Coxiella burnetii*, the current case definition is not designed to be used for that purpose. The LRN has different threshold levels which initiate additional testing and authoritative response. The case definition for public health surveillance is designed to better define the burden of disease due to this pathogen in the United States. In the current revision, the acute and chronic forms of the disease and the corresponding laboratory features are better delineated. By separating the acute and chronic forms of the disease, we believe we will be able to gain a better understanding of the Q Fever disease complex as it currently exists in U.S. populations. This should eliminate confusion that has existed in the previous definition. These improvements will also serve to improve Q fever surveillance and consequently will improve surveillance for possible use of this agent in a bioterrorism event.

2007 Position Statements

(continued)
07-ID-04

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

References:
- 1999 Case Definition

Coordination:

Agencies for Response:

(1) Julie L. Gerberding, MD
Director
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30333
404-639-7000
jyg2@cdc.gov

Agencies for Information:

(1) Robert F. Massung, PhD, Chief
Rickettsial Zoonoses Branch (RZB)
Division of Viral and Rickettsial Diseases (DVRD)
National Center for Zoonotic, Vector-borne, and Enteric Diseases (NCZVED)
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-13
Atlanta, GA 30333
Telephone: (404) 639-1082
Email: rfm2@cdc.gov

Submitting Authors:

(1) Jeffrey Engel, MD
NC State Epidemiologist
Division of Public Health
N.C. Department of Health and Human Services
1902 Mail Service Center
Raleigh, NC 27699-1902
Tel: (919) 715-7394
Fax: (919) 218-3384
Email: jeffrey.engel@ncmail.net

(2) Kristy Bradley, DVM, MPH
OK State Public Health Veterinarian/Acting State Epidemiologist
Oklahoma State Department of Health
Communicable Disease Division
1000 NE 10th St
Oklahoma City, OK 73117-1299
Tel: (405) 271-4060
Fax: (405) 271-6680
Email: kristyb@health.ok.gov

2007 Position Statements

(continued)
07-ID-04

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

Co-Authors:

(1) David Swerdlow, MD
Team Leader
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-13
Atlanta, GA 30333
Telephone: (404) 639-1329
Email: dls3@cdc.gov

(2) William Nicholson, PhD
Research Microbiologist
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-13
Atlanta, GA 30333
Telephone: (404) 639-1095
Email: wan6@cdc.gov

(3) Alicia Anderson, DVM, MPH
Epidemiologist
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-4499
Email: aha5@cdc.gov

(4) Marta Guerra DVM, PhD
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-3951
Email: hcg4@cdc.gov

(5) Marina Eremeeva MD, PhD
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-4612
Email: mge6@cdc.gov

(continued)
07-ID-04

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

(6) Gregory Dasch, PhD
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-4140
Email: ged4@cdc.gov

(7) John Krebs, MS
Public Health Scientist
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-1079
Email: jok2@cdc.gov

2007 Position Statements

07-ID-05

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Rocky Mountain spotted fever

Statement of the Problem:
The purpose of the recommended revisions to the surveillance case definition of Rocky Mountain spotted fever (RMSF), a tick-borne rickettsial disease under public health surveillance, is to clarify misleading or poorly defined laboratory statements, and to improve case classification for reporting.

Statement of the desired action to be taken:
Revise the national surveillance case definition for Rocky Mountain spotted fever (RMSF).

Goals of surveillance:
The improved case definition will provide the tools to help establish the burden of disease due to this pathogen. This will provide a greater understanding of this disease among physicians, nurses, and public health professionals and allow for appropriate prevention messages to the public.

Methods for surveillance:
Case finding is conducted through clinician and laboratory reporting. Core surveillance data will be reported to the National Notifiable Disease Surveillance System (NNDSS) through the National Electronic Telecommunications System for Surveillance (NETSS) or the National Electronic Disease Surveillance System (NEDSS), as per state protocol.

Case Definition:

Clinical presentation
Rocky Mountain spotted fever (RMSF) is an illness caused by *Rickettsia rickettsii*, a bacterial pathogen transmitted to humans through contact with ticks. *Dermacentor* species of ticks are most commonly associated with infection, including *Dermacentor variabilis* (the American dog tick), *Dermacentor andersoni* (the Rocky Mountain wood tick), and more recently *Rhiphicephalus sanguineus* (the brown dog tick). Disease onset averages one week following a tick bite. Agespecific illness is highest for children and older adults. Illness is characterized by acute onset of fever, and may be accompanied by headache, malaise, myalgia, nausea/vomiting, or neurologic signs; a macular or maculopapular rash appears 4-7 days following onset in many (~80%) patients, often present on the palms and soles. RMSF may be fatal in as many as 20% of untreated cases, and severe, fulminant disease can occur. Acute illness is best detected by polymerase chain reaction (PCR) and immunohistochemical methods (IHC) in skin biopsy specimens, and occasionally by PCR in appropriate whole blood specimens taken during the 1st week of illness, prior to antibiotic treatment. Serology can also be employed for detection, however an antibody response may not be detectable in initial samples, and paired acute and convalescent samples are essential for confirmation.

Clinical evidence:
Any reported fever and one or more of the following: rash, headache, myalgia, anemia, thromobocytopenia, or any hepatic transaminase elevation.

Laboratory evidence:
For the purposes of surveillance,

Laboratory confirmed:

- Serological evidence of a fourfold change in immunoglobulin G (IgG)-specific antibody titer reactive with *Rickettsia rickettsii* antigen by indirect immunofluorescence assay (IFA) between paired serum specimens (one taken in the first week of illness and a second 2-4 weeks later), or
- Detection of *R. rickettsii* DNA in a clinical specimen via amplification of a specific target by PCR assay, or
- Demonstration of spotted fever group antigen in a biopsy/autopsy specimen by IHC, or
- Isolation of *R. rickettsii* from a clinical specimen in cell culture.

(continued)
07-ID-05

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Rocky Mountain spotted fever

Laboratory supportive:

- Has serologic evidence of elevated IgG or IgM antibody reactive with *R. rickettsii* antigen by IFA, enzyme-linked immunosorbent assay (ELISA), dot-ELISA, or latex agglutination.

Note: Current commercially available ELISA tests are not quantitative, cannot be used to evaluate changes in antibody titer, and hence are not useful for serological confirmation. IgM tests are not strongly supported for use in serodiagnosis of acute disease, as the response may not be specific for the agent (resulting in false positives) and the IgM response may be persistent. Complement fixation (CF) tests and other older test methods are neither readily available nor commonly used.

CDC uses in-house IFA IgG testing (cutoff of≥1:64), preferring simultaneous testing of paired specimens, and does not use IgM results for routine diagnostic testing.

Exposure:
Exposure is defined as having been in potential tick habitats within the past 14 days before onset of symptoms. A history of a tick bite is not required.

Case definition tables:

Suggested codes for case ascertainment
To be developed.

Detailed definitions for case classification
Confirmed: A clinically compatible case (meets clinical evidence criteria) that is laboratory confirmed.

Probable: A clinically compatible case (meets clinical evidence criteria) that has supportive laboratory results.

Suspect: A case with laboratory evidence of past or present infection but no clinical information available (e.g. a laboratory report).

Period of surveillance:
Ongoing. This revision of the surveillance case definition will be effective January 1, 2008.

Data sharing/release and print criteria:
States and territories will send CDC case data for all confirmed and probable cases. Final printed counts published in MMWR by CDC will distinguish between confirmed and probable cases. Provisional case report data will not be used until verification procedures are completed. Suspect cases will be excluded from final printed counts published by CDC.

(continued)
07-ID-05

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Rocky Mountain spotted fever

Background and Justification:
The case definition for RMSF was last modified in 2004. CDC has noted an increase in calls from state epidemiologists regarding case classification. For many years, the case definition of RMSF relied upon testing conducted at either the CDC or at the state public health laboratories. Recently, a growing number of case reports have included commercial laboratory results as supportive evidence. The proposed revised case definition attempts to clarify the details of the testing as it has been traditionally conducted. For example, the previous case definitions have used the word "antibody". A review of testing protocols and reagents distributed to the state laboratories reveal that these existing tests were specific for IgG-class immunoglobulins. With the increased availability of IgM testing at commercial laboratories, it becomes necessary to clarify the traditional meaning of the word "antibody" as used in all previous definitions and routinely used by rickettsial laboratories. The use of IgM is less supported by scientific evidence, and actually is complicated by false negatives when IgG is present and false positives when rheumatoid factor or cross-reactive, non-rickettsial, antibodies are present. Thus, IgM testing cannot be recommended for confirmation of cases at this time.

References:

- 2004 Case Definition
- 1996 Case Definition
- 1990 Case Definition

Coordination

Agencies for Response:

(1) Julie L. Gerberding
Director
Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, GA 30333
(404) 639-7000
jyg2@cdc.gov

Agencies for Information:

(1) Robert F. Massung, PhD, Chief
Rickettsial Zoonoses Branch (RZB)
Division of Viral and Rickettsial Diseases (DVRD)
National Center for Zoonotic, Vector-borne, and Enteric Diseases (NCZVED)
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-13
Atlanta, GA 30333
Telephone: (404) 639-1082
Email: rfm2@cdc.gov

2007 Position Statements

(continued)
07-ID-05

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Rocky Mountain spotted fever

Submitting Authors:

(1) Jeffrey Engel, MD
NC State Epidemiologist
Division of Public Health
N.C. Department of Health and Human Services
1902 Mail Service Center
Raleigh, NC 27699-1902
Tel: (919) 715-7394
Fax: (919) 218-3384
Email: jeffrey.engel@ncmail.net

(2) Kristy Bradley, DVM, MPH
OK State Public Health Veterinarian/Acting State Epidemiologist
Oklahoma State Department of Health
Communicable Disease Division
1000 NE 10th St
Oklahoma City, OK 73117-1299
Tel: (405) 271-4060
Fax: (405) 271-6680
Email: kristyb@health.ok.gov

Co-Authors:

(1) David Swerdlow, MD
Team Leader
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-13
Atlanta, GA 30333
Telephone: (404) 639-1329
Email: dls3@cdc.gov

(2) William Nicholson, PhD
Research Microbiologist
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-13
Atlanta, GA 30333
Telephone: (404) 639-1095
Email: wan6@cdc.gov

(continued)
07-ID-05

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Rocky Mountain spotted fever

(3) Alicia Anderson, DVM, MPH
Epidemiologist
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-4499
Email: aha5@cdc.gov

(4) Marta Guerra DVM, PhD
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-3951
Email: hcg4@cdc.gov

(5) Marina Eremeeva MD, PhD
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-4612
Email: mge6@cdc.gov

(6) Gregory Dasch, PhD
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-4140
Email: ged4@cdc.gov

(7) John Krebs, MS
Public Health Scientist
RZB, DVRD, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Rd., N.E. MS G-44
Atlanta, GA 30333
Telephone: (404) 639-1079
Email: jok2@cdc.gov

2007 Position Statements

07-ID-06

Committee: Infectious Disease

Title: Events that May Constitute a Public Health Emergency of International Concern

Statement of the Problem:
The World Health Assembly adopted revised international health regulations (IHR) on 23 May 2005, referred to as the IHR (2005), which will officially take effect for the U.S. on July 17, 2007. Agreement is required on what events are reportable to the World Health Organization (WHO) under these regulations. CSTE is forwarding this position statement to help reporting entities (states and territories) identify what public health events should be reported to CDC as an event that may constitute a public health emergency of international concern under these new regulations. This will assist the Centers for Disease Control and Prevention (CDC) in responding to the IHR.

An event that may constitute a public health emergency of international concern as defined in the IHR (2005) is *"an extraordinary public health event which is determined to constitute a publichealth risk to other countries through the international spread of disease; and to potentially require a coordinated international response."*

Statement of the desired action(s) to be taken:

1. CDC should work with stakeholders, including CSTE, to develop criteria and processes for states and territories to use for contacting CDC regarding public health events that may constitute a public health emergency of international concern. Events should include infectious conditions and those related to biologic, chemical, or radiologic exposures; reported events should then be evaluated by the CDC, using the IHR decision instrument (Annex 2, attached) to determine whether they require reporting to WHO under the IHR.
2. CSTE recommends that reporting entities (state and territorial health departments) report events listed below as "events that may constitute a public health emergency of international concern" to the CDC.

   For purposes of reporting, these events should include any case, including suspected cases, of the following diseases, as defined in current CSTE/CDC Case Definitions:

   Smallpox
   Poliomyelitis due to wild-type poliovirus
   Human influenza caused by a new subtype
   Severe acute respiratory syndrome (SARS)

   These diseases should be reported to CDC as soon as feasible, using reporting methods already in place, including NEDSS-compatible methods, the CDC Emergency Operations Center at 770-488-7100, or eocreport@cdc.gov .

3. CSTE and CDC should review updated WHO case definitions for the above conditions, when they are available, to ascertain whether the current CSTE-CDC case definitions should be revised to align with the WHO case definitions.

Public Health Impact:
Rapid reporting of these events to CDC are designed to allow CDC and WHO prevent and provide protection against exposures to diseases and other health threats and the international spread of diseases while minimizing interference with world travel and trade.

(continued)
07-ID-06

Committee: Infectious Disease

Title: Events that May Constitute a Public Health Emergency of International Concern

Coordination

Agencies for Response:

(1) Julie L. Gerberding, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Road NE, Mailstop D-14
Atlanta, GA 30333
Telephone: 404-639-7000
E-Mail: lgy2@cdc.gov

Agencies for Information:

(1) Scott J. Becker
Executive Director
Association of Public Health Laboratories
8515 Georgia Avenue, Suite 700
Silver Spring, MD 20910
Telephone: 240-485-2745 ext 201
Fax: 240-485-2700
sbecker@aphl.org

(2) Paul E. Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officials
2231 Crystal Drive Suite 450
Arlington, VA 22202
Phone: (202) 371-9090
Fax: (571) 527-3189
pjarris@astho.org

Submitting Author:

(1) Christine Hahn, MD
State Epidemiologist
Idaho Department of Health and Welfare, Division of Health
450 W. State St
4th floor
Boise, ID, 83702
208-334-5939
hahnc@dhw.idaho.gov

(continued)
07-ID-06

Committee: Infectious Disease

Title: Events that May Constitute a Public Health Emergency of International Concern

Co-Authors:

(1) Gilberto F. Chave, MD
State Epidemiologist
California Department of Health Services
1616 Capitol Ave, Suite 74.321
Sacramento, CA 95899-7413
916-440-7434
gchavez1@dhs.ca.gov

(2) Steven C Macdonald
Surveillance Epidemiologist
Washington State Dept. of Health
Office of Epidemiology
PO Box 47812
Olympia WA 98504
360-236-4253
steven.macdonald@doh.wa.gov

2007 Position Statements

(continued)
07-ID-06

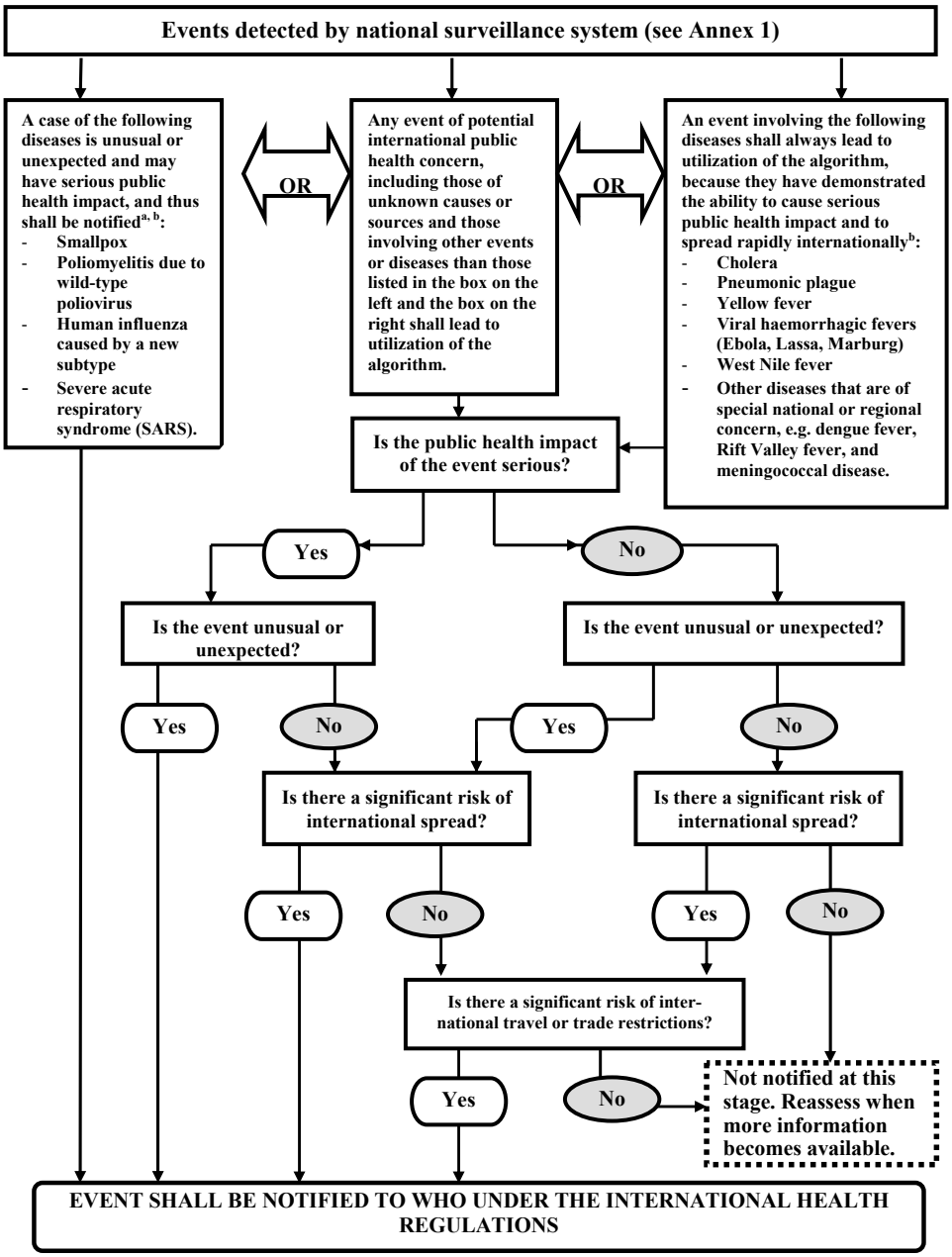
Committee: Infectious Disease

Title: Events that May Constitute a Public Health Emergency of International Concern

FIFTY-EIGHTH WORLD HEALTH ASSEMBLY

ANNEX 2

DECISION INSTRUMENT FOR THE ASSESSMENT AND NOTIFICATION OF EVENTS THAT MAY CONSTITUTE A PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN



[a] As per WHO case definitions.
[b] The disease list shall be used only for the purposes of these Regulations.

(continued)
07-ID-06

Committee: Infectious Disease

Title: Events that May Constitute a Public Health Emergency of International Concern

RESOLUTIONS AND DECISIONS

EXAMPLES FOR THE APPLICATION OF THE DECISION INSTRUMENT FOR THE ASSESSMENT AND NOTIFICATION OF EVENTS THAT MAY CONSTITUTE A PUBLIC HEALTH EMERGENCY OF INTERNATIONAL CONCERN

The examples appearing in this Annex are not binding and are for indicative guidance purposes to assist in the interpretation of the decision instrument criteria.

DOES THE EVENT MEET AT LEAST TWO OF THE FOLLOWING CRITERIA?

Is the public health impact of the event serious?	**I. Is the public health impact of the event serious?**
	1. *Is the number of cases and/or number of deaths for this type of event large for the given place, time or population?*
	2. *Has the event the potential to have a high public health impact?* THE FOLLOWING ARE EXAMPLES OF CIRCUMSTANCES THAT CONTRIBUTE TO HIGH PUBLIC HEALTH IMPACT: ✓ Event caused by a pathogen with high potential to cause epidemic (infectiousness of the agent, high case fatality, multiple transmission routes or healthy carrier). ✓ Indication of treatment failure (new or emerging antibiotic resistance, vaccine failure, antidote resistance or failure). ✓ Event represents a significant public health risk even if no or very few human cases have yet been identified. ✓ Cases reported among health staff. ✓ The population at risk is especially vulnerable (refugees, low level of immunization, children, elderly, low immunity, undernourished, etc.). ✓ Concomitant factors that may hinder or delay the public health response (natural catastrophes, armed conflicts, unfavourable weather conditions, multiple foci in the State Party). ✓ Event in an area with high population density. ✓ Spread of toxic, infectious or otherwise hazardous materials that may be occurring naturally or otherwise that has contaminated or has the potential to contaminate a population and/or a large geographical area.
	3. *Is external assistance needed to detect, investigate, respond and control the current event, or prevent new cases?* THE FOLLOWING ARE EXAMPLES OF WHEN ASSISTANCE MAY BE REQUIRED: ✓ Inadequate human, financial, material or technical resources – in particular: – Insufficient laboratory or epidemiological capacity to investigate the event (equipment, personnel, financial resources) – Insufficient antidotes, drugs and/or vaccine and/or protective equipment, decontamination equipment, or supportive equipment to cover estimated needs – Existing surveillance system is inadequate to detect new cases in a timely manner.
	IS THE PUBLIC HEALTH IMPACT OF THE EVENT SERIOUS? **Answer "yes" if you have answered "yes" to questions 1, 2 or 3 above.**

(continued)
07-ID-06

Committee: Infectious Disease

Title: Events that May Constitute a Public Health Emergency of International Concern

FIFTY-EIGHTH WORLD HEALTH ASSEMBLY

Is the event unusual or unexpected?	**II. Is the event unusual or unexpected?**
	4. *Is the event unusual?* THE FOLLOWING ARE EXAMPLES OF UNUSUAL EVENTS: ✓ The event is caused by an unknown agent or the source, vehicle, route of transmission is unusual or unknown. ✓ Evolution of cases more severe than expected (including morbidity or case-fatality) or with unusual symptoms. ✓ Occurrence of the event itself unusual for the area, season or population.
	5. *Is the event unexpected from a public health perspective?* THE FOLLOWING ARE EXAMPLES OF UNEXPECTED EVENTS: ✓ Event caused by a disease/agent that had already been eliminated or eradicated from the State Party or not previously reported.
	IS THE EVENT UNUSUAL OR UNEXPECTED? **Answer "yes" if you have answered "yes" to questions 4 or 5 above.**

Is there a significant risk of international spread?	**III. Is there a significant risk of international spread?**
	6. *Is there evidence of an epidemiological link to similar events in other States?*
	7. *Is there any factor that should alert us to the potential for cross border movement of the agent, vehicle or host?* THE FOLLOWING ARE EXAMPLES OF CIRCUMSTANCES THAT MAY PREDISPOSE TO INTERNATIONAL SPREAD: ✓ Where there is evidence of local spread, an index case (or other linked cases) with a history within the previous month of: – international travel (or time equivalent to the incubation period if the pathogen is known) – participation in an international gathering (pilgrimage, sports event, conference, etc.) – close contact with an international traveller or a highly mobile population. ✓ Event caused by an environmental contamination that has the potential to spread across international borders. ✓ Event in an area of intense international traffic with limited capacity for sanitary control or environmental detection or decontamination.
	IS THERE A SIGNIFICANT RISK OF INTERNATIONAL SPREAD? **Answer "yes" if you have answered "yes" to questions 6 or 7 above.**

(continued)
07-ID-06

Committee: Infectious Disease

Title: Events that May Constitute a Public Health Emergency of International Concern

RESOLUTIONS AND DECISIONS

Risk of international restrictions?	**IV. Is there a significant risk of international travel or trade restrictions?**
	8. *Have similar events in the past resulted in international restriction on trade and/or travel?*
	9. *Is the source suspected or known to be a food product, water or any other goods that might be contaminated that has been exported/imported to/from other States*?
	10. *Has the event occurred in association with an international gathering or in an area of intense international tourism?*
	11. *Has the event caused requests for more information by foreign officials or international media?*
	IS THERE A SIGNIFICANT RISK OF INTERNATIONAL TRADE OR TRAVEL RESTRICTIONS? **Answer "yes" if you have answered "yes" to questions 8, 9, 10 or 11 above.**

States Parties that answer "yes" to the question whether the event meets any two of the four criteria (I-IV) above, shall notify WHO under Article 6 of the International Health Regulations.

2007 Position Statements

07-ID-07

Committee: Infectious Disease

Title: Enhancing Disease Control for Cruise Ship Travel

Statement of the Problem:

Cruise ship travel has become increasingly popular during the past decade. (1,2) In recent years, approximately 9 million passengers embarked from North American ports for cruise travel, and approximately 50% of these passengers embarked from a Florida port. (1) According to the Cruise Line International Association (CLIA), the North American Cruise Industry's main marketing and lobbying organization, consisting of 17,000 travel agencies and 20 major cruise lines (representing 80% of global cruise capacity), over the next three years 51 million North Americans plan to take a cruise, and 17% of the U.S. population has already cruised once in their lifetime. (1) CLIA exists to promote all measures that foster a safe, secure and healthy cruise ship environment, educate and train its travel agent members, and promote and explain the value, desirability and affordability of the cruise vacation experience. (1)

As the demand for cruise travel has grown, so has the capacity of cruise ships -- the average carries 3000 passengers and 1500 crew members. Time lines between cruises are typically tight, leaving very little time for public health interventions. Many cruises last 7 – 10 days, after which the ship docks in port, unloads its passengers, is cleaned and restocked, and picks up a new complement of passengers, all in a single day. (3)

Cruise ships have been operating at near full capacity, and offer unique opportunities for diverse interpersonal interactions and sharing of common food and beverages. Passengers tend to originate from affluent countries (79% of all cruise passengers are U.S. residents) with low rates of many infectious diseases and high rates of vaccination, while crew members tend to come from developing countries that may not have incorporated certain vaccines such as rubella into their national vaccination programs and have higher rates of many infectious diseases. Although historically, passengers tended to be older, recently cruises have been popular with middle-aged and young adults, children, and pregnant women. (1-3)

No international body regulates the practice of medicine at sea, and the quality of care varies widely. Consensus-based guidelines for the practice of medicine on cruise liners exist, but their implementation depends upon each individual cruise line. CLIA monitors and participates in domestic and international maritime policy development, and accordingly sets compliance standards among its member cruise lines. The CLIA recommends that its members follow and exceed the "Health Care Guidelines for Cruise Ship Medical Facilities," developed by American College of Emergency Physicians (ACEP) Section on Cruise Ship and Maritime Medicine. (4) The guidelines address standards for medical facility design, medical staff qualifications, diagnostic equipment and formulary selection, with a goal to providing general and emergency medical services to passengers and crew. However, no industry standards exist regarding primary care and preventive services of the crew aboard the ship.

International Health Regulations stipulate health and sanitation requirements for international conveyances. In the United States, the US Coast Guard enforces maritime safety requirements and CDC has regulatory responsibilities for sanitation and public health on cruise ships. (2,3) The U.S. Public Health Service (USPHS) is authorized by the Public Health Service Act (42 U.S.C. Section 264) to take measures necessary to prevent the introduction, transmission, or spread of communicable diseases into the United States from a foreign country. In addition, the Public Health Service Act (42 U.S.C. Section 269) authorizes the promulgation of regulations applicable to vessels for preventing the introduction into the United States of "any communicable disease by securing the best sanitary condition of such vessels, their cargoes, passengers, and crews." (5)

The CDC is the lead agency of the USPHS on issues related to communicable disease control at international ports of entry in to the United States. Regulations require that international carriers report death and certain illnesses in arriving international passengers and crew to CDC. Operationally, CDC has divided the responsibilities for enforcing foreign quarantine regulations between the Vessel Sanitation Program (VSP) and the Division of Global Migration and Quarantine (DGMQ). The CDC established the Vessel Sanitation Program in 1975, as a cooperative activity with the cruise ship industry. VSP takes the lead on overseeing the gastrointestinal illness surveillance and outbreak investigation activities on cruise ships, as well as the routine sanitation inspection activities in partnership with cruise lines. When there are illnesses or outbreaks on ships for diseases of public health importance other than gastrointestinal (GI) illness, or a death due to any cause, then DGMQ will take the lead. In addition, DGMQ takes the lead on investigating all illness, outbreaks, and deaths on cargo ships and air carriers arriving at international ports of entry into the United States.

(continued)
07-ID-07

Committee: Infectious Disease

Title: Enhancing Disease Control for Cruise Ship Travel

Communicable diseases seen on board cruise ships are similar to those seen on land; however, disease exposure and transmission may be exacerbated by the densely populated, semi-closed cruise environment which requires many shared activities and resources among international passengers and crew. People disembarking from cruise ships may incubate an infectious disease acquired during the voyage, and lead to outbreaks, especially in closed settings (such as nursing homes), in their home communities. Therefore, the public health significance of illness aboard cruises lies not only in possible widespread morbidity onboard ships, but dissemination of diseases into communities all over the world.

Heightened surveillance efforts by the cruise ship industry, and improved communications between the cruise ship industry and federal and state public health authorities have yielded detection of illnesses of public health significance that might otherwise have gone unnoticed. Clusters of various communicable diseases – for example influenza, measles, rubella, varicella, meningococcal meningitis, hepatitis A, Legionnaire's Disease, and respiratory and gastrointestinal illnesses – among cruise ship travelers have been reported and investigated. (6 – 14) In recent years, influenza and norovirus outbreaks have posed particularly difficult challenges to public health and the cruise ship industry. (6,12)

In addition, clusters of vaccine preventable diseases such as influenza, measles, rubella, and varicella have been reported and investigated aboard cruise ships. (14-16) In 1997, the.CDC and the Florida Department of Health investigated two outbreaks of rubella affecting crew on two separate cruise ships sailing from Florida to the Bahamas. In one outbreak, of the 400 crew members, 4% were found with acute infection, of which half were asymptomatic, and an additional 7% were susceptible to infection. (14) The crew came from 50 different countries, and 75% had no known immunity to rubella or had a negative antibody result on testing. No cases of rubella resulted among passengers. Based on this outbreak, recommendations were made to the cruise ship industry to vaccinate crew members without adequate proof of immunity with MMR. However, compliance with this recommendation has varied among cruise lines. (16)

While States have no authority to regulate the cruise ship industry, States have a great stake in what happens aboard ship, as illness among passengers who disembark immediately become a responsibility of the State of disembarkation, and passengers disperse widely across the country. Improving preventive health for both passengers and crew members is in the enlightened selfinterest of all parties.

Statement of the desired action(s) to be taken:

1. CDC's Division of Global Migration and Quarantine (DGMQ), National Center for Preparedness, Detection and Control of Infectious Diseases, (NCPDCID); National Center for Immunization and Respiratory Disease (NCIRD); the Vessel Sanitation Program (VSP), National Center for Environmental Health (NCEH); the National Center for HIV, Hepatitis, Sexually Transmitted Diseases, and Tuberculosis Prevention (NCHHSTP); and the cruise ship industry as well as CLIA, should work with CSTE, particularly with states that have ports, to work to develop uniform recommendations for preventive health measures for passengers and crew members, including such provisions as recommendations for pre-employment crew vaccination, in particular for measles, mumps and rubella (MMR) if adequate proof of immunity is lacking; documentation (electronic if possible) of immunity to these diseases for crew members; and, collection of contact information such as e-mail addresses of passengers at the time of booking to enable rapid communication in the event of a disease outbreak. In addition, guidance for cruise travelers for preventative health measures, including recommendations for routine and destination-specific, pre-cruise immunization should be made widely available on web sites of public health agencies, cruise lines, and travel agencies.
2. An ongoing working group of key stakeholders should be created under CSTE coordination to facilitate communications and uniformity of evidence-based, public health recommendations between CDC, the States, and the cruise ship industry.

(continued)
07-ID-07

Committee: Infectious Disease

Title: Enhancing Disease Control for Cruise Ship Travel

Public Health Impact:
While authority for regulation of international travel rests with the federal government, States have a major stake in the prevention of illness among cruise ship passengers and crew members. Providing recommendations and guidelines from States that improve the ability of State public health agencies to communicate with and collaborate with CDC and the cruise ship industry strengthen prevention programs.

Coordination:

Agencies for Response:

(1) Julie L. Gerberding, MD
Director
US Centers for Disease Control and Prevention
600 Clifton Road
Atlanta, GA 30333
404-639-7000
Jyg2@cdc.gov

(2) Cruise Lines International Association
910 SE 17th Street, Suite 400
Fort Lauderdale, FL 33316
754-224-2200

Submitting author:

John P. Middaugh, M.D.
State Epidemiologist
Florida Department of Health
john_middaugh@doh.state.fl.us
850-245-4356

(continued)
06-ID-07

Committee: Infectious Disease

Title: Enhancing Disease Control for Cruiseship Travel

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2007 Position Statements

07-ID-08

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

Statement of the Problem:
In 1997, CSTE recommended that all states and territories institute HIV reporting, specifically by name and not by unique identifier (CSTE Position statement 1997-ID-4). CSTE has consistently supported named HIV reporting since that time as the best way to get complete, unduplicated and comparable HIV data from all states and territories. In discussions around the 2006 reauthorization of the Ryan White CARE Act, CSTE supported adding HIV data from name-based HIV surveillance systems to AIDS case counts, as the most accurate measure of disease burden for calculating Ryan White funding formulas and determining eligibility. Barring that, CSTE supported CDC, the only federal agency with the required expertise, to certify the HIV surveillance data from states with non-named HIV reporting systems. The final reauthorized CARE Act (which was renamed the Ryan White HIV/AIDS Treatment Modernization Act of 2006 - RWHATMA) incorporated the use of reported living HIV and AIDS case data into allocation formulas. Further, it allowed counting of HIV infection reports that were reported by code and for these case counts to go directly from the states to HRSA with a 5% reduction applied to the totals to account for duplication. It also continued the use of only AIDS cases in determining eligibility for Part A (AKA Title I) Eligible Metropolitan Areas, Part A Transitional Grant Areas, and Part B (AKA Title II) Emerging Communities. Although the RWHATMA legislation requires areas to have begun name-based HIV reporting by April 1, 2008, it is assumed that, following the sunset date of September 30, 2009, some combination of named and non-named HIV surveillance data will be proposed to be used to determine future funding formulas, for some areas with less mature name-based HIV reporting systems. The purpose of this Position Statement is to confirm CSTE's position on the use of name based HIV/AIDS surveillance data for implementation of legislation used to fund care of HIV-infected persons that would go into effect after September 30, 2009.

CSTE reiterates its recommendation that HIV reporting by name is the most viable method for conducting HIV surveillance and deduplicating cases both within and between states. This ensures an equitable measure of HIV disease burden to be used as the basis for determining eligibility and allocating funds for care of HIV-infected persons and for other comparisons of HIV cases between reporting jurisdictions. This position statement reiterates that code based data should not be used as a part of formulas designed either for determining eligibility or for funding future HIV care programs

Statement of the desired action(s) to be taken:
CSTE recommends that:

1. CDC, in collaboration with CSTE, determine the most scientifically valid method for combining data from states that are in various stages of implementing name-based HIV reporting for the purposes of the formulas used to fund care programs.
2. Any future eligibility and funding formulas should include name-based reported cases living with HIV infection (including AIDS), confirmed by CDC, as the basis of the formula(s).
3. CDC should provide technical support to ensure and require that by September 30, 2009 all project areas (states, cities and territories) : a) de-duplicate their HIV/AIDS cases both inside their state as well as with jurisdictions outside of their state within six months of receiving their list of potential interstate duplicates from CDC and, b) perform a match with their state death registry at least annually. Following the death match CDC should verify that the area uses the results of the match to update vital status of reported cases in the HIV/AIDS registry. They should assure that states have the necessary funding to perform these fundamental activities and should be able to assure and verify that these activities are taking place.
4. Future legislation to determine formulas for funding the care of HIV-infected persons should reflect the input of CSTE HIV/AIDS surveillance experts who have experience with, and understand the complexities of HIV and AIDS data and can work to ensure a science-based approach to the use of these data for funding.

(continued)
07-ID-08

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

Public Health Impact:
Public health programs that provide care for persons infected with HIV will benefit from more equitable funding formulas. Use of HIV and AIDS surveillance data as the basis for both eligibility and funding formulas will result in the most equitable allocation of resources and maximize positive health outcomes for people living with HIV. Passage of this Position Statement will encourage the activities that need to be in place before the sunset date of the current legislation: reporting of prevalent cases of HIV infection, unduplicating HIV and AIDS cases and assuring that vital status information is current. These activities will allow the country to have, 25+ years after the beginning of the epidemic, a single integrated, national HIV/AIDS reporting system to provide high quality data to be used for planning prevention and care programs on both the local and national levels.

The authors acknowledge that hold harmless provisions have been helpful for minimizing large swings in funding that can disrupt the local infrastructure that is necessary for the continued care of HIV infected persons throughout the United States. However, they undermine the use of HIV/AIDS data in formulas. We believe that the hold harmless provisions should be re-evaluated when a fully mature integrated name-based HIV/AIDS reporting system has been implemented nationally.

Fiscal Impact on CSTE:
None.

References
CSTE Position statement 1997-ID-4

Agencies for Response:

(1) Julie L. Gerberding, MD, MPH
Director, Centers for Disease Control and Prevention
1600 Clifton Road NE, Mailstop D-14
Atlanta, GA 30333

(2) Elizabeth Duke
Director
Health Resources and Services Administration
5600 FISHERS LANE
Rockville MD 20857
Phone 301-443-1993

2007 Position Statements

(continued)
07-ID-08

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

Agencies for Information

(1) Paul E. Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officials
2231 Crystal Drive
Suite 450
Arlington, VA 22202-3711
pjarris@astho.org

(2) Christopher Brown, MBA, MPH
Chair, Communities Advocating Emergency AIDS Relief (CAEAR) Coalition
P.O. Box 21361
Washington, DC 20009-1361
Brown_christopher@cdph.org
Agencies for Response:

(3) Julie Scofield
Executive Director
National Alliance of State and Territorial AIDS Directors
444 North Capitol St NW
Suite 339
Washington, DC 20005
Telephone: (202) 434-8073
Email: jscofield@nastad.org

Submitting Author:

Eve Mokotoff, MPH
Chair, HIV/AIDS Surveillance Work Group; HIV Co-consultant, CSTE
HIV/AIDS Epidemiology Manager, Michigan Department of Community Health
Herman Kiefer Health Complex
1151 Taylor, Room 210B
Detroit, MI 48202
Email: mokotoffe@michigan.gov
Telephone: 313.876.4769
Fax: 313.876.0888

(continued)
07-ID-08

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

Co-authors:

(1) Guthrie S. Birkhead, MD, MPH
Director, AIDS Institute
Director, Center for Community Health
New York State Department of Health
ESP, Corning Tower, Rm. 1417
Albany, New York 12237
Email: gsb02@health.state.ny.us
Telephone: 518.402.5382
Fax: 518.486.1455

(2) James J.Gibson, MD
CSTE, Infectious Disease Committee, HIV/AIDS Workgroup, HIV Lead Consultant
Chief, South Carolina Department of Health and Environmental Control Bureau of Disease Control
2600 Bull Street
Columbia, S.C. 29201
Telephone: 803.898.0861
Fax: 803.898.0897
Email: qibsonij@crdhec.sc.gov

(3) Luisa Pessoa-Brandão, MS
HIV/AIDS Surveillance Coordinator
Minnesota Department of Health
STD & HIV Section
Freeman Building
625 Robert Street N.
St. Paul, MN 55164-0975
Telephone: 651.201.4032
Fax: 651.201.4000
Email: luisa.pessoa-brandao@health.state.mn.us

2007 Position Statements

07-ID-09

Committee: Infectious Disease

Title: Heterosexual HIV Transmission Classification

Statement of the Problem

Since the beginning of active AIDS surveillance in the early 1980s the Centers for Disease Control and Prevention (CDC) and the jurisdictions reporting AIDS cases (and later HIV infection) have used a virtually unchanged hierarchy to classify the most likely means of HIV transmission. This hierarchy is calculated from the answers to the questions in the patient history section of the case report form§. During this time there have been more cases to report as well as increases in cases reported without an identified mode of transmission. These increases result from both 1) death rates dropping dramatically in the mid- 1990's following the introduction of more effective anti-retroviral treatments leading to an increase in prevalence and, 2) increasing use of the laboratory as the initial source of the report. Because laboratories cannot report mode of transmission (they don't collect it), surveillance programs must rely on medical record reviews to complete case report forms. As surveillance funding has decreased and the number of medical records to review has increased it is increasingly difficult to obtain mode of transmission information.

Further compounding the problem is the decentralization of medical care. As more physicians diagnose and care for HIV-infected persons our ability to "train our providers" in how to document risk factors for surveillance purposes decreases. In addition, there has been a decrease in documentation in the medical record on mode of HIV transmission. This decrease is likely to continue as recent CDC HIV testing guidelines are implemented. These guidelines recommend integrating HIV testing into routine medical care and no longer recommend that clinicians conduct pre and post-test counseling[1]. These changes will likely result in more cursory risk behavior information being documented in the medical record.

The number and proportion of cases reported with "No identified Risk" (NIR) cases has increased over time from approximately 20% in 1994 to 35% in 2004[2]. The current standard is that at least 85% of reported cases or a representative sample for a diagnosis year has an identified HIV risk factor within 12 months of the date of the initial HIV/AIDS case report, measured at 12 months after the close of the diagnosis year.[3]

CDC uses the phrase "high risk heterosexual contact" (HRH) to describe transmission attributed to "heterosexual contact with a person known to have, or to be at high risk for, HIV infection."[4] The HIV/AIDS reporting software system that CDC distributes to reporting jurisdictions also categorizes state and city level data using this same definition of "high risk heterosexual contact". This definition is particularly problematic when trying to classify cases reported without a mode of transmission because it requires that, prior to the person's HIV infection diagnosis, at least one heterosexual sex partner was: 1) an injecting drug user (IDU), 2) a bisexual man (this applies only to women), 3) HIV infected from blood or blood products or 4) HIV-infected with no known behavioral risk factor. Condition #4 is the most common way persons are initially classified as "high risk heterosexual contact" cases, requiring knowledge of partner serostatus. The fact that this is the most common way that cases are counted as HRH reflects the person's lack of knowledge of his/her partners' behavioral risk factors or the inability of the medical system to elicit this information. For example, among all cases of HIV infection/not AIDS due to "high risk heterosexual contact" and reported through 2005 (among the 38 states and U.S. dependent areas with confidential name-based HIV reporting), 77% are attributed to sex with an HIV-infected person, risk not specified. For AIDS cases reported from all 50 states and Washington, DC the comparable proportion is 66%[4].

In the 1990's, CDC developed a method to address the problem of increasing proportions of cases reported to CDC without a risk factor by using a statistical model to redistribute unreported risk factors based on the distribution of known risk factors. However, risk factor redistribution weights were calculated based on two assumptions: 1) the distribution of risk factors initially reported without risk factors (NIRs) does not change over time and 2) reclassified NIR cases are representative of all NIR cases. Neither of these assumptions is valid. The pattern of risk factors has changed since the beginning of the epidemic[5, 6] and reclassified cases usually represent cases on which risk factors are easiest to find. An additional problem of using the statistical model to redistribute risk is that CDC uses this model when presenting data in the national HIV/AIDS statistical reports, resulting in "artificially" low NIRs published in the national HIV/AIDS statistics. Although the national statistics do include some unadjusted numbers[4] (Tables 17-22), the majority of the presented data have been adjusted. Areas (states and or cities) that choose not to redistribute their NIRs appear to have much higher NIR rates than the national average leading to perceived lower credibility of local data and the erroneous conclusion that they are less able to obtain risk factors than the national average.

(continued)
07-ID-09

Committee: Infectious Disease

Title: Heterosexual HIV Transmission Classification

Schmidt and Mokotoff[7] conducted a record review and transmission category validation study using Michigan data (1995-1998) from two sources in addition to surveillance data to examine whether additional risk factors were recorded but not captured by the CDC transmission categories. The study led the authors to conclude that the current CDC hierarchy may be inadequate to describe recent trends in HIV transmission in women and they proposed that CDC add a presumed heterosexual category for women.

In response to the publication by Schmidt and Mokotoff, Lee and colleagues analyzed national AIDS and available HIV data[8]. The Michigan results could not be duplicated on a national level. The authors concluded that "Our inability to reduce substantially the proportion of NRR (No Reported Risk) cases in the national database simply by creating additional categories or assigning cases to presumed heterosexual based on currently available data suggests a measurement or information ascertainment issue" (page 406). Further exploration of the issue reveals that, on a national level, there is a large proportion of cases where no answer is recorded to the basic questions "sex with male" and "sex with female" on the case report form§ and therefore most remained as NIRs. Based on these results, Lee and colleagues concluded that more should be done to improve risk factor ascertainment rather than add additional risk factor categories. For example, they proposed that with improved documentation of standard CDCdefined risk factors in the medical record, additional investigations (involving more time and other resources) would be unnecessary.

Since that time CDC and CSTE have worked to respond to Lee et al's recommendations. More specifically they have written the Risk Factor Ascertainment Technical Guidance[3]. CDC has been engaged in a process of assisting states to implement this Guidance which includes the goal of increasing ascertainment of "yes", "no" or "unknown" answers (and not having blank boxes with no option checked) for individual risk factor questions, including answers to the variables "sex with male" and "sex with female" on the case report form§. However, at the same time, demands on surveillance programs have increased as the funding available to support them has decreased and the NIR rate has increased.

This position statement is proposing the addition of a presumed heterosexual category for females. Several large cities and states have already begun using some version of a presumed heterosexual category in the presentation of their local data*. Proposing this category for females is relatively uncomplicated since there is no other likely mode of transmission for heterosexually active, non-injection drug using women. For males, however, the question is less straightforward. The most common mode of HIV transmission for men in the United States, regardless of race, has always been and continues to be, having sex with other men. Strong societal stigma against this behavior exists in virtually all race and ethnic groups, although the strength of it varies, making elicitation of MSM behavior by medical care providers difficult at best. This social stigmatization of male-to-male sex is likely to produce under-reporting of MSM transmission, making a presumed heterosexual category for men potentially less accurate. Given the likely confounding factor presented by male-male sex this Position Statement recommends further exploration of the issue for males and does not recommend applying the Presumed Heterosexual category to males at this time.

In December 2001 CDC held a Risk Consultation. The summary of this Consultation states "Dr Fleming (the Branch Chief at the time) ended by outlining that there is more work to be done. The category of "probable heterosexual" must be defined with additional input from health department surveillance experts. . . .and there is a need to strike a balance between national needs and local level realities through flexible protocols."[9] The authors of this Position Statement believe that the actions proposed here meet Dr Fleming's challenge.

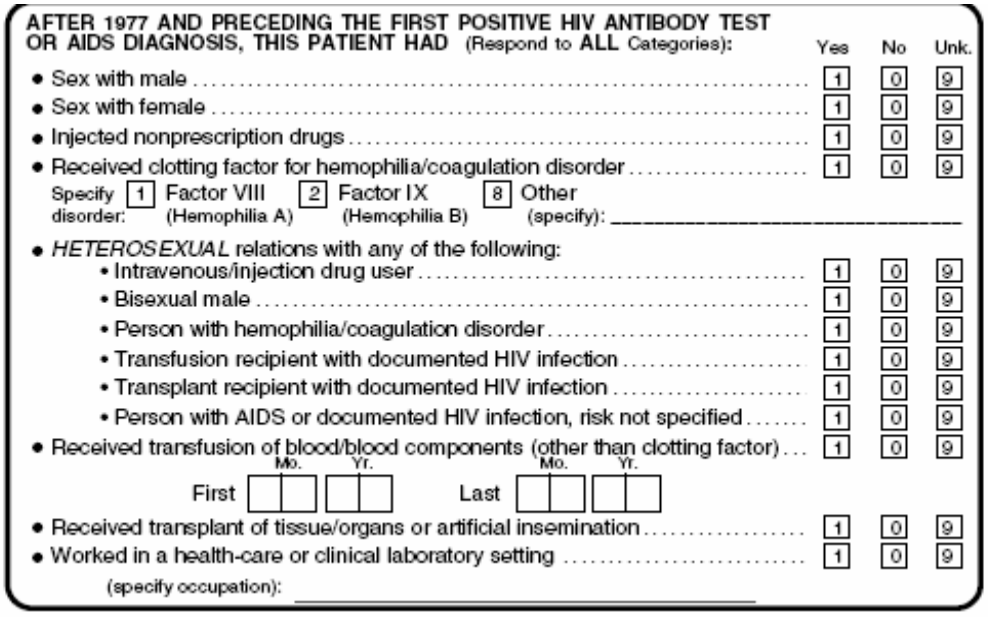
2007 Position Statements

(continued)
07-ID-09

Committee: Infectious Disease

Title: Heterosexual HIV Transmission Classification

§Patient History Section from CDC HIV/AIDS case report form



AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to ALL Categories):

	Yes	No	Unk.
• Sex with male	1	0	9
• Sex with female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9
Specify disorder: 1 Factor VIII (Hemophilia A) 2 Factor IX (Hemophilia B) 8 Other (specify): _____			
• *HETEROSEXUAL* relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
First Mo. Yr. Last Mo. Yr.			
• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting	1	0	9
(specify occupation): _____			

*New York City, Florida, Michigan, North Carolina, Indiana, Massachusetts, Virginia, Los Angeles County, New Jersey

Statement of desired actions to be taken:
CSTE:

1. Recommends that CDC add the category "Presumed Heterosexual" to the categories used to describe HIV infected females with HIV infection (including AIDS). These cases are currently classified as No Identified Risk but will be moved into the new category when all of the following statements are true:
   – The case is not already classified in one of the existing categories IDU, Heterosexual (as defined by CDC and described above), Blood, or Perinatal.
   – The case is a female.
   – Negative history of Injection drug use – i.e., the "No" option must be checked on the case report form for this risk factor question.
   – Positive history of sex with a male prior to diagnosis of HIV is documented and/or reported by the woman—i.e., the "Yes" option must be checked on the case report form for the question "sex with a male" prior to infection. This box can be checked following report by the female case or a health care provider - it does not have to be documented in the medical record nor be present on the first submitted case report form.
   – There is no other known information that would suggest a likely alternative source of HIV infection (for example, occupational exposure).

These cases are considered heterosexual transmission in the absence of information to show otherwise. Presumed heterosexual female cases should be displayed either as their own category or be included with the existing Heterosexual category when presenting data. They should not be displayed as a subset of NIRs. Note that all reported HIV/AIDS cases are open to future reclassification based on better or more complete behavioral information.

(continued)
07-ID-09

Committee: Infectious Disease

Title: Heterosexual HIV Transmission Classification

2. Recommends that additional information be collected on female presumed heterosexual cases in areas for which this is feasible in order to better qualify and understand heterosexual HIV transmission. However, this information is not required for classification as presumed heterosexual transmission. Such information could include:
   – History of sexually transmitted infections
   – History of non-injection drug use
   – History of alcohol abuse
   – Exchanging sex for money, drugs, shelter or other items/services of value
   – Having sex under the influence of drugs or alcohol
   – History of incarceration or history of heterosexual partner with history of incarceration

3. Recommends that CDC and CSTE convene one or more workgroups to:
   a) Select and standardize the data elements listed in recommendation #2 above;
   b) Begin the process of changing the current hierarchical system to one that is nonhierarchical and allows for multiple categories of risk factor classification. This work should build upon use the work already completed by the December 2001 Risk Consultation9 summarized in the Risk Factor Ascertainment Technical Guidance and included here as Appendix 1;
   c) Evaluate the impact of adding this presumed heterosexual category for females;
   d) Explore the issues related to, and the feasibility of, creating a presumed heterosexual category for males in the future.

   This Workgroup should contain HIV/AIDS Surveillance Coordinators along with subject matter experts from CDC and other informed and interested parties.

Fiscal Impact on CSTE:
None.

Public Health Impact:
The current CDC risk factor hierarchy under-represents the contribution of heterosexual transmission to women and does not serve the prevention needs of women and people who make prevention policy and allocate prevention resources to preventing infection in women. Public health programs will benefit from increasing the number and proportion of cases classified with a mode of transmission. This change will result in data that are more believable to our data users and produce data that are more useful for planning prevention programs.

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2007 Position Statements

(continued)
07-ID-09

Committee: Infectious Disease

Title: Heterosexual HIV Transmission Classification

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Agencies for Response:

Julie L. Gerberding, MD, MPH
Director, Centers for Disease Control and Prevention
1600 Clifton Road NE, Mailstop D-14
Atlanta, GA 30333

Agencies for Information:

None

Submitting Author:

Eve Mokotoff, MPH
Chair, HIV/AIDS Surveillance Work Group; HIV Co-consultant, CSTE
HIV/AIDS Epidemiology Manager, Michigan Department of Community Health
Herman Kiefer Health Complex
1151 Taylor, Room 210B
Detroit, MI 48202
Telephone: 313.876.4769
Fax : 313.876.0888
Email: mokotoffe@michigan.gov

Co-authors:

(1) Lucia V. Torian, PhD
Deputy Director, Epidemiology and Field Services Program
OAR 345 Broadway, Room 701
Bureau of HIV Prevention and Control
New York City Department of Health
(212) 442-3461
ltorian@aol.com

(2) Monica Olkowski, MS
HIV/AIDS Surveillance Coordinator
HIV & Hepatitis Epidemiology Program
New Mexico Department of Health
(505) 827-0074
monica.olkowski@state.nm.us

(continued)
07-ID-09

Committee: Infectious Disease

Title: Heterosexual HIV Transmission Classification

(3) James T. Murphy, MPH
Director, HIV/AIDS Surveillance and Epidemiology
Massachusetts Department of Public Health
305 South Street
Jamaica Plain, MA 02130
(617) 983-6560

(4) Dena Bensen, MPH
Director, HIV/AIDS Surveillance
Virginia Department of Health Division of Disease Prevention
109 Governor Street, 3rd Floor, RM 326
Richmond, VA 23219
Phone: (804) 864-7959
dena.bensen@vdh.virginia.gov

(5) Maree Kay Parisi
Program Director
HIV/AIDS Statistics and Epidemiology
AIDS Office
San Francisco Department of Public Health
415 554-9095
Maree.Kay.Parisi@sfdph.org

(6) Jennifer Chase, MSPH
Epidemiologist
HIV/STD Epidemiology and Surveillance Branch
Texas Department of State Health Services
1100 West 49th Street
Austin, Texas 78756
(512) 533-3046
jennifer.chase@dshs.state.tx.us

(continued)
07-ID-09

Committee: Infectious Disease

Appendix 1

From Risk Factor Ascertainment Technical Guidance:
Page 27: "**Transmission category**" should be the term for summarizing the multiple risk factors (as defined in risk factors) that an individual may have had by selecting the one through which HIV was most likely to have been transmitted. The selection of the most likely route of transmission is based on a presumed hierarchical order of transmission that was developed in the early years of the AIDS epidemic, and was based on what was known at the time about how HIV was transmitted. The hierarchy has not changed even though our understanding of the most efficient ways of HIV transmission has changed.

Pages 28-29: "**Exposure category**" should be the term for a new classification (or any of the categories in it) that summarizes the multiple risk factors that an individual may have had by including combination categories of the three most common ones (MSM, IDU, HTC). The exposure category classification was developed in response to the "Risk Consultation" of December 3-4, 2001, as an alternative to the transmission category classification. The consultants stated that the assumption on which the current hierarchical classification ("transmission category") is based—that sufficient information is collected to allow accurate selection of the most likely mode of transmission from among multiple possible routes of exposure—is probably not true, and that the resulting concealment of routes of exposure lower in the hierarchy by those that are higher is therefore unjustified and misleading. They therefore recommended a classification that would be less hierarchical, particularly so that HTC would not be concealed as a risk factor when it occurred in combination with MSM or IDU.

The exposure category still is hierarchical with respect to risk factors other than the primary three groups (e.g., receipt of a blood transfusion), which appear only in single categories ranked lower hierarchically than the combinations of MSM, IDU, and HTC.

Unlike transmission category, exposure category adheres strictly to the rules for "cases of public health importance" (COPHI), which require that certain rare routes of exposure not be accepted unless they are confirmed by a special investigation, and that, if they are confirmed, should then take hierarchical precedence in the classification over other possible routes of exposure in the same individual. Thus, if the COPHI investigation confirms that HIV transmission probably resulted from sexual abuse of a child or from a blood transfusion that became contaminated with HIV despite the screening of blood donors for HIV antibody, then this rare route of exposure should be selected as the single most likely mode of transmission. In contrast, transmission category, as it exists currently, does not adhere strictly to the COPHI rules. For example, transmission category attributes some cases to a risk factor like receipt of blood transfusions after screening of blood donors for HIV antibody had begun, despite lack of confirmation that the blood donor had been HIV-infected. For that reason, many cases that are classified in the transmission category for transfusion recipients are classified in the exposure category for no identified risk factor. Also, unlike transmission category, exposure category eliminates the age distinction between adult/adolescent and pediatric categories for receipt of blood products, transfusion, or transplant, and for absence of reported/identified risk factors. Finally, the exposure category classification distinguishes between cases reported without any risk factor within the preceding 12 months and those remaining with no identified risk factor for 12 or more months.

2007 Position Statements

07-ID-10

Committee: Infectious Disease

Title: Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months

Statement of Problem:
CSTE Position Statement 06-ID-01 approved in 2006 entitled, "Revision of the Surveillance Case Definition for HIV Infection among Children age < 18 months" needs to be changed to account for more recent data. A minor change is being made to 06-ID-01 due to review of additional data sources and further discussion with pediatric experts at the American Academy of Pediatrics after publication of 06-ID-01. The only change is to the presumptive uninfected category. This Position Statement is an amendment to 06-ID-01.

Statement of desired action to be taken:
CSTE recommends that CDC adopt the revised presumptive uninfected category which will be incorporated into the new HIV surveillance case definition for children age <18 months, as presented below.

Goals of Surveillance:
The goal is to be sufficiently accurate to presumptively classify perinatally exposed infants as HIV negative for surveillance purposes.

Methods for Surveillance
Data are obtained from HIV surveillance programs at the state, city and territorial levels as a part of their active HIV/AIDS surveillance systems. Areas obtain the information in a variety of ways: laboratory and clinician reporting are the most prominent.

Case Definition narrative:
For the presumptive uninfected category, CSTE proposes the inclusion of the following change:

- Two negative RNA or DNA virologic tests, for which both specimens were obtained ≥ 2 weeks of age and for which one specimen was obtained ≥4 weeks of age.[1]

[1] When both specimens are obtained at greater than or equal to 4 weeks of age the specimens should be obtained on separate days.

DRAFT: 2007 REVISION OF THE SURVEILLANCE CASE DEFINITION FOR HIV INFECTION AMONG CHILDREN AGED <18 MONTHS

This revised definition of HIV infection supersedes the definition published in 1999 (1), applies to any variant of HIV (e.g., HIV-1, HIV-2), and is intended for public health surveillance only. This definition is not presented as a guide for clinical diagnosis or for other uses.

This revised definition takes into account more recent data related to the use of newer testing technologies. Laboratory criteria for children aged <18 months at the time of diagnosis include revisions to the category *presumptive uninfected*. However, no substantial changes are made to the categories *definitive and presumptive* infected or definitive uninfected, and no changes are made to exclude conditions that meet criteria in the 1987 pediatric surveillance case definition for AIDS for children aged <18 months (1,2). Perinatally exposed children aged <18 months of age whose illness meets the AIDS case definition on the basis of existing clinical criteria will still be considered HIV-infected because of the greater uncertainty associated with diagnostic testing for HIV in this population and because of a positive HIV test result for the mother. The result of these changes is to reduce the number of HIV-exposed infants who have a very low probability of infection but whose infection status is classified for surveillance purposes as indeterminate according to the prior surveillance diagnostic criteria (1). The definitive or presumptive exclusion of HIV infection for surveillance purposes does not mean that one can rule out HIV infection clinically. For the purposes of calculating the exact timing of tests (e.g. when a specimen was obtained for laboratory testing) based on the surveillance case definition, 1 month corresponds to 30 days.

(continued)
07-ID-10

Committee: Infectious Disease

Title: Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months

A. HIV Infected (Definitive, Presumptive)
A child aged <18 months born to an HIV-infected mother will be categorized for surveillance purposes as "HIV infected" if at least one of the following criteria is met.

Definitive
Laboratory Criteria
Positive results on two separate specimens (excluding cord blood) by the use of one or more of the following HIV virologic (non-antibody) tests:

- HIV nucleic acid (DNA or RNA) detection*
- HIV p24 antigen test, including neutralization assay, for a child ≥1 month of age
- HIV isolation (viral culture)

Presumptive
A child will be categorized as presumptive HIV-infected if the criteria for definitively HIV-infected are not met, but the following criteria are met:

Laboratory Criteria
Positive results on only one specimen (excluding cord blood) by the use of the HIV virologic tests listed above (Definitive—Laboratory Criteria) and no subsequent negative results from HIV virologic or HIV antibody tests*

OR

Clinical or Other Criteria (if the above laboratory criteria for definitively or presumptively HIV-infected are not met, but the child is born to an HIV-infected mother)

- Diagnosis of HIV infection, based on the laboratory criteria above, that is documented in a medical record by a physician

  or

- When diagnostic testing for HIV infection or the results of such testing are not available, conditions that meet the criteria in the 1987 pediatric surveillance case definition for AIDS (2, Appendix)

B. Uninfected with HIV (Definitive, Presumptive)
A child aged <18 months born to an HIV-infected mother will be categorized for surveillance purposes as "uninfected with HIV" if the criteria for "definitive or presumptive HIV-infected" are not met, but the following criteria are met.

Definitive
Laboratory Criteria

- Virologic testing: At least two negative HIV virologic tests* from separate specimens, both of which were obtained at ≥ 1 month of age and one of which was obtained at ≥ 4 months of age

or

- Serologic testing: At least two negative HIV antibody tests from separate specimens obtained at ≥ 6 months of age

AND

No other laboratory or clinical evidence of HIV infection (i.e., no positive results from virologic tests* if tests were performed and no current or previous AIDS-defining condition – Appendix)

(continued)
07-ID-10

Committee: Infectious Disease

Title: Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months

Presumptive
Laboratory Criteria
A child aged <18 months will be categorized as presumptive uninfected with HIV if the criteria for definitive uninfected with HIV are not met, but the following criteria are met:

- Two negative RNA or DNA virologic tests* of which both specimens were obtained ≥2 weeks of age and one of which was obtained ≥4 weeks of age2

  or
- One negative RNA or DNA virologic test* of a specimen from a child ≥8 weeks of age

  or
- One negative enzyme immunoassay (EIA) HIV antibody test of a specimen from a child ≥6 months of age

  or
- One positive result from an HIV virologic test* followed by at least two negative tests, one of which is from a virologic test of a specimen from a child ≥8 weeks of age or from an HIV antibody test of a specimen from a child >6 months of age

  AND

No other laboratory or clinical evidence of HIV infection (i.e., no AIDS-defining condition for which there is no other underlying condition indicative of immunosuppression and no subsequent positive results from virologic tests if tests were performed)

OR

Clinical or Other Criteria (if the above criteria for definitive or presumptive uninfected with HIV are not met)

- Determination of "uninfected with HIV" made by a physician and a physician has noted the HIV diagnostic tests results in the medical record

  and
- No other laboratory or clinical evidence of HIV infection (i.e., no positive results from virologic tests if tests were performed, and no AIDS-defining condition for which there is an underlying condition indicative of immunosuppression – listed below)

C. Indeterminate HIV infection
A child aged <18 months born to an HIV-infected mother will be categorized as having perinatal exposure with an "indeterminate HIV infection" status if the criteria for "HIV-infected" or the criteria for "uninfected with HIV" are not met (see Sections A and B).

2 When both specimens are obtained at greater than or equal to 4 weeks of age the specimens should be obtained on separate days.

*HIV nucleic acid (DNA or RNA) detection tests are the virologic methods of choice for the diagnosis or exclusion of infection in children aged <18 months. Although HIV culture can be used for this purpose, it is more complex, less standardized, and less sensitive than nucleic acid detection tests. The use of p24 antigen testing to exclude infection in children aged <18 months is not recommended because of poor sensitivity, especially in the presence of HIV antibody. During the past decade, commercial tests for RNA and DNA detection have become widely available. Quantitative RNA tests have been approved by the Food and Drug Administration (FDA) for monitoring HIV infection and qualitative RNA tests have been approved as an aid to diagnosis. The quantitative and qualitative RNA tests meet FDA standards for high analytic and clinical sensitivity and specificity (3, 4, 5). Currently, all the commercial virologic tests detect the major (M) subtypes of HIV-1 as well as most O-subtypes. HIV-2 can be diagnosed with HIV-2 DNA PCR. Because of the possibility of mutation or recombination in the sequences detected by a particular test, an occasional specimen in an HIV-2 individual may not be detected. If suspicion for HIV-2 infection is high and results are negative, it may be prudent to test with another test.

(continued)
07-ID-10

Committee: Infectious Disease

Title: Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months

AIDS-defining Conditions

- Bacterial infections, multiple or recurrent (including Salmonella septicemia)†
- Candidiasis of bronchi, trachea, or lungs
- Candidiasis, esophageal*
- Cervical cancer, invasive§
- Coccidioidomycosis, disseminated or extrapulmonary
- Cryptococcosis, extrapulmonary
- Cryptosporidiosis, chronic intestinal (>1 month's duration)
- Cytomegalovirus disease (other than liver, spleen, or nodes), onset at >1 month of age
- Cytomegalovirus retinitis (with loss of vision)*
- Encephalopathy, HIV-related
- Herpes simplex: chronic ulcer(s) (>1 month's duration); or bronchitis, pneumonitis, or esophagitis, onset at >1 month of age
- Histoplasmosis, disseminated or extrapulmonary
- Isosporiasis, chronic intestinal (>1 month's duration)
- Kaposi's sarcoma*
- Lymphoid interstitial pneumonia or pulmonary lymphoid hyperplasia complex*,†
- Lymphoma, Burkitt's (or equivalent term)
- Lymphoma, immunoblastic (or equivalent term)
- Lymphoma, primary, of brain
- *Mycobacterium avium* complex or *M. kansasii*, disseminated or extrapulmonary*
- *Mycobacterium tuberculosis*, any site (pulmonary*,§, disseminated*, or extrapulmonary*)
- *Mycobacterium*, other species or unidentified species, disseminated* or extrapulmonary*
- *Pneumocystis* pneumonia*
- Pneumonia, recurrent*,§
- Progressive multifocal leukoencephalopathy
- *Salmonella septicemia*, recurrent
- Toxoplasmosis of brain, onset at >1 month of age*
- Wasting syndrome due to HIV

* Conditions that may be diagnosed presumptively.
† Restricted to *only* children aged <13 years.
§ Restricted to *only* adults and adolescents (persons ≥13 years).

Period of Surveillance:
From the present time forward.

(continued)
07-ID-10

Committee: Infectious Disease

Title: Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months

Data sharing/release and print criteria:
Data are shared with CDC in the same manner as all other HIV/AIDS surveillance data: individual cases are sent without names to CDC monthly.

Background and Justification:
In order to further evaluate the accuracy of the proposed test interval periods in the revised case definition, we used data from the Women and Infants Transmission Study (WITS) combined with data from the Pediatric Spectrum of Disease (PSD) Project. Requiring two negative RNA or DNA virologic tests, both of which were obtained at ≥2 weeks of age and one of which was obtained at ≥ 4 weeks of age, would have resulted in the correct diagnosis of over 99% of the cases as being negative, with a negative likelihood ratio of 15. These data and analyses will be published in a future manuscript.

Table 1 indicates all definitive and presumptive infected (diagnosed HIV, not AIDS), definitive and presumptive uninfected, and indeterminate cases of HIV infection among children <18 months of age from 1996-2005 by birth year reported to the National HIV/AIDS Reporting System. The table's "Current (before)" rows satisfy the current case definition based on infant HIV infection status and birth year. The "After Proposed Change" rows take into account the recommended change to the presumptive uninfected category among children aged <18 months based on infant HIV infection status and birth year. The highlighted rows indicate the impact of the proposed case definition change in the number of cases by year. These data indicate that from 1996-2005, the percent of indeterminate cases would decrease from 32% to 25% with a corresponding increase in the number of presumptive uninfected cases (from 8% to 15%) when taking into account the case definition change (e.g. the proposed change in testing interval). This suggests that a moderate reduction of children aged <18 months classified as indeterminate in the National HIV/AIDS Reporting System can be attained with implementation of the proposed revision of the perinatal HIV surveillance case definition. No changes to the definitive infected, presumptive infected or definitive uninfected criteria are proposed to the case definition.

Table 1. Number and percentage of infants <18 months of age by infant birth year and HIV infection status before and after proposed case definition change reported to the CDC HIV/AIDS Reporting System 1996-2005
Revised data are highlighted

	Infection Status	Year of Birth														Total	
		1996-1999		2000		2001		2002		2003		2004		2005			
		N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Current (before proposed change)	Definitive +	955	9.53	155	4.97	128	4.44	91	3.51	73	3.19	57	2.90	37	2.21	1496	6.09
	Presumptive +	122	1.22	29	0.93	32	1.11	20	0.77	23	1.01	17	0.87	18	1.07	261	1.06
	Definitive -	5544	55.30	1860	59.65	1670	57.89	1462	56.36	1147	50.13	898	45.75	413	24.61	12994	52.93
	Presumptive-	**972**	**9.70**	**227**	**7.28**	**214**	**7.42**	**212**	**8.17**	**180**	**7.87**	**168**	**8.56**	**92**	**5.48**	**2065**	**8.41**
	Indeterminate	**2431**	**24.25**	**847**	**27.16**	**841**	**29.15**	**809**	**31.19**	**865**	**37.81**	**823**	**41.93**	**1118**	**66.63**	**7734**	**31.50**
After Proposed Change	Definitive +	955	9.53	155	4.97	128	4.44	91	3.51	73	3.19	57	2.90	37	2.21	1496	6.09
	Presumptive +	122	1.22	29	0.93	32	1.11	20	0.77	23	1.01	17	0.87	18	1.07	261	1.06
	Definitive -	5544	55.30	1860	59.65	1670	57.89	1462	56.36	1147	50.13	898	45.75	413	24.61	12994	52.93
	Presumptive-	**1523**	**15.19**	**400**	**12.83**	**405**	**14.04**	**350**	**13.49**	**344**	**15.03**	**342**	**17.42**	**289**	**17.22**	**3653**	**14.88**
	Indeterminate	**1880**	**18.75**	**674**	**21.62**	**650**	**22.53**	**671**	**25.87**	**701**	**30.64**	**649**	**33.06**	**921**	**54.89**	**6146**	**25.03**

2007 Position Statements

(continued)
07-ID-10

Committee: Infectious Disease

Title: Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months

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Coordination:

Agencies for Response:

(1) Julie L. Gerberding, MD
Director, Centers for Disease Control and Prevention 1600 Clifton Road NE,
Mailstop D-14 Atlanta, GA 30333
Telephone: (404) 458-3800
Email: jvq2@cdc.gov

Agencies for Information:

Julie Scofield
Executive Director
National Alliance of State and Territorial AIDS Directors
444 North Capitol St NW
Suite 339
Washington, DC 20005
Telephone: (202) 434-8073
Email: jscofield@nastad.org

(continued)
07-ID-10

Committee: Infectious Disease

Title: Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months

Submitting Authors:

(1) Eve Mokotoff, MPH
CSTE, Chair, HIV/AIDS Surveillance Work Group; HIV/AIDS Co-consultant
HIV/AIDS Epidemiology Manager
HIV/STD and Other Bloodborne Infections Surveillance Section
Michigan Department of Community Health
Herman Kiefer Health Complex
1151 Taylor, Rm 210B
Detroit, MI 48202
mokotoffe@michigan.gov

(2) James Jerry Gibson, MD, MPH
CSTE, Infectious Disease Committee, HIV/AIDS Lead Consultant
State Epidemiologist and Director, Bureau of Disease Control2600 Bull Street
Columbia, S.C. 29201
Telephone: (803) 898-0861
Fax: (803) 898-0897
Email: qibsonij@dhec.sc.gov

2007 Position Statements

07-ID-11

Committee: Infectious Disease

Title: Revised National Surveillance Case Definition for Lyme disease

Statement of the problem:
Lyme disease is the most commonly reported vector-borne disease in the United States. In 1990, CSTE adopted the position statement that added Lyme disease to the list of nationally notifiable diseases (http://www.cste.org/ps/1990/1990-01.htm). The Lyme disease national surveillance case definition was last updated in 1996 (http://www.cste.org/ps/1996/1996-18.htm) (ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4610.pdf). The purpose of this position statement is to revise the Lyme disease national surveillance case definition in accordance with the 2007 CSTE position statement template for placing diseases or conditions under national surveillance (http://www.cste.org/PositionStatement.asp). This revision permits states and territories to report confirmed and probable cases of Lyme disease to the National Notifiable Diseases Surveillance System (NNDSS), updates the laboratory evidence section to reflect current testing practices, and provides measures to assess the public health surveillance burden.

Statement of the desired action(s) to be taken:
Revise the national surveillance case definition for Lyme disease.

Goals of surveillance:
(1) Define the demographic, geographic, and seasonal distribution; (2) consistently monitor disease trends; (3) identify risk factors for transmission in areas where Lyme disease is newly emerging; and (4) evaluate the impact of prevention and control measures.

Methods for surveillance:
Case finding is conducted through standard clinician and laboratory reporting to local or state health agencies. Core surveillance data will be reported by state health agencies to the CDC NNDSS through the National Electronic Telecommunications System for Surveillance (NETSS) or the National Electronic Disease Surveillance System (NEDSS), as per state protocol.

Case definition:
This surveillance case definition was developed for national reporting of Lyme disease; it is not intended to be used in clinical diagnosis.

Clinical presentation:
A systemic, tickborne disease with protean manifestations, including dermatologic, rheumatologic, neurologic, and cardiac abnormalities. The best clinical marker for the disease is erythema migrans (EM), the initial skin lesion that occurs in 60%-80% of patients.

A systemic, tickborne disease with protean manifestations, including dermatologic, rheumatologic, neurologic, and cardiac abnormalities. The best clinical marker for the disease is erythema migrans (EM), the initial skin lesion that occurs in 60%-80% of patients. For purposes of surveillance, EM is defined as a skin lesion that typically begins as a red macule or papule and expands over a period of days to weeks to form a large round lesion, often with partial central clearing. A single primary lesion must reach greater than or equal to 5 cm in size across its largest diameter. Secondary lesions also may occur. Annular erythematous lesions occurring within several hours of a tick bite represent hypersensitivity reactions and do not qualify as EM. For most patients, the expanding EM lesion is accompanied by other acute symptoms, particularly fatigue, fever, headache, mildly stiff neck, arthralgia, or myalgia. These symptoms are typically intermittent. The diagnosis of EM must be made by a physician. Laboratory confirmation is recommended for persons with no known exposure.

For purposes of surveillance, late manifestations include any of the following when an alternate explanation is not found:

(continued)
07-ID-11

Committee: Infectious Disease

Title: Revised National Surveillance Case Definition for Lyme disease

- Musculoskeletal system. Recurrent, brief attacks (weeks or months) of objective joint swelling in one or a few joints, sometimes followed by chronic arthritis in one or a few joints. Manifestations not considered as criteria for diagnosis include chronic progressive arthritis not preceded by brief attacks and chronic symmetrical polyarthritis. Additionally, arthralgia, myalgia, or fibromyalgia syndromes alone are not criteria for musculoskeletal involvement.
- Nervous system. Any of the following, alone or in combination: lymphocytic meningitis; cranial neuritis, particularly facial palsy (may be bilateral); radiculoneuropathy; or, rarely, encephalomyelitis. Encephalomyelitis must be confirmed by demonstration of antibody production against Borrelia burgdorferi in the cerebrospinal fluid (CSF), evidenced by a higher titer of antibody in CSF than in serum. Headache, fatigue, paresthesia, or mildly stiff neck alone are not criteria for neurologic involvement.
- Cardiovascular system. Acute onset of high-grade (2nd-degree or 3rd-degree) atrioventricular conduction defects that resolve in days to weeks and are sometimes associated with myocarditis. Palpitations, bradycardia, bundle branch block, or myocarditis alone are not criteria for cardiovascular involvement.

Laboratory evidence
For the purposes of surveillance, the definition of a qualified laboratory assay is (1) a positive culture for B. burgdorferi, (2) two-tier testing interpreted using established criteria [1], or (3) single-tier IgG immunoblot seropositivity interpreted using established criteria [1-4].

Exposure
Exposure is defined as having been (less than or equal to 30 days before onset of EM) in wooded, brushy, or grassy areas (i.e., potential tick habitats) in a county in which Lyme disease is endemic. A history of tick bite is not required.

Disease endemic to county
A county in which Lyme disease is endemic is one in which at least two confirmed cases have been acquired in the county or in which established populations of a known tick vector are infected with B. burgdorferi.

Suggested codes for case ascertainment
To be developed (e.g. LOINC codes for finding suspected cases through automated review of laboratory electronic data).
Detailed definitions for case classification

Confirmed: a) a case of EM with a known exposure (as defined above), or b) a case of EM with laboratory evidence of infection (as defined above) and without a known exposure or c) a case with at least one late manifestation that has laboratory evidence of infection.

Probable: any other case of physician-diagnosed Lyme disease that has laboratory evidence of infection (as defined above).

Suspected: a) a case of EM where there is no known exposure (as defined above) and no laboratory evidence of infection (as defined above), or b) a case with laboratory evidence of infection but no clinical information available (e.g. a laboratory report).

Lyme disease reports will not be considered cases if the medical provider specifically states this is not a case of Lyme disease, or the only symptom listed is "tick bite" or "insect bite."

2007 Position Statements

(continued)
07-ID-11

Committee: Infectious Disease

Title: Revised National Surveillance Case Definition for Lyme disease

Period of Surveillance:
Ongoing. This revision of the surveillance case definition will be effective January 1, 2008.

Data sharing/release and print criteria:
States and territories will send CDC case data for all confirmed and probable cases. CDC will release only fully de-identified case data to the general public. Other releases require signed data sharing agreements using a format pre-approved by the state/territorial health agency.

Final printed counts published in the weekly MMWR by CDC will distinguish between confirmed and probable cases. Publication criteria will exclude suspected cases from final printed counts published by CDC. Provisional case report data will not be used until verification procedures are complete.

Background and Justification:
Since 1991, the number of reported Lyme disease cases has nearly doubled increasing to over 20,000 reported cases in 2005 (5). The increase in reported cases is likely the result of multiple factors, including a true increase in disease incidence and surveillance artifact due to the addition of laboratory surveillance methods. The increase in the number of reported cases has created a burden on both the local and state health departments due to the overall volume of cases reported and the follow up of clinical manifestations required for laboratory reported cases to determine case confirmation status.

To address the surveillance burden and create more sustainable Lyme disease surveillance systems, some states have modified the components of their systems (e.g. by dropping laboratory reporting) or modified the number of laboratory cases that are followed up (e.g. sampling a proportion of reported cases for follow up to limit the burden but to still generate an estimate of overall confirmed cases). While these strategies have somewhat decreased the burden of Lyme disease surveillance for the health departments, these changes have also contributed to a decrease in the number of reported cases nationally. There is concern that the reduction in reported cases will give the erroneous impression that the incidence of Lyme disease is decreasing.

The process that begins with the receipt of a positive laboratory report by a public health department and ends with the determination of surveillance case status is often very labor intensive. The revised surveillance case definition permits local and state health departments the flexibility to classify Lyme disease reports as confirmed, probable, or suspect cases and permits the reporting of confirmed and probable case totals at the national level. The revised surveillance case definition alone will not decrease the Lyme disease surveillance burden, but will give public health officials a more complete measure of the surveillance burden that can be used to guide the allocation of scarce public health surveillance resources.

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07-ID-11

Committee: Infectious Disease

Title: Revised National Surveillance Case Definition for Lyme disease

Coordination:

Agencies for Response:

(1) Julie L. Gerberding, MD
Director
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30333
404-639-7000
jyg2@cdc.gov

Agencies for Information:

(1) Scott J. Becker, MS
Executive Director
Association of Public Health Laboratories
8515 Georgia Avenue, Suite 700
Silver Spring, MD 20910
Telephone: 240-485-2745 ext 201
Fax: 240-485-2700:
sbecker@aphl.org

(2) Paul E. Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officials
2231 Crystal Drive Suite 450
Arlington, VA 22202
Phone: (202) 371-9090
Fax: (571) 527-3189
pjarris@astho.org

Submitting Author:

(1) Matthew L. Cartter, MD, MPH
Epidemiology Program Coordinator
Connecticut Department of Public Health
410 Capitol Ave.
MS# 11EPI
P.O. Box 340308
Hartford, CT 06134-0308
Phone: (860) 509-7994
Fax: (860) 509-7910
matt.cartter@ct.gov

2007 Position Statements

07-ID-12

Committee: Infectious Disease

Title: Establishing Neonatal Herpes Surveillance

Statement of the problem:
Neonatal herpes simplex virus (HSV) infection of the newborn is a serious disease that results in death in up to 65% of untreated patients; even with treatment, fewer than 20% of neonates with CNS involvement develop normally. While most cases of neonatal herpes are perinatallyacquired, some are postnatally-acquired and clusters of such cases have occurred. Currently, ten states have neonatal herpes as a reportable condition. However, few states have a specified case definition and among those that do, the case definitions are not standardized. Furthermore, in 2004, only 0-5 cases were reported in each of these jurisdictions, undoubtedly an underestimate of the true burden. No national case definition exists. As a result, much is to be learned about the true incidence of this infection, risk factors for disease, and opportunities for prevention.

Statement of the desired action(s) to be taken:
- CDC should convene an expert panel to include those states that currently have neonatal herpes as a reportable condition as well as those states that would like to consider making this a reportable condition, to develop a standard case definition for neonatal herpes surveillance that could be considered for use by those states.

Goals of surveillance:
- Describe the incidence of neonatal herpes infection
- Describe risk factors for neonatal herpes infection
- Recognize and respond to emergent disease patterns
- Identify missed opportunities for prevention and early treatment of affected neonates; use that knowledge to promote awareness of neonatal herpes infection among providers
- Establish a baseline measure of disease burden from which to monitor the effectiveness of any future herpes vaccine or other future prevention strategies

Methods for surveillance:
Reports will be made to state and local health departments by clinicians and laboratories. A case ascertainment form will be used to collect data elements. This form (to be developed) will include core and optional data elements. Core data elements will be reported through the CDC's National Notifiable Disease Surveillance System (NNDSS).

Background and Justification:
In June 2006 CSTE adopted position statement 06-ID-07 that called for the convening of an expert panel to: 1) develop a candidate case definition for neonatal herpes surveillance that could be considered by CSTE for approval; 2) identify the specific needs and goals of surveillance and propose the means by which surveillance might best be accomplished; 3) determine whether making neonatal herpes a nationally reportable condition might meet these needs; 4) if reporting is warranted, identify those epidemiologically and clinical variables that should accompany the description of those cases; and 5) assess the resources and training required by state, territorial, and local health departments to implement surveillance.

In March 2007, CSTE, in partnership with and with the support of CDC convened this expert panel. The panel included representatives from the American Academy of Pediatrics, the American College of Obstetrics and Gynecology, the National Coalition of STD Directors and the Association of Public Health Laboratories; representatives from state and local health departments, including state and local STD prevention and control programs; and clinicians from academic centers with specialties in pediatric infectious disease, neonatology and obstetrics/gynecology.

References:

- CSTE Position Statement - 06-ID-07: Surveillance for Neonatal Herpes

2007 Position Statements

(continued)
07-ID-12

Committee: Infectious Disease

Title: Establishing Neonatal Herpes Surveillance

Coordination:

Agencies for Response:

(1) Julie L. Gerberding, MD, MPH
Director, Centers for Disease Control and Prevention
1600 Clifton Road, Mailstop D-14
Atlanta, GA 30333
Telephone: 404 639-7000
Email: jvg2@cdc.gov

Agencies for Information:

(1) Don Clark, MA
Executive Director
National Coalition of STD Directors
1275 K Street NW Suite 1000
Washington, DC 20005
Telephone: 202 842-4660
Email: dclark@ncsddc.org

(2) Scott Becker
Executive Director
Association of Public Health Laboratories
8515 Georgia Avenue, Suite 700
Silver Spring, MD 20910
Telephone: 240-485-2745 ext 201
Fax: 240-485-2700:
sbecker@aphl.org

(3) Paul Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officers
2231 Crystal Drive Suite 450
Arlington, VA 22202
Phone: (202) 371-9090
Fax: (571) 527-3189
pjarris@astho.org

Submitting Author:

(1) Cort Lohff, MD, MPH
State Epidemiologist
Vermont Department of Health
108 Cherry Street
PO Box 70
Burlington, VT 05402
Telephone: 802 863-7225
Email: clohff@vdh.state.vt.us

2007 Position Statements

07-ID-13

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Coccidioidomycosis

The purpose of this recommended revision to the surveillance case definition for coccidioidomycosis is to more accurately reflect current laboratory diagnosis of coccidioidomycosis (Appendix A). Recommended revisions to the coccidioidomycosis surveillance case definition primarily involve the following:

The proposed changes would allow a positive serologic test (any of several clinically accepted methods) for IgG without a confirmation of a rising IgG titer to be sufficient for case confirmation (Appendix A). If this change to the laboratory criteria is adopted, it is also recommended that health departments performing surveillance for coccidioidomycosis check for and remove duplicate cases during the previous five years, at minimum.

Statement of the problem:

A single positive IgG by any one of several serologic tests for coccidioidomycosis (Appendix A) is sufficient for clinical diagnosis of coccidioidomycosis in a patient living in or having recently traveled to *Coccidioides* endemic areas, with a clinically compatible syndrome [1]. However, under the current surveillance case definition, a single positive IgG for coccidioidomycosis is not sufficient for case confirmation (Appendix B).

Unlike serologic tests for other infections, the majority of positive serologic tests for IgG among patients with coccidioidomycosis revert to negative within one year [1]. In a minority of patients with coccidioidomycosis, such as patients who develop chronic disease (<1%), disseminated disease (<1%), or asymptomatic pulmonary residua (about 5%), IgG may persist [1, 2]. It is therefore possible that a small number of cases with persistently positive serology would be reported by laboratories in more than one year. However, it is common surveillance practice to remove duplicate cases reported in previous years, such as with HIV. This practice would likely address problems surrounding multiple reporting of case-patients with persistently positive IgG, especially if the de-duplication procedure involves several previous years (e.g. five years).

In 1997, Arizona Department of Health Services (ADHS) adopted a case definition for their *Coccidioides* surveillance involving one positive IgG serology. ADHS has procedures for removal of duplicates to avoid double reporting and have had success with this modified case definition.

In light of the current understanding of *Coccidioides* serology and clinical diagnosis of coccidioidomycosis, and an inability of the current surveillance case definition to classify many clinically relevant cases of coccidioidomycosis as confirmed cases, we conducted a consultation with experts from state and local health departments, CDC and the academic community. The goals of this consultation were to:

1) Review the current case definition for coccidioidomycosis and the proposals for revision
2) Review evidence for changes that would simplify and improve the case definition for coccidioidomycosis based on current scientific evidence, and ultimately
3) Recommend revisions to the surveillance case definition for coccidioidomycosis. Consultation participants included experts in coccidioidomycosis surveillance and epidemiology, and in clinical infectious diseases with particular expertise in the diagnosis of coccidioidomycosis.

Consultants represented CDC, state and local health departments from all six states in the U.S. endemic area (AZ, CA, NM, NV, TX, UT), and the academic community. Upon conclusion of the consultation, a plan was composed for revision of the case definition (see Statement of Desired Action below). If implemented, the revised definition (Appendix A) will supersede the 1996 case definition for coccidioidomycosis (Appendix B)

Statement of the desired action(s) to be taken:

CSTE recommends adoption of the new surveillance case definition for coccidioidomycosis, as presented in Appendix A. In conjunction with this new case definition, CSTE also recommends that state and/or local health departments performing surveillance for coccidioidomycosis have procedures for removing duplicate case-patients, reported within the previous five years.

(continued)
07-ID-13

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Coccidioidomycosis

Public Health Impact:
All proposed changes to the coccidioidomycosis surveillance case definition are shown in Appendix A. There are several benefits of this new definition.

1) Increased Representativeness. The acceptance of serologic evidence involving a single positive IgG (with or without a confirmation of a rising IgG titer) as sufficient for case confirmation, will allow surveillance data to better reflect the true disease burden. Since the adoption of this change will also increase simplicity and acceptability and decrease cost (see below, Public Health Impact #2), laboratory-based reporting is more likely to be adopted by state and local health departments, thereby also increasing representativeness.
2) Increased Simplicity and Acceptability and Decreased Cost. Since the current case definition requires confirmation of a rising IgG titer, extensive resources are required to perform follow up of laboratory reports of a positive IgG serology to assess whether a second IgG serology has been performed and whether these results represent a rising titer. State and local health departments currently requiring laboratory-based reporting differ in their methods for handling a single positive IgG serology, in large part due to differences in health department resources to perform follow up. For example, some health departments requiring laboratory reporting are able to perform follow up on all positive IgG serologic tests to attempt to confirm a rising titer, while others are unable to perform follow up. The proposed changes will obviate the need for such follow up and improve uniformity among state and local health departments. In summary, surveillance for coccidioidomycosis will be simpler, more acceptable to stakeholders, and require fewer resources from health departments.

Other minor modifications are proposed:

1) Primary pulmonary coccidioidomycosis, the most important clinical syndrome, encompasses a syndrome accurately described as both "influenza-like" and "pneumonialike" [3]. Therefore, it is proposed that the clinical description include disease which "resembles influenza-like or pneumonia-like febrile illness" (Appendix A).
2) It is proposed that "*Coccidioides immitis*" be changed to "*Coccidioides species*" since it is now recognized that more than one Coccidioides species may cause coccidioidomycosis [4].
3) Although positive serologic tests for coccidioidal antibodies from other body fluids (e.g. pleural fluid, peritoneal fluid), are much less common than tests from serum and cerebrospinal fluid, they are also clinically diagnostic of coccidioidomycosis [1]. It is therefore proposed that "other body fluids" be added as an acceptable specimen type in the case definition (Appendix A).

2007 Position Statements

(continued)
07-ID-13

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Coccidioidomycosis

Coordination:

Agencies for Response:

(1) Julie L. Gerberding, MD
Director, Centers for Disease Control and Prevention
1600 Clifton Road NE, Mailstop D-14
Atlanta, GA 30333
Telephone: (404) 458-3800
Email: jvq2@cdc.gov

(2) Scott Becker, MS
Executive Director, Association of Public Health Laboratories
8515 Georgia Avenue, Suite 700
Silver Spring, MD 20910
Telephone: (240) 485-2747
Email: scott.becker@aphl.org

Agencies for Information:

Not applicable

Submitting Authors:

(1) Gilberto F. Chavez, MD, MPH
State Epidemiologist
California Department of Health Services
1616 Capitol Ave, MS-7300
P.O. Box 997413
Sacramento, CA 95899-7413
Phone: (916) 440-7434
Email: GChavez1@dhs.ca.gov

(2) Kenneth K. Komatsu, MPH
State Epidemiologist
Arizona Department of Health Services
150 N. 18th Avenue, Suite 150
Phoenix, AZ 85007
Telephone: (602) 364-3587
Email: kkomatsu@siren.az.gov

(3) C. Mack Sewell, DrPH, MS
State Epidemiologist
New Mexico Department of Health
1190 South Saint Francis Drive
Santa Fe, NM 87502
Telephone: (505) 827-0006
Email: mack.sewell@state.nm.us

(continued)
07-ID-13

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Coccidioidomycosis

Co-Authors:

(1) Douglas C. Chang, MD
Epidemic Intelligence Service Officer
Mycotic Diseases Branch, Division of Foodborne, Bacterial and Mycotic Diseases, National Center for Zoonotic, Vector-borne, and Enteric Diseases
1600 Clifton Rd. MS C-09
Atlanta, GA 30333
Telephone: (404) 639-4748
Email: dchang@cdc.gov

(2) Tom Chiller, MD, MPH
Epidemiology Unit Chief
Mycotic Diseases Branch, Division of Foodborne, Bacterial and Mycotic Diseases, National Center for Zoonotic, Vector-borne, and Enteric Diseases
1600 Clifton Rd. MS C-09
Atlanta, GA 30333
Telephone: (404) 639-4753
Email: tnc3@cdc.gov

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07-ID-13

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Coccidioidomycosis

APPENDIX A:
2007 CSTE Case Definition for Coccidioidomycosis

CLINICAL DESCRIPTION
Infection may be asymptomatic or may produce an acute or chronic disease. Although the disease initially resembles an influenza-like or pneumonia-like febrile illness primarily involving the bronchopulmonary system, dissemination can occur to multiple organ systems.

CLINICAL CASE DEFINITION
An illness characterized by one or more of the following:

- Influenza-like signs and symptoms (e.g., fever, chest pain, cough, myalgia, arthralgia, and headache)
- Pneumonia or other pulmonary lesion, diagnosed by chest radiograph
- Erythema nodosum or erythema multiforme rash
- Involvement of bones, joints, or skin by dissemination
- Meningitis
- Involvement of viscera and lymph nodes

LABORATORY CRITERIA FOR DIAGNOSIS
A confirmed case must meet at least one of the following laboratory criteria for diagnosis:

- Cultural, histopathologic, or molecular evidence of presence of Coccidioides species, or
- Positive serologic test for coccidioidal antibodies in serum, cerebrospinal fluid, or other body fluids by:
  - Detection of coccidioidal immunoglobulin M (IgM) by immunodiffusion, enzyme immunoassay (EIA), latex agglutination, or tube precipitin, or
  - Detection of coccidioidal immunoglobulin G (IgG) by immunodiffusion, EIA, or complement fixation, or
  - Coccidioidal skin-test conversion from negative to positive after onset of clinical signs and symptoms

CASE CLASSIFICATION
Confirmed: A case that meets the clinical case definition and is laboratory confirmed.

(continued)
07-ID-13

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Coccidioidomycosis

APPENDIX B:
1996 CSTE Case Definition for Coccidioidomycosis (Revised 1996)

CLINICAL DESCRIPTION
Infection may be asymptomatic or may produce an acute or chronic disease. Although the disease initially resembles an influenza-like febrile illness primarily involving the bronchopulmonary system, dissemination can occur to multiple organ systems.

CLINICAL CASE DEFINITION
An illness characterized by one or more of the following:

- Influenza-like signs and symptoms (e.g., fever, chest pain, cough, myalgia, arthralgia, and headache)
- Pneumonia or other pulmonary lesion, diagnosed by chest radiograph
- Erythema nodosum or erythema multiforme rash
- Involvement of bones, joints, or skin by dissemination
- Meningitis
- Involvement of viscera and lymph nodes

LABORATORY CRITERIA FOR DIAGNOSIS

- Cultural, histopathologic, or molecular evidence of presence of Coccidioides immitis, or
- Positive serologic test for coccidioidal antibodies in serum or cerebrospinal fluid by:
  - Detection of coccidioidal immunoglobulin M (IgM) by immunodiffusion, enzyme immunoassay (EIA), latex agglutination, or tube precipitin, or
  - Detection of rising titer of coccidioidal immunoglobulin G (IgG) by immunodiffusion, EIA, or complement fixation, or
- Coccidioidal skin-test conversion from negative to positive after onset of clinical signs and symptoms

CASE CLASSIFICATION
Confirmed: A case that meets the clinical case definition and is laboratory confirmed.

2007 Position Statements

07-ID-14

Committee: Infectious Disease

Title: Influenza-Associated Pediatric Mortality

Statement of the problem:
In 2004, CSTE adopted influenza-associated pediatric mortality reporting with a provision for review in three years. It is critical to maintain national surveillance for pediatric mortality as a core component of national influenza surveillance. An average of approximately 36,000 deaths in the U.S. are attributable to influenza annually. While a majority of these deaths occur among the elderly, reports of pediatric influenza-related deaths were prominent during the 2003-04 season. More complete data are needed to define the burden of severe influenza in children and to develop appropriate strategies for prevention of influenza-associated mortality among them.

Statement of the desired action(s) to be taken:
Influenza-associated pediatric death should be maintained on the national reportable disease list and placed under surveillance through the National Notifiable Diseases Surveillance System (NNDSS).

Goals of Surveillance:
1. Monitor and describe the incidence, distribution, and basic epidemiologic characteristics of deaths among children related to influenza virus infection.
2. Provide data to guide future influenza immunization policy.
3. Rapidly recognize influenza seasons in which the impact of influenza appears to be unusually severe among children.

Methods for Surveillance:
Deaths in children associated with laboratory-confirmed influenza reported by clinicians, laboratories, vital statistics registrars, and medical examiners will be collected by state health departments and reported each week throughout the year to CDC through the National Notifiable Diseases Surveillance System (NNDSS). Core data will be published in the NNDSS MMWR provisional tables and the MMWR Annual Summary of Notifiable Diseases, United States, while additional clinical, epidemiologic, and virologic data will be presented in separate reports. Reporting will occur through the usual NNDSS compliant mechanisms.

Case Definition:
An influenza-associated death is defined for surveillance purposes as a death resulting from a clinically compatible illness that was confirmed to be influenza by an appropriate laboratory or rapid diagnostic test. There should be no period of complete recovery between the illness and death. Influenza-associated deaths in all persons aged <18 years should be reported.

A death should not be reported if:
1. There is no laboratory confirmation of influenza virus infection.
2. The influenza illness is followed by full recovery to baseline health status prior to death.
3. The death occurs in a person 18 years or older.
4. After review and consultation there is an alternative agreed upon cause of death.

(continued)
07-ID-14

Committee: Infectious Disease

Title: Influenza-Associated Pediatric Mortality

Laboratory criteria for diagnosis:
Laboratory testing for influenza virus infection may be done on pre- or post-mortem clinical specimens, and include identification of influenza A or B virus infections by a positive result by at least one of the following:

- Influenza virus isolation in tissue cell culture from respiratory specimens
- Reverse-transcriptase polymerase chain reaction (RT-PCR) testing of respiratory specimens
- Immunofluorescent antibody staining (direct or indirect) of respiratory specimens
- Rapid influenza diagnostic testing of respiratory specimens
- Immunohistochemical (IHC) staining for influenza viral antigens in respiratory tract tissue from autopsy specimens
- Four-fold rise in influenza hemagglutination inhibition (HI) antibody titer in paired acute and convalescent sera*.
- Serologic testing for influenza is available in a limited number of laboratories, and should only be considered as evidence of recent infection if a four-fold rise in influenza (HI) antibody titer is demonstrated in paired sera. Single serum samples are not interpretable.

* Serologic testing for influenza is available in a limited number of laboratories, and should only be considered as evidence of recent infection if a four-fold rise in influenza (HI) antibody titer is demonstrated in paired sera. Single serum samples are not interpretable.

Case Classification:
Confirmed - A death meeting the clinical case definition that is laboratory confirmed. Laboratory or rapid diagnostic test confirmation is required as part of the case definition; therefore, all reported deaths will be classified as confirmed.

Period of Surveillance:
Reporting anticipated to continue throughout the year. States may begin participating as soon as this condition is made notifiable in their state.

Background and Justification:
Influenza in children can present with fever, respiratory, and/or gastrointestinal symptoms. Serious complications of influenza in children include pneumonia, respiratory failure, nonrespiratory conditions such as shock and encephalopathy, and exacerbations of underlying chronic illness. Death associated with influenza can be directly related to the primary viral infection, or can result from a secondary complication. In certain cases, the progression from onset of illness to death can occur rapidly.

An average of approximately 36,000 deaths in the U.S. are attributable to influenza annually. Deaths in children comprise a small percentage of all influenza-associated deaths, and estimates of pediatric influenza mortality are therefore much less precise than those for adults. Limited studies indicate, however, that young children are at increased risk for hospitalization related to influenza.

During the fall of 2003, there were several widely publicized reports of influenza-associated deaths in children. These accounts generated concern that children were disproportionately affected by influenza during the current season. In December 2003, CDC requested that states voluntarily report influenza-associated deaths in children <18 years of age during the 2003-04 season. During October 11, 2003 - March 22, 2004, CDC received a total of 142 reports of pediatric fatalities associated with laboratory-confirmed influenza. Whether this represented an increase over baseline was unclear, since comparative data did not exist. In addition, a heightened awareness of severe complications and deaths associated with influenza and the increased availability of testing may have contributed to the identification of more influenzaassociated fatalities.

(continued)
07-ID-14

Committee: Infectious Disease

Title: Influenza-Associated Pediatric Mortality

Further, of these reported deaths, a significant number were 2 years of age or older and had no medical conditions recognized as high risk for influenza-related complications. Thus, these children were not among any groups currently targeted for influenza vaccination. Additional information is needed to further characterize those children at increased risk of influenza-related complications and deaths and to reassess current vaccination recommendations based on such information. This information could influence influenza vaccine policy by identifying specific pediatric groups at high risk for influenza-associated death or by providing data to support the expansion of pediatric age groups for targeted influenza vaccination.

Surveillance of influenza-associated pediatric deaths will serve to complement the current national influenza surveillance strategies. By including this element in the national reporting system, basic population-based epidemiologic characteristics, such as incidence, age and geographic distribution can be determined.

The collection of selected clinical information could potentially describe uncommon or previously unrecognized presentations, possible risk factors, and the impact of influenza vaccination. Linkage of mortality data with virologic and other laboratory data may provide information on strain virulence and abnormal host responses, and may guide vaccine strain selection.

Coordination:

Agencies for Response:

(1) Julie L. Gerberding
Director, Centers for Disease Control and Prevention
1600 Clifton Road, NE, Mailstop D-14
Atlanta, GA 30333
Telephone: (404) 639-7000
Email: JGerberding@cdc.gov

Agencies for Information:

(1) Paul Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officers
2231 Crystal Drive Suite 450
Arlington, VA 22202
Phone: (202) 371-9090
Fax: (571) 527-3189
pjarris@astho.org

(2) Scott Becker
Executive Director
Association of Public Health Laboratories
8515 Georgia Avenue, Suite 700
Silver Spring, MD 20910
Telephone: 240-485-2745 ext 201
Fax: 240-485-2700:
sbecker@aphl.org

(continued)
07-ID-14

Committee: Infectious Disease

Title: Influenza-Associated Pediatric Mortality

(3) Michael Tapper, MD
President, Society of Healthcare Epidemiology of America
19 Mantua Road
Mt. Royal, NJ 08061
Telephone: (856) 423-0087
Email: MTapper@lenoxhill.net

(4) James G. Masland
Executive Director, Association for Professionals in Infection Control and Epidemiology, Inc.
1275 K Street NW, Suite 1000
Washington, DC 20005-4006
Telephone: (202) 789-1890
Email: JMasland@apic.org

(5) Michael Graham, MD
President, National Association of Medical Examiners
1300 Clark Avenue
St. Louis, MO 63101-2718
Telephone: (314) 622-4971
Email: grahamma@slu.edu

(6) Pat Libby
Executive Director
National Association of County and City Health Officials
1100 17th Street, NW, Second Floor
Washington, DC 20036

(7) Steven Schwartz, PhD
President, National Association for Public Health Statistics and Information Systems
801 Roeder Road, Suite 650
Silver Spring, MD 20910
Telephone: (301) 563-6001
Fax: (301) 563-6012
Email: sschawrt@health.nyc.gov

Submitting Author:

(1) Kathleen F. Gensheimer MD, MPH
State Epidemiologist and Director of Medical Epidemiology
Division of Disease Control
Maine Bureau of Health
11 State House Station
Augusta, ME 04333
Telephone: (207) 287-5183
Email: Kathleen.F.Gensheimer@maine.gov

2007 Position Statements

(continued)
07-ID-14

Committee: Infectious Disease

Title: Influenza-Associated Pediatric Mortality

Co-Author:

(1) Lynn Finelli, MD, MPH
Influenza Division
Coordinating Center for Infectious Diseases
Centers for Disease Control and Prevention
1600 Clifton Road, NE, Mailstop A-32
Atlanta, GA 30333
Telephone: (404) 639-2554
Email: LyF8@cdc.gov

References:

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2007 Position Statements

07-INJ-01

Committee: ENV/OH/INJ

Title: Improving External Cause Coding in Hospital Discharge Data

Statement of Problem:
Injuries, both unintentional and intentional, remain one of the most neglected and costly public health problems in our society.[1,2] Surveillance is the basis for the public health approach to assessing, preventing and controlling injuries, 1 and statewide hospital discharge databases are a core dataset recommended for injury surveillance by state health departments.[3]

Hospital discharge data are coded using the International Classification of Diseases Clinical Modification, revision 9 (ICD-9-CM), which provides codes to specify both the nature of the injury (e.g. skull fracture) and the mechanism or external cause (e.g. bike collision with motor vehicle).[4] Improved external cause of injury coding helps planners identify and address issues involving patient safety, elderly falls, motor vehicle crashes, suicide attempts and other injuries that present a significant economic burden to the health care system. [2,5, 6]

Presently, hospitals routinely code injury according to the nature of the injury while the external cause code is not consistently or uniformly included in hospital discharge databases. [1,7,8] Limited progress has been made on this issue since 1990; as of 2005 only 26 states currently have a mandate for external cause coding, and in states that have evaluated their systems, only 55% of statewide hospital emergency department datasets have an external cause code for more than 90% of injury records. [9] Even when external cause codes are present, the use of non-specific codes greatly limits their utility. [10]

Both Healthy People 2010 Objectives and the Patient Safety Indicators promulgated by the Agency for Healthcare Research and Quality require external cause-coded data, [5, 11] and organizations such as the Council of State and Territorial Epidemiologists,[12] the State and Territorial Injury Prevention Directors Association,[13] the American Academy of Pediatrics[14] and the Suicide Prevention Action Network [6] currently endorse improvements in external cause of injury coding.

The costs of fully implementing external cause coding as part of hospital discharge data are minimal.[15] Federal data systems (UHDDS) and uniform billing (UB) procedures mandate the submission of data to statewide hospital discharge databases, butthese procedures do not currently require the submission of external cause codes.

Statement of desired action to be taken:
CSTE recommends:

- The Centers for Disease Control and Prevention National Center for Injury Prevention and Control and National Center for Health Statistics lead a national effort to develop a strategy to improve the completeness and specificity of external cause coding in hospital discharge databases. This strategy should include:
  1. Facilitation of a unified federal effort involving agencies affected by this issue, such as the Agency for Healthcare Research and Quality, the Center for Medicaid and Medicare Services, and the National Highway Traffic Safety Administration
  2. Exploration of the use of federal data systems (UHDDS) and uniform billing (UB) procedures as a tool to address this issue
  3. Promotion of the assessment of external cause coding completeness and specificity in statewide hospital discharge databases.
- The organization that oversees the collection of hospital discharge data in each state assure that external cause of injury codes be recorded in the hospital discharge data for each hospital discharge having an injury diagnosis.
- Other professional organizations such as the American Public Health Association (APHA), the State and Territorial Injury Prevention Directors Association, and the American Academy of Pediatrics and the Suicide Prevention Action Network join with CSTE in endorsing the importance of complete and specific external cause coding in statewide hospital discharge databases.

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07-INJ-01

Committee: ENV/OH/INJ

Title: Improving External Cause Coding in Hospital Discharge Data

Public Health Impact:

1. Evaluation and accountability for enhanced public health surveillance funding
2. More efficient use of public funding for surveillance for injury and violence prevention
3. More effective surveillance resulting in decreased morbidity and mortality
4. Prioritization of funding to projects and initiatives with positive public health outcomes, or with a reasonable expectation of such.

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07-INJ-01

Committee: ENV/OH/INJ

Agencies for Response:

(1) Julie L. Gerberding, Director
Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, GA 30333
(404) 639-7000
jyg2@cdc.gov

Agencies for Information:

(1) Ileana Arias, Director
National Center for Injury Prevention and Control (NCIPC)
Centers for Disease Control and Prevention
4770 Buford Hwy, NE
MS K-65
Atlanta, GA 30341
aa4@cdc.gov

(2) Ed Sondik
Director
National Center for Health Statistics (NCHS)
3311 Toledo Road
Metro 4 Building, Room 7204
Hyattsville, MD 20782
(301) 458-4500
efs2@cdc.gov

(3) Amber Williams
Executive Director
The State and Territorial Injury Prevention Directors Association (STIPDA)
2965 Flowers Road South
Suite 105
Atlanta, Georgia 30341
(770) 690-9000
amber.williams@stipda.org

(4) Georges C. Benjamin, MD, FACP
Executive Director
American Public Health Association (APHA)
800 I Street, NW
Washington, DC 20001
(202) 777-2742
georges.benjamin@apha.org

(continued)
07-INJ-01

Committee: ENV/OH/INJ

(5) Paul E. Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officials
2231 Crystal Drive Suite 450
Arlington, VA 22202
Phone: (202) 371-9090
Fax: (571) 527-3189
pjarris@astho.org

(6) Denise Love
Executive Director
National Association of Health Data Organizations (NAHDO)
448 East 400 South Suite 301
Salt Lake City, Utah 84111
(801) 532-2262
dlove@nahdo.org

(7) Anna Orlova, PhD
Executive Director
Public Health Data Standards Consortium (PHDSC)
3311 Toledo Road
Metro 4 Building, Room 7204
Hyattsville, MD 20782
(301) 458-4000
aorlova@jhsph.edu

(8) Garland Land
Executive Director
National Association for Public Health Statistics and Information Systems (NAPHSIS)
801 Roeder Road, Suite 650
Silver Spring, MD 20910
(301) 563-6001

(9) Linda Kloss, RHIA, CAE, FAHIMA, CEO
American Health Information Management Association (AHIMA)
233 N. Michigan Avenue
21st Floor
Chicago, IL 60601-5800
(312) 233-1100
linda.kloss@ahima.org

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07-INJ-01

Committee: ENV/OH/INJ

Submitting Author:

(1) Jon Roesler, Epidemiologist Supervisor
Minnesota Department of Health
85 East Seventh Place, Suite 400
PO Box 64882
St. Paul, MN 55164-0882
(651) 201-5487
jon.roesler@health.state.mn.us

(2) Melvin Kohn, State Epidemiologist
Oregon Department of Human Services
800 NE Oregon Street, Suite 730
Portland, OR 97232
(971) 673-1071
melvin.a.kohn@state.or.us

Co-Author:

(1) Susan Gallagher
34 Satuit Trail
Scituate, MA 02066
(617) 694-1788
ssgallagher@earthlink.net

2007 Position Statement Author Progress Report

Author Progress Report: 07-CD-01

Committee: Chronic Disease

Title: State-level Chronic Disease Epidemiology Capacity

Position Statement Progress Report:
07-CD-01 "State Level Chronic Disease Epidemiology Capacity"

The CSTE National Office received a written response to the position statement from CDC on August 22, 2007. The response states:

> "CDC has a long history of supporting chronic disease epidemiology capacity through its State-Based Epidemiology for Public health program Support (STEPPS) activity. Since its inception in 1991, STEPPS has provided staff or salary support to 33 states or jurisdictions. Of the 24 states and jurisdictions no longer receiving support from CDC, at least two-thirds have the successful transition to having one or more state-supported positions for chronic disease epidemiology that function independently of financial support from STEPPS. This successful program demonstrates the strong relationship between the states and CDC and the positive impact of these partnerships.
> The new CSTE position statement reinforces our past work and points to a constructive direction for the future. CDC is already working on many of the strategies outlined in the statement, which includes allowing grater flexibility across chronic diseases in future cooperative agreements and, of course, supporting chronic disease epidemiologist positions at the state level."

Progress on these items will be reported in response to Statement of Desired Actions to Be Taken in the Position Statement.

"CSTE will work with CDC, ASTHO, NACDD, and other partner organizations to support states in their efforts to recruit and retain adequate numbers of trained and experienced chronic disease epidemiologists to carry out the functions described in the *Essential Functions of Chronic Disease Epidemiology in State Health Departments* (3). States should be encouraged to deploy chronic disease epidemiologists in ways consistent with state chronic disease priorities and in an organizational structure that maximizes their ability to coordinate activities with chronic disease program staff and ensures coordination among chronic disease epidemiologists. This support should allow maximum flexibility for states to address their own chronic disease needs and respect state and local organizational structure."

Update: Since the position statement was passed, small group of representatives from CSTE Chronic Disease/MCH/Oral Health Committee, ASTHO, NACDD Science and Epidemiology Committee, and CDC has been meeting roughly monthly to implement different recommendations in the position statement. This group is working on several avenues simultaneously (see below).

- "CDC shall encourage as many states as possible to achieve the recommended minimum CDE workforce through 1) language in cooperative agreements that explicitly encourages hiring of CDEs; and 2) mechanisms and opportunities that give states greater flexibility in using categorical funding, including resources from multiple grants, to support these positions. Project officers from categorical CDC programs should be included in this coordination process.

- ASTHO and its affiliates (e.g., NACDD and CSTE) will work for and with states to take advantage of the funding flexibility and other resources to ensure hiring of needed CDEs."

2007 Position Statement Author Progress Report

Author Progress Report: 07-CD-01 (continued)

Committee: Chronic Disease

Title: State-level Chronic Disease Epidemiology Capacity

Update: The work group drafted language for NCCDPHP funding applications to encourage building epidemiologic work force. This draft was vetted by CDC NCCDPHP OD (Janet Colins and Kaetz Beartusk), who identified the "program guidance" that NCCDPHP programs attach to their FOAs as the appropriate vehicle. Dr. Colins has also agreed to request that NACDD and ASTHO endorse this language to its memberships. Potential outlets for this integration language include work plans for the states that will be selected for "Negotiated Agreements" to integrate NCCDPHP funding across categorical programs and the combined FOA for BRFSS/Tobacco/Diabetes (in 2009). Review by NACDD Executive Committee is underway.

Jillian Jacobelis led/coordinated two sessions at the Project Officer of the Future course: "Using epidemiology to understand public health problems" and "Using and understanding the surveillance infrastructure".

- "CSTE should disseminate standards for and strongly encourage the development of competency-based Epidemiology Job series in state personnel systems."

Update: No progress to report at this time.

- "CSTE and partners shall continue the work of the CDE capacity building work group to assist states in meeting the capacity targets set in the 2004 National Assessment of Epidemiologic Capacity in Chronic Disease (5)."

Update: The Chronic Disease STEPPS (State-based Epidemiology for Public Health Program Support) activity at the Division of Adult and Community Health (DACH), CDC National Center for Chronic Disease Prevention and Health Promotion expects to have three openings for chronic disease epidemiology positions at a state health department beginning Spring/Summer, 2008.

DACH will provide FTEs for these positions and help interested states recruit an appropriate Federal candidate. Funding for the position will need to be arranged by the state in partnership with CDC programs. States will:

1. ***Document a clear plan to develop and sustain chronic disease epidemiology capacity in a manner consistent with the Chronic Disease Epidemiology Workforce (07-CD—01.pdf) and Chronic Disease Epidemiology Functions recommendations of the Council of State and Territorial Epidemiologists (CSTE).***
2. ***Document a strong commitment to developing chronic disease epidemiology capacity at the senior health official and chronic disease program director levels.***
3. ***Not previously received support from STEPPS.***

- **"CSTE, in partnership with CDC, NACDD and ASTHO, should develop a list of capacity indicators that correspond to the capacity domains described in the 2004 CSTE chronic disease epidemiology capacity survey (i.e., workforce, access to data and consultants, data analysis/interpretation, dissemination, and outreach/partnership)"**

Update: CSTE President, Ed Bresnitz, has agreed to propose that ASTHO distribute the one-page chronic disease epidemiology capacity profiles to (Deputy) Health Officers.

- **"CSTE should develop and conduct an on-line rapid assessment tool to measure these indicators in each state approximately once every two years. A profile including the state/territory's results of this rapid assessment and nationwide averages should be sent to CSTE Chronic Disease Epidemiology Point of Contact in each state/territory so that each can compare its current capacity with aggregate data from other states. "**

2007 Position Statement Author Progress Report

Author Progress Report: 07-EC-01

Committee: CSTE Executive Committee

Title: Research to study and disseminate evidence of effective community health assessments

Position Statement Progress Report:

07-CD-01 "State Level Chronic Disease Epidemiology Capacity"

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2007 Position Statement
Author Progress Report

Author Progress Report: 07-CD-01 (continued)

Committee: Chronic Disease

Title: State-level Chronic Disease Epidemiology Capacity

Update: A draft tool has been drafted based on the 2003 survey. This tool is being reviewed by a few work group members and will be discussed at the CSTE conference. Discussions have been held about how this tool could be administered electronically.

- **"ASTHO will use the results of the state profiles to advocate for the development of Chronic Disease Epidemiology capacity in its annual consultations with the DHHS Secretary."**

Update: Negotiations are underway to share State profiles with ASTHO Deputy Health Officers

Respectfully submitted by Sarah Lyon-Callo, John Horan, and Paul Siegel. May 6, 2008.

2007 Position Statement
Author Progress Report

Author Progress Report: 07-EC-01 (continued)

Committee: CSTE Executive Committee

Title: Research to study and disseminate evidence of effective community health assessments

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2007 Position Statement
Author Progress Report

Author Progress Report: 07-EC-01 (continued)

Committee: CSTE Executive Committee

Title: Research to study and disseminate evidence of effective community health assessments

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Respectfully submitted by Sarah Lyon-Callo, John Horan, and Paul Siegel. May 6, 2008

2007 Position Statement Author Progress Report

Author Progress Report: 07-EC-03

Committee: Executive

Title: Support and reinstatement of funding for CDC's Outbreak Management System

Statement of the desired action(s) to be taken:

1. CSTE requests that CDC immediately provide ongoing funding for the development of OMS, including the messaging component while an evaluation is taking place, to prevent further loss of OMS development team staff and loss of institutional knowledge and momentum.
2. CDC reinstate support for OMS version 1.2 for training, deployment, and help desk and reconvene the OMS working group.
3. Prioritization of future enhancements of OMS should include feedback from experience of OMS 1.2 in the field and from the OMS working group.
4. Messaging and other specific high value enhancements should be prioritized for completion in the next version.
5. If funding for the messaging component is not provided, CDC should provide the source code for OMS to States and Territorial health departments, so that a consortium of State and Territorial health departments can collaboratively work on developing the messaging component or other necessary enhancements.
6. CDC should investigate the options to provide source code to States and Territorial health departments that need access to the source code for the purpose of integrating with other electronic surveillance systems.

A. Please summarize what, if anything has happened since the resolution passed:

1. (a) In January 2008, the co-chairs of the AHIC Population Health and Clinical Care Connections Workgroup (Drs. Lumpkin and Gerberding) signed a letter to the Chairman of AHIC and Secretary Leavitt (available at http://www.hhs.gov/healthit/documents/m20080115/06-phccc_recs_ltr.html) making the following recommendations with respect to an outbreak and event management system:

"Recommendation 3.0: By March 2008, CDC with the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), the Council of State and Territorial Epidemiologists (CSTE), the Association of Public Health Laboratories (APHL) and other appropriate groups, should undertake a program that will result in:

- Requirements gathering to define functionality that is minimal but sufficient to support the needs of managing complex outbreaks across jurisdictions.
- Identification of existing standards and/or definition of standards that will allow OEMS to interoperate with local, state, tribal and vendor OEMS, and other public health systems such as laboratory information systems (LIS), systems that manage countermeasures, fatality management tracking systems, and tools for monitoring of quarantine and isolation.
- Identification of existing standards and/or definition of standards that will allow OEMS to access interoperable clinical data from the Nationwide Health Information Network (NHIN) and CCHIT certified EHRs.
- The development of interoperable Outbreak and Event Management Systems (OEMS) that are based on an open architecture and comply with HITSP harmonized standards.
- Dissemination of Outbreak and Event Management Systems (OEMS) among state and local public health departments.

2007 Position Statement Author Progress Report

(continued)
Author Progress Report: 07-EC-03

Committee: Executive

Title: Support and reinstatement of funding for CDC's Outbreak Management System

Recommendation 3.1: CDC, with input and assistance from state and local public health should support the development and testing of software systems designed to manage public health investigations (e.g., CDC Outbreak Management System, state or commercially-developed systems), including identification of important exposures, laboratory diagnostics, contact tracing and indication for preventive countermeasures such as infection control, isolation, quarantine, prophylaxis or treatment. CDC should create a nationwide network of interoperable OEMS's meeting the criteria of 3.0, with input and assistance from state and local public health officials, CSTE, ASTHO and NACCHO that:

- Further refine the CDC's existing outbreak management software and make this software available for free use by public health departments by October of 2008. Interoperability features should be extended with each update of the software.
- Develop a detailed plan for creation of this nationwide network by October 2008.
- Develop detailed use cases for interoperability between OEMS systems and among OEMS and other systems, including LIS and EMRs by October 2008 building from the relevant AHIC Use Cases (i.e., Biosurveillance, Public Health Case Reporting, Immunizations and Response Management and Electronic Health Records: Laboratory Results Reporting).
- Develop functional specifications for OEMS software by December 2008.
- Identify relevant standards for vocabulary, security, data elements, and data transmission by December 2008 and advance these standards for harmonization by HITSP.
- Develop preliminary systems and software architecture for interoperable OEMS systems by June 2009.
- Develop and test prototype interoperable OEM systems by October 2009.
- Conduct a nationwide demonstration project linking interoperable OEM systems in multiple jurisdictions in an interoperable system of systems starting December 2009.
- Initiate certification of OEMS' including the definition of certification criteria through an open participatory process of certification for public health information systems as referenced in the PH/CCC Recommendations from March 2007."

1.(b) CDC's Coordinating Office for Terrorism Preparedness and Response (COTPER) reinstated funding for OMS for fiscal year 2008; funds were distributed to NCPHI in February 2008. For fiscal year 2008, funding was secured for three interrelated projects consisting of transition planning, enterprise architecture evaluation and development of OMS version 2. The enterprise architecture evaluation is underway, and progress has been made towards developing OMS version 1.3. As of May 23, 2008 CDC and CSTE have participated in one teleconference to discuss transition planning. It is unclear whether funding will continue for these three projects in fiscal years 2009 and 2010. In June 2008, the National Center for Public Health Informatics (NCPHI) will be submitting a competitive funding proposal for ongoing funding of OMS to COTPER for FY 2009. COTPER has requested NCPHI to prioritize between several projects, including OMS, as there will be a reduction in funds available to be distributed to NCPHI from COTPER for FY 2009.

2007 Position Statement
Author Progress Report

(continued)
Author Progress Report: 07-EC-03

Committee: Executive

Title: Support and reinstatement of funding for CDC's Outbreak Management System

2. Support (training, deployment and help-desk) for OMS version 1.2 has been reinstated for fiscal year 2008. As of May 19, 2008 there have been three OMS working group calls. The OMS working group will be split into two focus areas: (i) OMS Development and (ii) Outbreak Management Blueprint (development of a digital business model of outbreak management). Each of these two groups is scheduled to hold monthly conference calls commencing May 2008.

3. The OMS working group and persons who have used OMS 1.2 in the field have provided feedback on prioritization of future enhancements of OMS. High priority items were: (a) data-exchange (in particular to- and from surveillance and laboratory information systems), (b) enhancements to allow easier set-up and configurations and (c) web-access (in particular for data-entry). It is unclear whether or not FY 2008 development will focus on implementation of OMS working group-defined priorities and/or AHIC recommendations. Further priority items for implementation for FY 2009 and 2010 have not been defined/communicated. The status of funding for FY 2009 and 2010 development is also unclear.

4. See (3). Data exchange/ messaging was identified as the highest ranking priority by members of the OMS working group. It is unknown whether or not development will continue to focus on working group-defined priorities and/or AHIC recommendations for other high-value enhancements.

5. There are plans for the application to transition to an open-source governance model.

6. See (5).

B. Has there been any positive action or outcome due to the resolution?
See response to A. above

C. Is there any action needed by CSTE at this time to assist in further implementation?
CSTE members need to provide feedback and input into the enterprise architecture evaluation and need to participate in the OMS community advisory group and the OMS user group in both focus areas to ensure that the needs of States and local health departments are met. CSTE staff and members need to continue dialogue with CDC on transition planning for OMS, its governance and the role of CSTE. Advocacy for ongoing funding for OMS is also needed in the current budget environment. There may be efficiencies gained by incorporating some of the functionality (e.g., aggregate data entry and capacity for rapid-data entry) of the Countermeasure Response Administration (CRA) into the OMS as many of the data-elements of these two applications overlap. This would decrease confusion, free up resources (development, training, and implementation) and streamline messaging and interoperability.

D. Were any partners mobilized because of the resolution?
CDC

2007 Position Statement
Author Progress Report

(continued)
Author Progress Report: 07-EC-03

Committee: Executive

Title: Support and reinstatement of funding for CDC's Outbreak Management System

Author:

(1) Marion A. Kainer MD, MPH
Medical Epidemiologist
Tennessee Department of Health
425 5th Avenue
Cordell Hull Building
Nashville, 37243
615 7417247
marion.kainer@state.tn.us

2007 Position Statement Author Progress Report

Author Progress Report: 07-EH-01

Committee: Occupational/Environmental Health

Title: Support for Continuity of Environmental Public Health Indicators Development

KANSAS
DEPARTMENT OF HEALTH AND ENVIRONMENT
Division of Health

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Patrick J. McConnon, MPH
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard
Suite 303
Atlanta GA 30341-4015

May 2, 2008

Dear Mr. McConnon:

I received your request for an author progress report to the 2007 position statement **07-EH-01** entitled ***"Support for Continuity of Environmental Public Health Indicators Development"*** for the CSTE Annual Report. Below please find summary comments regarding the five identified questions about the status of this position statement.

1. Please summarize what, if anything, has happened since the resolution was passed.

The SEHIC has continued to develop and refine indicators for asthma, air quality, and most notably climate change. The Co-Chairs and the Steering Committee have worked with the CSTE Environmental Health Committee Chair in advancing the scope and vision for SEHIC for 2007-08. Work groups have continued their efforts with substantial outcomes. The climate change workgroup has been on the forefront of establishing priority areas for indicator development and has outlined core indicators for states to develop as part of their long term strategies for addressing climate change within state health departments. This suite of recommended indicators and tools are the first tools provided to state epidemiologists for addressing an emerging environmental health priority for which states currently have little to no funding to support despite its growing significance as a public health issue.

2. Has there been any positive action or outcome due to the resolution? If so, please summarize.

Work groups have conducted numerous conference calls, finalized documents (e.g., summary of the piloted indicators and "lessons learned" reflecting upon the process), developed new products (e.g., maps), and coordinated a conference on the high profile topic of Climate Change. Broader-based discussions have occurred about the integration of National Environmental Public Health Tracking Network (Tracking Network) efforts and SEHIC. CSTE has demonstrated commitment to the success of these efforts throughout the year in conducting semi-

CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 310, TOPEKA, KS 66612-1366
Voice 785-296-2501 Fax 785-296-1545

2007 Position Statement Author Progress Report

Author Progress Report: 07-EH-01

Committee: Occupational/Environmental Health

Title: Support for Continuity of Environmental Public Health Indicators Development

weekly conference calls with leadership of SEHIC to assure coordination; assisting with technical consultations; facilitating communications for work groups; and maintaining a website including SEHIC information and links.

3. Is there any action needed by CSTE at this time to assist in further implementation?

Communicating with federal partners and integrating indicator and environmental health activities continues to be a challenge. It is critical that CSTE maintain its leadership role in promoting systematic approaches to indicator development and linking environmental health surveillance activities at the national level. CDC continues to focus its efforts on those entities to which CDC directs funding. CSTE's support to the majority of states and territories that would otherwise have limited voice and representation is vital.

There are numerous emerging environmental health issues that impact population health. These are regularly reflected in national media. These issues are often complex scientific concerns which pit availability of resources against consumer and public demands. States need capacity, training and tools to help in addressing these emerging issues in a consistent, scientifically defensible manner. Indicator development offers a foundation of scientific knowledge and baseline data to frame these issues in a scientific way. The SEHIC has provided a substantial connection of technical experts in asthma, air quality, and other emerging health concerns relating to climate change among states.

CDC has made great progress in indicator development; however, access to tools and information are not uniform among non-funded Tracking Network states. As the Tracking Network is implemented, it is crucial that there are no states left behind. CSTE's work with SEHIC is an example of how this can be accomplished.

Environmental health indicator development is also challenged because topics are very multidisciplinary, exposure scenarios are diverse and health effects span across infectious and chronic disease outcomes. CSTE could assist in fostering cross-indicator collaboration to ensure a synergy of efforts given state epidemiologists' limited resources and time.

4. Were any partners mobilized because of the resolution?

Although the CDC responded to the position statement with a generally positive tone, there are significant challenges with the Tracking Network program efforts. And, though no response was received from the U.S. EPA, it is important to note that representatives have participated and provided technical assistance in accessing and interpreting EPA-gathered data, standards, and web-based resources, as well as participating in the Climate Change work shop. For example, Christine Davis, Ecosystem/Multimedia Team Lead for the Climate, International and Multimedia Group of the U.S. EPA, is co-chair of the SEHIC Climate Change workgroup.

Several professionals in the scientific community have contributed heavily to the climate change initiative this year, particularly through the Climate Change work shop (e.g., Jason Samenow, Climate Science & Impacts Branch, Climate Change Division U.S. EPA; Helene Margolis, California DHS; Uriel Kitron, Professor & Chair, Dept. of Environmental Studies, Emory University). Outreach has been made to engage other outside partners, such as presentations to the ASTHO Climate Change workgroup. Additionally, through CSTE's support, SEHIC was

2007 Position Statement Author Progress Report

Author Progress Report: 07-EH-01

Committee: Occupational/Environmental Health

Title: Support for Continuity of Environmental Public Health Indicators Development

able to engage its own technical consultants who have provided research and product development assuring the activities of SEHIC provide tangible results.

5. Any other comments or suggestions.

The evaluation of the SEHIC will occur, in part, during the State Environmental Health Indicators Collaborative (SEHIC) Workgroup Meeting. A more formalized evaluation may result once the participants have had an opportunity for open, face-to-face discussion.

The issues of environmental health and surveillance will continue to be of concern as issues of capacity, resource limitations, data interpretation and redundancies/coordination in indicator development persist. CSTE must maintain a leadership role to ensure that these concerns are addressed with the best technical experts, in the most appropriate way for comprehensive public health protection. This means inclusion of all states, not just states receiving CDC support. This is a critical advancement toward the mutual goal of protecting the health of the public from harmful environmental exposures.

I hope that these responses adequately detail the actions that have followed the 2007 position statement. Please feel free to contact me if other questions arise. It is always my pleasure to assist CSTE.

Sincerely,

Lesa Roberts, MPH, BSN, RN
Environmental Health Officer, KDHE
Co-Chair, SEHIC

cc: Dr. Melvin Kohn
Dr. Kristen Maleki

2007 Position Statement
Author Progress Report

Author Progress Report: 07-EH-02

Committee: Occupational/Environmental

Title: Occupational and Environmental Risks of Nanotechnology

Progress Report on the 2007 Position Statement, "Occupational and Environmental Risks of Nanotechnology"

Summary

Considerable research on the environmental, health and safety effects of nanotechnology is being conducted. According to the Project on Emerging Nanotechnologies (PEN) of the Woodrow Wilson International Center for Scholars, there are well over 500 such ongoing research projects.

The number of nanotechnology applications continues to grow dramatically. In 2007 the PEN counted something over 200 such products, and as of April 2008 the number was 609, an increase of 3-4 per week.

In the regulatory arena, very little progress has occurred at the national level in the U.S. In Europe, the European Union is considering revising its chemical regulatory regime (REACH – Regulation, Evaluation and Authorization of Chemicals) to specifically address nanomaterials.

Resolution Outcomes

The House of Representatives' Science and Technology Committee is currently considering a bill to re-authorize the National Nanotechnology Initiative (NNI), the program that coordinates research and development of nanomaterials at the federal level. The bill includes a provision requiring that 10% of the funds be designated for research on the environmental, health and safety of nanotechnology, up from the current expenditure of about 4%.

In the past year, the Environmental Protection Agency, contrary to the position of CSTE and that of several other public health and environmental organizations, ruled that it would not require manufacturers to submit "Pre-manufacture Notices" to the EPA when developing products using nanotechnology. OSHA, in responding to CSTE's position statement, gave no indication that it would consider issuing a standard to protect workers exposed to nanomaterials. No responses were received from either the Food and Drug Administration, any member of Congress, or any federal agency that funds nanotechnology research.

Recommended Further Action

CSTE should urge members of Congress to support the NNI re-authorization bill that designates 10% of funding for research on the environmental, health and safety effects of nanotechnology.

Submitted by: Richard Rabin
Coordinator, Lead Registry
Massachusetts Department of Labor
1001 Watertown St.
Newton, MA 02465
617-969-7177
rick.rabin@state.ma.us

2007 Position Statement Author Progress Report

Position Statement Response: 07-EH-03

Committee: Environmental Health

Title: Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance

NYC Health

May 21, 2008

Patrick McConnon
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, GA 30341-4015

Dear Pat,

Concerning the progress report for 2007 position statement 07-EH-03 (***"Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance"***):

1. I am not aware of any actions taken as a result of this position statement.

2. A desired outcome would be improved sensitivity and equal specificity in identifying cases of carbon monoxide poisoning. We may be able to take on this evaluation via the national Carbon Monoxide Surveillance Work Group (CO-SWG). The CO-SWG includes the Carbon Monoxide Content team of the Environmental Public Health Tracking Network, which meets monthly for that purpose; it also includes a larger body of members that currently meet bi-annually. I am the current Chair of the EPHT CO Content Team, and also lead the bi-annual general surveillance meeting. Our primary focus is currently the implementation of the EPHT network, but I can propose this as a project for our larger surveillance work group.

3. It would be helpful if there were a central repository on the CSTE website for surveillance case definitions, showing current versions and archiving older versions. This may exist already but I haven't been able to find it (apart from the position statement archives).

It would also be of interest to determine which states have used the 1998 or the 2007 revised case definition – perhaps CSTE could assist in this effort?

4. I am not aware of partner mobilization as the result of this resolution – I am not sure this question applies.

2007 Position Statement
Author Progress Report

Position Statement Response: 07-EH-03 (continued)

Committee: Environmental Health

Title: Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance

NYC Health

Please let me know if you would like any other information, and I will keep you informed of any updates if we are able to make progress on #2 above.

Best,

Katie Wheeler, MPH
Bureau of Environmental Surveillance and Policy
NYC Department of Health and Mental Hygiene
Phone: 212-676-2536
Email: kwheeler@health.nyc.gov

2007 Position Statement Author Progress Report

Author Progress Report: 07-ID-06

Committee: Infectious Disease

Title: Events that May Constitute a Public health Emergency of International Concern

To: Patrick McConnon April 30, 2008

As requested, I'm providing a progress report to the 2007 position statement 07-ID-06 entitled "Events that May Constitute a Public Health Emergency of International Concern".

Since the resolution passed, the following has occurred:

- CDC has included the position statement in their slide presentation about the International Health Regulations (IHR), presented to clinicians as "Revised International Health Regulations: Clinician Role in Implementation" as part of their Clinician Outreach and Communication Activity (COCA).
- The Government Accountability Office (GAO) was asked by the Senate Committee on Homeland Security and Governmental Affairs to review the sequence of events surrounding cases involving international travel infected with drug-resistant tuberculosis and the federal response to this potentially significant public health incident, and the authors of this statement participated in a conference call with GAO to discuss this issue.
- A panel presentation on the IHR at the American Public Health Association (APHA) meeting included an author from the position statement to discuss the impact of implementation on states.
- CDC has communicated extensively with states on IHR implementation steps.
- State Health Departments have been developing IHR implementation plans.

Positive actions/outcomes: This position statement was written in response to a request from CDC to foster acceptance and understanding of the new Regulations by state epidemiologists. The statement has been widely distributed and used by CDC to show continued partnering with the states on this issue, and continues to affirm that they will include CSTE members in further IHR implementation planning.

Action needed by CSTE: No action needed at this time.

Partners mobilized: CDC has responded very positively to this statement and continues to express interest in furthering collaborative efforts on IHR implementation.

Other comments/suggestions: I think this statement was a very positive example of collaboration between CSTE and CDC which has strengthened our position in working with CDC on issues relating to the changing global public health picture. It has also allowed us to reaffirm our position that "international" events are still, ultimately, local, and that local systems must be engaged and functioning correctly for this international process to work.

Please let me know if you have any questions. Also feel free to contact the co-authors, Steve Macdonald, and Gil Chavez, directly for further details if needed.

Christine Hahn, MD
State Epidemiologist
Idaho Division of Health

2007 Position Statement Author Progress Report

Position Statement Response: 07-ID-07

Committee: Infectious Disease

Title: Enhancing Disease Control for Cruise Ship Travel

FLORIDA DEPARTMENT OF HEALTH

RECEIVED MAY 5 2008

Charlie Crist
Governor

Ana M. Viamonte Ros, M.D., M.P.H.
State Surgeon General

April 30, 2008

Patrick J. McConnon, M.P.H.
Executive Director
2872 Woodstock Boulevard, Suite 303
Atlanta, GA 30341-4015

Re: Progress Report: 07-ID-07, "Enhancing Disease Control for Cruise Ship Travel"

Dear Mr. McConnon:

I am pleased to report some significant progress since this resolution was passed last June. Happily, the Centers for Disease Control and Prevention (CDC) Division of Global Migration and Quarantine (DGMQ), and the CDC Vessel Sanitation Program (VSP), were active partners in developing and supporting this resolution. Both agencies have continued their ongoing efforts to improve public health-related activities with the cruise line industry. In Florida, both agencies have collaborated with the Florida Department of Health, a valued partnership.

With support and technical assistance from CDC's VSP and DGMQ, Surgeon General Ana Viamonte Ros, M.D., M.P.H., Florida Department of Health, sent letters to all of the cruise lines operating out of Florida calling on the industry to strengthen the partnership between the industry, the CDC, and state health departments to protect the health of cruise ship passengers and crew members.

Recently, in response to her request, a member of the Medical Working Group, Cruise Lines International Association (CLIA MWG), made contact and offered to work with CSTE's new work group. The CLIA MWG consists of physicians representing the largest cruise lines active in the United States.

As a result of this recent, favorable response, I have taken steps to establish a CSTE work group and hope to have an orientation and organizational meeting at the annual meeting in Denver. I appreciate the support from the CSTE office and am delighted that Lisa Dwyer will be our support person. Once we have established the CSTE work group, we will schedule a meeting by teleconference with representatives from CDC's VSP and DGMQ, and representatives from the CLIA MWG to further develop and finalize our agenda and work plan. I believe we have an excellent opportunity to accomplish the steps recommended in CSTE's resolution and to improve the public health of cruise ship passengers and crew members.

Sincerely,

John P. Middaugh, MD

John P. Middaugh, MD
State Epidemiologist

JPM

2007 Position Statement Author Progress Report

Author Progress Report: 07-ID-08

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

I am in receipt of your letter of April 15, 2008 asking me for author progress reports on the three 2007 Position Statements I authored/coauthored in 2007: 07-ID-08- use of HIV surv data in future Ryan White funding formulas; 07-ID-09 Heterosexual HIV Transmission Classification and 07-ID-10 Revision of CSTE 06-ID-01: surveillance case definition for HIV infection in children under age 18 months.

1) #08 Ryan White formulas: both HRSA and CDC responded to this PS and I believe that the actions outlined in the CDC response letter do indicate a positive outcome. Ongoing communications between CDC leadership on the HIV Case Surveillance Branch and CSTE HIV Workgroup leadership is assisting in follow-up actions to the recommendations in this PS. No further action is needed by CSTE at this time.

2) #09 Heterosexual risk classification: I have been co-chairing a workgroup with the CDC Subject Matter Expert on risk to implement this PS. No further action is needed by CSTE at this time.

3) #10 HIV case definition for children <18 months of age: CDC is in the process of clearing an MMWR that will implement this PS. They are hopeful this MMWR will be published over the summer of 2008. No further action is needed by CSTE at this time.

Thank you for your ongoing support of the work of the CSTE HIV Workgroup.

Eve

Eve Mokotoff, MPH
HIV Epidemiology Manager
HIV/STD/VH/TB Epidemiology Section
Michigan Department of Community Health
Herman Kiefer Health Complex
1151 Taylor, Rm 211B
Detroit, MI 48202

Phone: 313 876- 4769 (0353)
Fax: 313 876-0888
E Mail: mokotoffe@michigan.gov

2007 Position Statement
Author Progress Report

Author Progress Report: 07-ID-09

Committee: Infectious Disease

Title: Heterosexual HIV Transmission Classification

I am in receipt of your letter of April 15, 2008 asking me for author progress reports on the three 2007 Position Statements I authored/coauthored in 2007: 07-ID-08- use of HIV surv data in future Ryan White funding formulas; 07-ID-09 Heterosexual HIV Transmission Classification and 07-ID-10 Revision of CSTE 06-ID-01: surveillance case definition for HIV infection in children under age 18 months.

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Thank you for your ongoing support of the work of the CSTE HIV Workgroup.

Eve

Eve Mokotoff, MPH
HIV Epidemiology Manager
HIV/STD/VH/TB Epidemiology Section
Michigan Department of Community Health
Herman Kiefer Health Complex
1151 Taylor, Rm 211B
Detroit, MI 48202

Phone: 313 876- 4769 (0353)
Fax: 313 876-0888
E Mail: mokotoffe@michigan.gov

2007 Position Statement Author Progress Report

Author Progress Report: 07-ID-10

Committee: Infectious Disease

Title: Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months

I am in receipt of your letter of April 15, 2008 asking me for author progress reports on the three 2007 Position Statements I authored/coauthored in 2007: 07-ID-08- use of HIV surv data in future Ryan White funding formulas; 07-ID-09 Heterosexual HIV Transmission Classification and 07-ID-10 Revision of CSTE 06-ID-01: surveillance case definition for HIV infection in children under age 18 months.

1) #08 Ryan White formulas: both HRSA and CDC responded to this PS and I believe that the actions outlined in the CDC response letter do indicate a positive outcome. Ongoing communications between CDC leadership on the HIV Case Surveillance Branch and CSTE HIV Workgroup leadership is assisting in follow-up actions to the recommendations in this PS. No further action is needed by CSTE at this time.

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Thank you for your ongoing support of the work of the CSTE HIV Workgroup.

Eve

Eve Mokotoff, MPH
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HIV/STD/VH/TB Epidemiology Section
Michigan Department of Community Health
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1151 Taylor, Rm 211B
Detroit, MI 48202

Phone: 313 876- 4769 (0353)
Fax: 313 876-0888
E Mail: mokotoffe@michigan.gov

2007 Position Statement
Author Progress Report

Author Progress Report: 07-ID-12

Committee: Infectious Disease

Title: Establishing neonatal Herpes Surveillance

Here is an update on position statement 07-ID-12 for inclusion in the upcoming CSTE Annual Report:
In April 2008, CSTE, in partnership with CDC, invited representatives from jurisdictions that currently have neonatal herpes as a reportable condition to participate in a conference call. During that call, a draft case definition (that was developed in March 2007) was reviewed. Following much discussion, it was agreed to amend the case definition by extending the period of time a case could be considered confirmed or probable from 42 to 60 days of age, as well as extend the period of time a case could be considered suspect from 30 to 60 days of age. No other changes were proposed.
A second conference call is scheduled during May to identify next steps, which may include the formation of a working group to share best practices for surveillance and to discuss data acquired from surveillance efforts.

Cortland Lohff
State Epidemiologist
Vermont Department of Health
108 Cherry Street
Burlington, VT 05403

2007 Position Statement
Author Progress Report

Author Progress Report: 07-ID-14

Committee: Infectious Disease

Title: Influenza-Associated Pediatric Mortality

Dear Pat;

In response to your letter of April 15, requesting a progress report on the 2007 CSTE position statement: Influenza Associated Pediatric Mortality, I am pleased to report that since the position statement was passed, States have continued to report pediatric deaths to the federal CDC, as was evidenced by the case reports recently reported for the 2007-08 influenza season in the MMWR. There is no further action required with respect to the reporting of pediatric deaths at this point in time. However, further action and attention is required for enhancing and strengthening seasonal influenza surveillance, as evidenced by the consultancies which the federal CDC coordinated with CSTE during 2006 and 2007. Hence, another position statement broadening and standardizing influenza surveillance strategies will be introduced during the 2009 CSTE annual meeting.

Please let me know if I can be of further assistance.

Kathy

Kathleen F. Gensheimer, MD MPH
State Epidemiologist
Maine Department of Health and Human Services
State House #11
Augusta, Maine 04333

Telephone: 207 287 5183
Fax: 207 287 6865

2007 Position Statement
Author Progress Report

Author Progress Report: 07-INJ-01

Committee: ENV/OH/INJ

Title: Improving External Cause Coding in Hospital Discharge Data

TO: CSTE National Office
FROM: Mel Kohn, MD MP
State Epidemiologist
Public Health Division
Oregon Department of Human Services

DATE: April 21, 2008

RE: Progress Report on 2007 position statement 07-INJ-01, "Improving External Cause Coding in Hospital Discharge Data

In response to this position statement Dr. Gerberding, the Director of CDC, sent a letter dated September 10, 2007. In her letter Dr. Gerberding described plans to publish a Morbidity and Mortality Weekly Report, Reports and Recommendations (MMWR R&R) article about external cause coding, and to work with other federal agencies to improve coding, as requested in the position statement.

The MMWR R&R was published on March 28, 2008, under the leadership of Lee Annest at NCIPC and Lois Fingerhut at NCHS. Lee and Lois have begun efforts to disseminate the report to other agencies, and are planning a summit on the issue, possibly this summer.

CSTE's Workgroup for External Cause Coding Improvement (WECCI) also plans to use this report to advance its agenda. WECCI has successfully engaged 7 organizations to endorse efforts to improve external cause coding, and is working to add additional supporters. Also, WECCI is currently working with several partner organizations to get injury program directors in each state to partner with their state's representative of the National Safety Council and approach the organization that owns their state's hospital discharge data in order to create an action plan for improving external cause coding.

For the future, CSTE should:

- continue to support WECCI and participate in the national summit planned by Lois and Lee
- continue to press the issue of using UHDDS and UB procedures to improve external cause coding
- continue to ask CDC to develop ways to assure that each state assesses external cause coding completeness and specificity in its statewide hospital discharge database.

2007 Position Statement Responses

Position Statement Response: 07-CD-01

Committee: Chronic Disease

Title: State-level Chronic Disease Epidemiology Capacity

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

RECEIVED AUG 2 2 2007

AUG 2 0 2007

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

Thank you for your letter regarding the Council of State and Territorial Epidemiologists' (CSTE) position statement 07-CD-01 on "State-level Chronic Disease Epidemiology Capacity." The newly adopted position statement codifies your organization's strong support of chronic disease epidemiology, and the Centers for Disease Control and Prevention (CDC) applauds your efforts.

CDC has a long history of supporting chronic disease epidemiology capacity through its State-Based Epidemiology for Public Health Program Support (STEPPS) Activity. Since its inception in 1991, STEPPS has provided staff or salary support to 33 states or jurisdictions. Of the 24 states and jurisdictions no longer receiving support from CDC, at least two-thirds have made the successful transition to having one or more state-supported positions for chronic disease epidemiology that function independently of financial support from STEPPS. This successful program demonstrates the strong relationship between the states and CDC and the positive impact of these partnerships.

The new CSTE position statement reinforces our past work and points to a constructive direction for the future. CDC is already working on many of the strategies outlined in the statement, which includes allowing greater flexibility across chronic diseases in future cooperative agreements and, of course, supporting chronic disease epidemiologist positions at the state level. Building this capacity at the state level will help states and the nation to prevent and combat chronic disease more effectively. We look forward to continuing this valuable work with your organization.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director

2007 Position Statement Responses

Position Statement Response: 07-EC-02

Committee: Executive

Title: CSTE official list of Nationally Notifiable Conditions

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

RECEIVED NOV 2 6 2007

October 26, 2007

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

Dr. Julie Louise Gerberding has asked me to respond to your letter of July 9 regarding the Council of State and Territorial Epidemiologists (CSTE) approved position statement 07-EC-02 titled "CSTE official list of Nationally Notifiable Conditions" at your annual conference held during the week of June 28, 2007. Please excuse the delay of this response.

We agree this position statement outlines efforts that will ultimately support more timely and complete reporting of conditions of importance to the public's health. We are committed to working in close collaboration with CSTE and others to bring to completion the important outcomes described in the position statement. This position statement will require that CDC and CSTE continue to collaborate to develop and/or refine processes and governance structures for the following:

- Creating and maintaining a CSTE list of nationally notifiable diseases.
- Working with informaticians and public health specialists to implement a knowledge base for notifiable conditions that can make available in real-time domain knowledge about notifiable conditions, which includes documenting which conditions are reportable in each reporting jurisdiction.
- Developing standardized reporting definitions, criteria, core and disease-specific data elements, and exclusion criteria to address the American Health Information Community (AHIC) recommendations to facilitate automated case reporting from the healthcare sector to local and state public health.
- Expanding the list of nationally notifiable infectious diseases to include non-infectious diseases, as necessary and appropriate.

CDC and CSTE share a long history of collaboration on important public health issues. We look forward to continuing our work with you to implement AHIC recommendations and in support of the public health surveillance for nationally notifiable diseases.

Sincerely,

Steven L. Solomon, M.D.
Director
Coordinating Center for Health
Information and Service

2007 Position Statement Responses

Position Statement Response: 07-EC-03

Committee: Executive

Title: Support and reinstatement of funding for CDC's Outbreak Management System

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

RECEIVED SEP 7 2007

SEP 5 2007

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

Thank you for your letter regarding position statement 07-EC-03 titled "Support and Reinstatement of Funding for CDC's Outbreak Management System (OMS)."

We greatly appreciate the support that the Council of State and Territorial Epidemiologists (CSTE) consistently contributes to the Centers for Disease Control and Prevention (CDC) and our programs. Your organization has always provided important leadership and advice on practical methods and best practices for disease surveillance and control.

It is one of our imperatives to provide robust data management software to meet the demands of those confronting unexpected adverse events in public health, and I appreciate your confidence that our Outbreak Management System (OMS) has the potential to do this. Our staff has been diligently working to assess OMS. The CDC Coordinating Office for Terrorism Preparedness and Emergency Response (COTPER) has been collaborating with the Division of Integrated Surveillance Systems and Services (DISSS) at the National Center for Public Health Informatics in our Coordinating Office for Health Information and Service, as well as others at CDC to come up with a feasible plan to provide a product that will meet the needs of public health practitioners.

Our consensus has been to propose three interdependent projects to compete for COTPER funding for fiscal year 2008. The realization of these projects should address the concerns listed on your position statement. The projects cover three areas: transition planning, enterprise architecture evaluation, and development of OMS version 2. The transition planning project will allow CDC, in collaboration with CSTE, to engage in discussions about transitioning governance of the OMS application over a three-year period. The strategy may include such options as transitioning the application to a third party. The enterprise architecture evaluation project is to evaluate the business process and establish a strategy for developing interoperability between outbreak management tools. The third project addresses further development of OMS version 2. Over a three-year period, CDC, CSTE, and the OMS Working Group will thoughtfully prioritize user requirements, including messaging, as well as interoperability with other systems and different platforms.

Position Statement Response: 07-EC-03 (continued)

Committee: Executive

Title: Support and reinstatement of funding for CDC's Outbreak Management System

As a very important partner, we look forward to continuing our work with CSTE in the years to come, and I would greatly enjoy the opportunity to engage in discussions about ways to enhance our partnership and collaboration in the development of OMS. Please contact Dr. Scott McNabb, Director of CDC's DISSS, at (404) 498-6427 or e-mail SMcNabb@cdc.gov if you have any further questions.

Thank you for your continued interest in and support of OMS.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director

2007 Position Statement Responses

Position Statement Response: 07-EH-01

Committee: Occupational/Environmental Health

Title: Support for Continuity of Environmental Public Health Indicators Development

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

AUG 22 2007

RECEIVED AUG 27 2007

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

Thank you for your letter regarding the Council of State and Territorial Epidemiologists (CSTE) Position Statement 07-EH-01, "Support for Continuity of Environmental Public Health Indicators Development." The Centers for Disease Control and Prevention (CDC) appreciates the continued support of CSTE on environmental health issues. Our partnership continues to advance toward the ultimate goal of protecting the health of the public from harmful environmental exposures.

Since 1999, CDC has collaborated with CSTE on the development of environmental public health indicators. Our early efforts cumulated in the publication of the CSTE/CDC Environmental Public Health Indicators in 2002. CDC continues to support work on environmental public health indicators by supporting state-based assessments of the published CSTE/CDC indicators through its National Environmental Public Health Tracking pilot projects; providing funding and participating in current State Environmental Public Health Indicators Collaborative (SEHIC) efforts; and providing technical assistance in evaluating the SEHIC process.

CDC and its state program partners for both asthma surveillance and environmental health tracking are actively engaged in the SEHIC effort. The work of SEHIC includes indicators and measures of (1) air quality; (2) asthma; and (3) drinking water provided a base for federal and state efforts to develop nationally consistent data and measures in CDC's National Environmental Public Health Tracking Network. This congressionally mandated effort is building a surveillance network that brings together information on environmental hazards, exposures, and environmentally-related health effects. It has also provided an opportunity for asthma grantees and tracking grantees to work together on some common issues.

Position Statement Response: 07-EH-01 (continued)

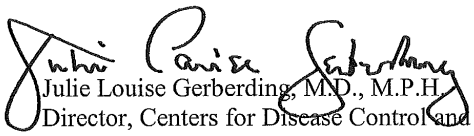
Committee: Occupational/Environmental Health

Title: Support for Continuity of Environmental Public Health Indicators Development

Page 2 - Patrick J. McConnon, M.P.H.

I hope this information is helpful and look forward to continuing to work with you on important environmental public health issues.

Sincerely,



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

2007 Position Statement Responses

Position Statement Response: 07-EH-02

Committee: Occupational/Environmental

Title: Occupational and Environmental Risks of Nanotechnology

U.S. Department of Labor

Assistant Secretary for
Occupational Safety and Health
Washington, D.C. 20210

AUG 27 2007

RECEIVED AUG 31 2007

Mr. Patrick J. McConnon, M.P.H
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

Thank you for your July 9, 2007, letter to the Occupational Safety and Health Administration (OSHA) concerning nanotechnology. Thank you also for enclosing a copy of your position statement entitled "Occupational and Environmental Risks of Nanotechnology."

Please be assured that OSHA is very interested in the issues regarding the potential health and safety concerns of nanotechnology. Several existing OSHA health standards are currently applicable to nanotechnology operations. These standards are: Hazard Communication, Respiratory Protection Program, Personal Protective Equipment, Laboratory Standard, and certain substance-specific standards and permissible exposure limits. These standards can be found in 29 Code of Federal Regulations (CFR) Part 1910.

In addition, OSHA is currently collecting and evaluating information on nanotechnology work processes and health and safety concerns, participating in a Federal Government inter-agency working group addressing safety, health, and risk issues, and planning guidance development.

OSHA is also working with the National Institute for Occupational Safety and Health (NIOSH) as a partner in the NIOSH Nanotechnology Research Center Surveillance Working Group for Occupational Health Surveillance for Nanotechnology Workers and in an Interagency Agreement on research on the potential use of "control banding" as a strategy to address employee exposures in nanotechnology workplaces.

Position Statement Response: 07-EH-02 (continued)

Committee: Occupational/Environmental

Title: Occupational and Environmental Risks of Nanotechnology

Thank you for your interest in occupational safety and health.

Sincerely,

Edwin G. Foulke, Jr.

2007 Position Statement Responses

Position Statement Response: 07-EH-02

Committee: Occupational/Environmental

Title: Occupational and Environmental Risks of Nanotechnology

Progress Report on the 2007 Position Statement, "Occupational and Environmental Risks of Nanotechnology"

Summary

Considerable research on the environmental, health and safety effects of nanotechnology is being conducted. According to the Project on Emerging Nanotechnologies (PEN) of the Woodrow Wilson International Center for Scholars, there are well over 500 such ongoing research projects.

The number of nanotechnology applications continues to grow dramatically. In 2007 the PEN counted something over 200 such products, and as of April 2008 the number was 609, an increase of 3-4 per week.

In the regulatory arena, very little progress has occurred at the national level in the U.S. In Europe, the European Union is considering revising its chemical regulatory regime (REACH – Regulation, Evaluation and Authorization of Chemicals) to specifically address nanomaterials.

Resolution Outcomes

The House of Representatives' Science and Technology Committee is currently considering a bill to re-authorize the National Nanotechnology Initiative (NNI), the program that coordinates research and development of nanomaterials at the federal level. The bill includes a provision requiring that 10% of the funds be designated for research on the environmental, health and safety of nanotechnology, up from the current expenditure of about 4%.

In the past year, the Environmental Protection Agency, contrary to the position of CSTE and that of several other public health and environmental organizations, ruled that it would not require manufacturers to submit "Pre-manufacture Notices" to the EPA when developing products using nanotechnology. OSHA, in responding to CSTE's position statement, gave no indication that it would consider issuing a standard to protect workers exposed to nanomaterials. No responses were received from either the Food and Drug Administration, any member of Congress, or any federal agency that funds nanotechnology research.

Recommended Further Action

CSTE should urge members of Congress to support the NNI re-authorization bill that designates 10% of funding for research on the environmental, health and safety effects of nanotechnology.

2007 Position Statement Responses

Position Statement Response: 07-EH-03

Committee: Environmental Health

Title: Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

AUG 24 2007

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

Thank you for your letter regarding the Council of State and Territorial Epidemiologists' (CSTE) position statement 07-EH-03 entitled "Updates to 1998 Case Definition for Acute Carbon Monoxide Poisoning Surveillance."

We are pleased that the case definition was adopted at CSTE's Annual Conference on June 28, 2007. The Centers for Disease Control and Prevention concurs with the CSTE authors of the proposed changes to the CSTE case definition for Carbon Monoxide (CO) Poisoning Surveillance. An updated case definition will aid in the surveillance of unique data sources such as Poison Control Center data, thus helping to elucidate potential risk factors for CO poisoning.

We hope this information is helpful and look forward to continued collaboration with CSTE.

Sincerely,

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

2007 Position Statement Responses

Position Statement Response: 07-ID-02

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

RECEIVED OCT 1 1 2007

OCT 5 2007

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

I am responding to your letter to Dr. Julie Louise Gerberding regarding the Council of State and Territorial Epidemiologists (CSTE) position statements that provide recommendations around surveillance and recommended changes in current case definitions of several conditions. Enclosed is the Centers for Disease Control and Prevention's (CDC) response to the following CSTE Position Statements:

07-ID-02, Revision of the Surveillance Case Definition for Mumps
07-ID-03, Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)
07-ID-04, Revision of the Surveillance Case Definition for Q fever
07-ID-05, Revision of Surveillance Case Definition for Rocky Mountain spotted fever
07-ID-08, Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formula
07-ID-09, Heterosexual HIV Transmission Classification
07-ID-10, Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months
07-ID-11, Revised National Surveillance Case Definition for Lyme disease
07-ID-12, Establishing Neonatal Herpes Surveillance
07-ID-13, Revision of the Surveillance Case Definition for Coccidioidomycosis
07-ID-14, Influenza-Associated Pediatric Mortality

I appreciate the opportunity to provide a response to CSTE's position statements and applaud your commitment to these important public health issues. We look forward to continued collaboration with CSTE regarding public health issues of mutual concern.

Sincerely,

Mitchell L. Cohen, M.D.
Director, Coordinating Center for
Infectious Diseases

2007 Position Statement Responses

Position Statement Response: 07-ID-02 (continued)

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

The Centers for Disease Control and Prevention's Comments
Regarding the
2007 Council of State and Territorial Epidemiologists'
Position Statements

CSTE Position Statement 07-ID-01
Title: National Reporting for Novel Influenza A Virus Infections"

CDC Comments:
None.

CSTE Position Statement 07-ID-02
Title: "Revision of the Surveillance Case Definition for Mumps"

CSTE recommends modified mumps case definition, case classifications and case classifications of import status for mumps.

CDC Comments:
CDC supports the CSTE recommendations and suggests the following:

- Clarification of the suspected case status by changing the word "testing" to "confirmation." The suspected case would then read "A case with clinically compatible illness or meets the clinical case definition without laboratory confirmation, or a case with laboratory tests suggestive of mumps without clinical information." This change would provide a clear classification for a single clinically compatible case with laboratory testing but without a positive test result.
- Addition of two sentences in the comment section to (1) clarify the meaning of "without laboratory confirmation" in the suspect case classification and to (2) clarify the intent of the term "confirmed case" in the confirmed case classification. Suggested wording for these additions: (1) In the suspect case classification, a case "without laboratory confirmation" would include those not tested as well as those tested but with negative results. (2) To be considered a confirmed case based on epidemiologic linkage, there must be a laboratory confirmed case in the chain of transmission."

CSTE Position Statement 07-ID-03
Title: "Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)"

CSTE recommends revision of the national surveillance case definition for Ehrlichiosis.

Position Statement Response: 07-ID-02 (continued)

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

CDC Comments:
CDC concurs with and fully supports the CSTE recommendation and would suggest a minor revision to the definition of a suspect case. CDC believes that a "Suspect" case should be defined as "A clinically compatible case but with no supportive laboratory results." As written, a suspect case is defined as having laboratory evidence without clinical information. Laboratory testing on asymptomatic (or non-clinically compatible) individuals is not warranted.

CSTE Position Statement 07-ID-04
Title: "Revision of the Surveillance Case Definition for Q fever"

CSTE recommends revision of the national surveillance case definition for Q Fever.

CDC Comments:
CDC concurs with and fully supports the CSTE recommendation and would suggest adding a definition of a suspect case. As written, the document does not include case definitions for acute or chronic Q fever. For consistency with the other rickettsial case definitions, it would be beneficial to extend the acute case definition for Q fever to include a "suspect case" category. The suggestion by CDC is to add a definition for a suspect case, "A clinically compatible case but with no supportive laboratory results."

CSTE Position Statement 07-ID-05
Title: "Revision of the National Surveillance Case Definition for Rocky Mountain spotted fever"

CSTE recommends revision of the national surveillance case definition for Rocky Mountain Spotted Fever.

CDC Comments:
CDC concurs with and fully supports the CSTE recommendation and would suggest a minor revision to the definition of a suspect case. CDC believes that a "Suspect" case should be defined as "A clinically compatible case but with no supportive laboratory results." As written, a suspect case is defined as having laboratory evidence without clinical information. Laboratory testing on asymptomatic (or non-clinically compatible) individuals is not warranted.

CSTE Position Statement 07-ID-08
Title: "Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas"

2007 Position Statement Responses

Position Statement Response: 07-ID-02 (continued)

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

CSTE recommends that HIV reporting by name is the most viable method for conducting HIV surveillance and deduplicating cases both within and between states. This ensures an equitable measure of HIV disease burden to be used as the basis for determining eligibility and allocating funds for care of HIV-infected persons and for other comparisons of HIV cases between reporting jurisdictions. This position statement reiterates that code based data should not be used as a part of formulas designed either for determining eligibility or for funding future HIV care programs.

CDC Comments:

1. CDC, in collaboration with CSTE, determine the most scientifically valid method for combining data from states that are in various stages of implementing name-based HIV reporting for the purposes of the formulas used to fund care programs.

CDC supports the CSTE recommendation that "CDC, in collaboration with CSTE, determine the most scientifically valid method for combining data from states that are in various stages of implementing name-based HIV reporting for the purposes of the formulas used to fund care programs." During 2007, CDC has worked closely with the Health Resources and Services Administration (HRSA) and HIV/AIDS surveillance coordinators to develop technical guidance for submission of code-based HIV data to HRSA for use in funding formulas. This guidance provides standard criteria for data submissions that enable code-based states to submit data comparable to that of name-based reporting areas, which CDC then submits to HRSA for formula allocations. As the remaining states transition to name-based HIV reporting, CDC will continue to work with HRSA and surveillance coordinators on these issues and provide necessary input as revisions to the formulas are considered.

2. Any future eligibility and funding formulas should include name-based reported cases living with HIV infection (including AIDS), confirmed by CDC, as the basis of the formula(s).

CDC concurs with and supports the CSTE recommendation that future eligibility and funding formulas include name-based reported cases living with HIV infection (including AIDS), as confirmed by CDC.

3. CSTE recommends that CDC should provide technical support to ensure and require that by September 30, 2009 all project areas (states, cities and territories) : a) de-duplicate their HIV/AIDS cases both inside their state as well as with jurisdictions outside of their state within six months of receiving their list of potential interstate duplicates from CDC and, b) perform a match with their state death registry at least annually. Following the death match, CDC should verify that the area uses the results of the match to update vital status of reported cases in the HIV/AIDS registry. They should assure that states have the necessary funding to perform these fundamental activities and should be able to assure and verify that these activities are taking place.

Position Statement Response: 07-ID-02 (continued)

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

CDC supports the CSTE recommendation that CDC provide technical support to ensure areas de-duplicate their HIV/AIDS cases and perform state death registry matches annually. Both de-duplication and death ascertainment activities are part of routine core HIV/AIDS surveillance activities funded under CDC HIV/AIDS Surveillance cooperative agreements. These ongoing activities are currently part of the process standards for evaluation activities outlined in the Technical Guidance for HIV/AIDS Surveillance. In addition, CDC is currently developing standard protocols and procedures for these activities, which it will work with state and local health departments to implement over the next 2 years. As part of these protocols, CDC will work with areas to develop standard report cards to assist with assessing area progress in implementing these activities. Finally, CDC plans to continue technical support for these activities; however, the provision of additional funding, beyond that which is currently available, cannot be guaranteed and will be provided if resources allow.

CSTE Position Statement 07-ID-09
Title: "Heterosexual HIV Transmission Classification"

CDC Comments:

CSTE recommends that:
1. CDC add the category "Presumed Heterosexual" contact (PHC) to the categories used to describe females with HIV infection (including AIDS).

CDC is concerned that recommendation #1, as defined in the CSTE position statement, does not make it clear that a "no" or "unknown" on risk factors other than injection drug use must be documented. Without such a stipulation, it is unclear how to ensure future reported cases are not less valid than those that are currently reported. As surveillance staff may be tempted to report PHC when they are unable to find any risk factor information for an HIV-infected female, PHC could easily become a default category if measures to guard against such practices are not in place.

2. Additional information be collected on female presumed heterosexual cases in areas for which this is feasible in order to better qualify and understand heterosexual HIV transmission. However, this information is not required for classification as presumed heterosexual transmission.

CDC is concerned that state and city surveillance programs will be distracted with collecting additional information, the utility of which is as yet undetermined. Specifically, how will surveillance areas be able to collect more information on behavioral risk factors when they cannot collect what is currently being asked of them? It is problematic to introduce more work when it is unclear who will collect the data sought; how it will be used; and whether such information will even be useful in light of the first recommendation.

2007 Position Statement Responses

Position Statement Response: 07-ID-02 (continued)

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

3. **CDC and CSTE convene one or more workgroups to:**

a. Select and standardize the data elements listed in recommendation #2 above;
b. Begin the process of changing the current hierarchical system to one that is nonhierarchical and allows for multiple categories of risk factor classification.

Recommendation #3a suggests a workgroup be formed to standardize the data elements for Recommendation #2. Rather than work on issues for supplemental variables that may have limited value to surveillance, CDC thinks that this workgroup should address the definition, as well as implementation and evaluation plans for introducing the new category. Addressing these concerns and issues will help clarify a way to proceed on this topic.

With respect to recommendation #3b, CDC is working on implementation of the exposure category variable to present multiple risk factor categories in a nonhierarchical way. In fact, this variable is already available in eHARS. However, timing of its full implementation will depend on the availability of internal resources.

c. Evaluate the impact of adding this presumed heterosexual category for females;

CDC supports convening a workgroup to develop a definition for a female presumed heterosexual contact category and draft evaluation and implementation plans for the new category. The implementation plan should consider necessary systems changes, training, dissemination, and hardware or software needs at all levels of implementation, as well as other items identified by the workgroup. CDC will convene a workgroup before the end of 2007 to address these three documents (definition, evaluation plan, and implementation plan); execution of the agreed upon plans will follow that meeting.

d. Explore the issues related to, and the feasibility of, creating a presumed heterosexual category for males.

The adoption of a male presumed heterosexual contact category is likely to be far more problematic than it is for females. Therefore, CDC does not think it is appropriate to explore issues related to creation of a male presumed heterosexual contact category until the issues with a female presumed heterosexual contact category have been addressed.

CSTE Position Statement 07-ID-10
Title: "Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months"

CSTE recommends that CDC adopt the revised definition for the presumptive uninfected category for HIV infection among children age <18 months.

CDC concurs with, and fully supports, the CSTE recommendation that CDC adopt the revised presumptive uninfected category for HIV infection among children age <18

Position Statement Response: 07-ID-02 (continued)

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

months. Accordingly, the revised case definition will be incorporated into *HIV Infection Among Children Aged <18 Months* and disseminated through official CDC publications (e.g., the *Morbidity and Mortality Weekly Report, Recommendations and Reports*).

To further ensure that all HIV/AIDS surveillance coordinators are aware of this revised definition for categorizing children age <18 months as presumptive uninfected, CDC will immediately implement the revised definition and will update data management software accordingly. The revised definition will then be used in the data analyses of all subsequent papers and presentations.

CSTE Position Statement 07-ID-11
Title: "Revised National Surveillance Case Definition for Lyme disease"

CSTE recommends that CDC revise the national surveillance case definition for Lyme disease.

CDC Comments:
CDC concurs with and fully supports CSTE's recommended revised surveillance case definition. The revised definition provides local and state health departments the flexibility to classify Lyme disease reports as confirmed, probable, or suspect and therefore more effectively capture the public health impact of Lyme disease. CDC expects that this will appreciably increase the number of cases tallied. Therefore, the result of this revision will be to increase the accuracy of reporting while decreasing the burden on state and local health departments.

CDC has worked closely with state health officials and CSTE on the adopted revisions to the Lyme disease surveillance case definition. It is our belief that the changes to Lyme disease reporting proposed by CSTE will result in surveillance that is more consistent, sustainable, accurate, and complete.

CSTE Position Statement 07-ID-12
Title: Establishing Neonatal Herpes Surveillance

CSTE recommends that CDC should convene an expert panel to include those states that currently have neonatal herpes as a reportable condition as well as those states that would like to consider making this a reportable condition, to develop a standard case definition for neonatal herpes surveillance that could be considered for use by those states.

CDC Comments:
CDC appreciates the opportunity to comment on CSTE's position statement on neonatal herpes surveillance. After having worked closely with CSTE on the meeting of the expert panel in March 2007 and attending the CSTE annual meeting in June 2007, at which this issue was discussed, we support a slightly different strategy to further this discussion. The expert panel in March did an excellent job of discussing the relevant

Position Statement Response: 07-ID-02 (continued)

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

issues and making its recommendations. Instead of convening the expert panel again or convening a second expert panel, CDC supports a process by which CDC and CSTE would approach a number of states that currently have neonatal herpes under surveillance or have an interest in putting it under surveillance to assess these states' interest in adopting the case definition that was developed by the March 2007 Expert Panel. CDC and CSTE would use the March 2007 Expert Panel as advisors for clarification and consultation, as needed, but would do so via phone, conference calls, and e-mail exchanges. Implementing this strategy would assist those states in which neonatal herpes is reportable to improve their surveillance and the quality of their data. Improved data could be a basis for CSTE decision-making on future actions or position statement development.

CSTE Position Statement 07-ID-13
Title: Revision of the Surveillance Case Definition for Coccidioidomycosis

CSTE recommends adoption of the new surveillance case definition for coccidioidomycosis, as presented in Appendix A. In conjunction with this new case definition, CSTE also recommends that state and/or local health departments performing surveillance for coccidioidomycosis have procedures for removing duplicate case-patients, reported within the previous five years.

CDC Comments: CDC is in the process of developing an implementation plan for the revision to the coccidioidomycosis surveillance case definition and any other related changes. The new case definition will be implemented by January 2008.

CSTE Position Statement 07-ID-14
Title: 07-ID-14, Influenza-Associated Pediatric Mortality

CSTE recommends that influenza-associated pediatric death should be maintained on the national reportable disease list and placed under surveillance through the National Notifiable Diseases Surveillance System (NNDSS).

CDC Comments:
CDC supports the continued inclusion of influenza-associated pediatric mortality in the NNDSS and we will work toward integrating the variables needed for this condition into the National Electronic Disease Surveillance System.

Position Statement Response: 07-ID-02 (continued)

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

months. Accordingly, the revised case definition will be incorporated into *HIV Infection Among Children Aged <18 Months* and disseminated through official CDC publications (e.g., the *Morbidity and Mortality Weekly Report, Recommendations and Reports*).

To further ensure that all HIV/AIDS surveillance coordinators are aware of this revised definition for categorizing children age <18 months as presumptive uninfected, CDC will immediately implement the revised definition and will update data management software accordingly. The revised definition will then be used in the data analyses of all subsequent papers and presentations.

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Title: "Revised National Surveillance Case Definition for Lyme disease"

CSTE recommends that CDC revise the national surveillance case definition for Lyme disease.

CDC Comments:
CDC concurs with and fully supports CSTE's recommended revised surveillance case definition. The revised definition provides local and state health departments the flexibility to classify Lyme disease reports as confirmed, probable, or suspect and therefore more effectively capture the public health impact of Lyme disease. CDC expects that this will appreciably increase the number of cases tallied. Therefore, the result of this revision will be to increase the accuracy of reporting while decreasing the burden on state and local health departments.

CDC has worked closely with state health officials and CSTE on the adopted revisions to the Lyme disease surveillance case definition. It is our belief that the changes to Lyme disease reporting proposed by CSTE will result in surveillance that is more consistent, sustainable, accurate, and complete.

CSTE Position Statement 07-ID-12
Title: Establishing Neonatal Herpes Surveillance

CSTE recommends that CDC should convene an expert panel to include those states that currently have neonatal herpes as a reportable condition as well as those states that would like to consider making this a reportable condition, to develop a standard case definition for neonatal herpes surveillance that could be considered for use by those states.

CDC Comments:
CDC appreciates the opportunity to comment on CSTE's position statement on neonatal herpes surveillance. After having worked closely with CSTE on the meeting of the expert panel in March 2007 and attending the CSTE annual meeting in June 2007, at which this issue was discussed, we support a slightly different strategy to further this discussion. The expert panel in March did an excellent job of discussing the relevant

Position Statement Response: 07-ID-02 (continued)

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Mumps

issues and making its recommendations. Instead of convening the expert panel again or convening a second expert panel, CDC supports a process by which CDC and CSTE would approach a number of states that currently have neonatal herpes under surveillance or have an interest in putting it under surveillance to assess these states' interest in adopting the case definition that was developed by the March 2007 Expert Panel. CDC and CSTE would use the March 2007 Expert Panel as advisors for clarification and consultation, as needed, but would do so via phone, conference calls, and e-mail exchanges. Implementing this strategy would assist those states in which neonatal herpes is reportable to improve their surveillance and the quality of their data. Improved data could be a basis for CSTE decision-making on future actions or position statement development.

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CSTE recommends adoption of the new surveillance case definition for coccidioidomycosis, as presented in Appendix A. In conjunction with this new case definition, CSTE also recommends that state and/or local health departments performing surveillance for coccidioidomycosis have procedures for removing duplicate case-patients, reported within the previous five years.

CDC Comments: CDC is in the process of developing an implementation plan for the revision to the coccidioidomycosis surveillance case definition and any other related changes. The new case definition will be implemented by January 2008.

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Title: 07-ID-14, Influenza-Associated Pediatric Mortality

CSTE recommends that influenza-associated pediatric death should be maintained on the national reportable disease list and placed under surveillance through the National Notifiable Diseases Surveillance System (NNDSS).

CDC Comments:
CDC supports the continued inclusion of influenza-associated pediatric mortality in the NNDSS and we will work toward integrating the variables needed for this condition into the National Electronic Disease Surveillance System.

2007 Position Statement Responses

Position Statement Response: 07-ID-04

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

RECEIVED DEC 3 2007

November 26, 2007

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

I am following up on my letter to you dated October 5, 2007, regarding the Centers for Disease Control and Prevention's (CDC) response to the Council of State and Territorial Epidemiologists (CSTE) position statements providing recommended changes in current case definitions of several conditions.

After further review, enclosed are recommend amendments to our earlier comments on three of the CSTE position statements:

07-ID-03, Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)
07-ID-04, Revision of the Surveillance Case Definition for Q fever
07-ID-05, Revision of the Surveillance Case Definition for Rocky Mountain spotted fever

I appreciate the opportunity to update our response to CSTE's position statements. We look forward to continued collaboration with CSTE regarding these important zoonotic diseases and other public health issues of mutual concern.

Sincerely,

Mitchell L. Cohen, M.D.
Director, Coordinating Center for
Infectious Diseases

2007 Position Statement Responses

Position Statement Response: 07-ID-04 (continued)

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

The Centers for Disease Control and Prevention's Revised Comments Regarding the 2007 Council of State and Territorial Epidemiologists' Position Statements 07-ID-03, 07-ID-04, and 07-ID-05

The current comments replace those previously provided by CDC on October 5, 2007 for the following CSTE Position Statements:

CSTE Position Statement 07-ID-03
Title: Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)

CSTE recommends revision of the national surveillance case definition for Ehrlichiosis.

New CDC Comments: CDC concurs with and fully supports the CSTE recommendation.

CSTE Position Statement 07-ID-04
Title: Revision of the National Surveillance Case Definition for Q fever

CSTE recommends revision of the national surveillance case definition for Q fever.

New CDC Comments: CDC concurs with and fully supports the CSTE recommendation. If CSTE desires a case definition consistent with other rickettsial diseases, they may consider adding a suspect case definition that is similar to that for Rocky Mountain spotted fever and ehrlichiosis (i.e. laboratory evidence in the absence of clinical information).

CSTE Position Statement 07-ID-05
Title: Revision of the National Surveillance Case Definition for Rocky Mountain spotted fever

CSTE recommends revision of the national surveillance case definition for Rocky Mountain spotted fever.

New CDC Comments: CDC concurs with and fully supports the CSTE recommendation.

2007 Position Statement Responses

Position Statement Response: 07-ID-05

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Rocky Mountain spotted fever

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

RECEIVED DEC 3 2007

November 26, 2007

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Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

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After further review, enclosed are recommend amendments to our earlier comments on three of the CSTE position statements:

07-ID-03, Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)
07-ID-04, Revision of the Surveillance Case Definition for Q fever
07-ID-05, Revision of the Surveillance Case Definition for Rocky Mountain spotted fever

I appreciate the opportunity to update our response to CSTE's position statements. We look forward to continued collaboration with CSTE regarding these important zoonotic diseases and other public health issues of mutual concern.

Sincerely,

Mitchell L. Cohen, M.D.
Director, Coordinating Center for
Infectious Diseases

2007 Position Statement Responses

Position Statement Response: 07-ID-05 (continued)

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Rocky Mountain spotted fever

The Centers for Disease Control and Prevention's Revised Comments Regarding the 2007 Council of State and Territorial Epidemiologists' Position Statements 07-ID-03, 07-ID-04, and 07-ID-05

The current comments replace those previously provided by CDC on October 5, 2007 for the following CSTE Position Statements:

CSTE Position Statement 07-ID-03
Title: Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)

CSTE recommends revision of the national surveillance case definition for Ehrlichiosis.

New CDC Comments: CDC concurs with and fully supports the CSTE recommendation.

CSTE Position Statement 07-ID-04
Title: Revision of the National Surveillance Case Definition for Q fever

CSTE recommends revision of the national surveillance case definition for Q fever.

New CDC Comments: CDC concurs with and fully supports the CSTE recommendation. If CSTE desires a case definition consistent with other rickettsial diseases, they may consider adding a suspect case definition that is similar to that for Rocky Mountain spotted fever and ehrlichiosis (i.e. laboratory evidence in the absence of clinical information).

CSTE Position Statement 07-ID-05
Title: Revision of the National Surveillance Case Definition for Rocky Mountain spotted fever

CSTE recommends revision of the national surveillance case definition for Rocky Mountain spotted fever.

New CDC Comments: CDC concurs with and fully supports the CSTE recommendation.

2007 Position Statement Responses

Position Statement Response: 07-ID-06

Committee: Infectious Disease

Title: Events that May Constitute a Public Health Emergency of International Concern

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

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OCT 1 8 2007

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2875 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

Thank you very much for your letter informing us that the Council of State and Territorial Epidemiologist (CSTE) approved position statement 07-ID-06 entitled "Events that May Constitute a Public Health Emergency of International Concern" at your Annual Conference held during the week of June 28, 2007. Please excuse the delay of this response.

The Centers for Disease Control and Prevention's (CDC) National Center for Public Health Informatics, Division of Integrated Surveillance Systems and Services (DISSS) and CDC's Acting Interim Governance Council for the implementation of the revised International Health Regulations (IHR) enthusiastically support this position statement. We interpret this policy statement to indicate CSTE's intent to work with CDC to implement the revised IHR. This collaboration is critical to ensure successful implementation of these new international legal requirements.

Position statement 07-ID-06 lists three statements of desired actions. The remainder of this letter will summarize each of these statements and describe how CDC plans to address each of these issues:

- The first statement of desired action calls for CDC to work with stakeholders, including CSTE, to develop criteria and processes for states and territories to use for contacting CDC regarding events that may constitute a public health emergency of international concern (PHEIC). In addition, this statement calls for CDC to evaluate reported events using the IHR decision instrument in Annex 2 of the IHR (2005).

  CDC is in the process of establishing an internal PHEIC Analysis Team tasked with the responsibility to receive and assess whether reported events meet the criteria for notification to the World Health Organization (WHO). The Secretary's Operations Center of the Department of Health and Human Services (HHS) is responsible for reporting events within the United States and its territories to WHO. Processes have been established for reporting events from CDC to HHS and then from HHS to WHO.

Position Statement Response: 07-ID-06 (continued)

Committee: Infectious Disease

Title: Events that May Constitute a Public Health Emergency of International Concern

Page 2 - Patrick J. McConnon, M.P.H.

The CDC Acting Interim Governance Council has studied how information about a potential PHEIC may reach CDC through formal and informal information mechanisms and how this information should be channeled to the CDC PHEIC Analysis Team. These information mechanisms include reports through Epi-X, public inquiries (via mail, e-mail, or telephone calls), CDC Info, public health surveillance systems, calls to internal CDC staff, data mining of online and print media, as well as other sources. To successfully implement the revised IHR, it will be crucial for us to assess all potential sources of information about potential PHEIC.

We are interested in collaborating with CSTE on a number of activities, including but not limited to: (1) development of guidance for the interpretation of the decision algorithm in Annex 2 for use at the local, county, or state public health level; (2) adding viral hemorrhagic fevers to the list of nationally notifiable diseases; and (3) developing case studies for the IHR and pilot testing to determine if the guidance for the interpretation of Annex 2 helps to support identification of events about which CDC should be notified. We hope that representatives from CSTE's Infectious Disease Committee, Surveillance Coordination Group, and other relevant committees will collaborate with us on these activities.

- The second statement of desired action recommends that U.S. States and territories report any cases, including suspected cases, of the following conditions to CDC as events that may constitute a PHEIC, using CDC-CSTE national surveillance case definitions: smallpox, poliomyelitis due to wild-type poliovirus, human influenza caused by a new subtype, and severe acute respiratory syndrome (SARS). In addition, this statement of desired action indicates these conditions should be reported to CDC as soon as feasible through existing reporting mechanisms, including NEDSS-compatible systems and CDC's Director's Emergency Operations Center at (770) 488-7100 or eocreport@cdc.gov.

  We agree with this statement of action. It is imperative for CDC to learn as quickly as possible of any events that may constitute a PHEIC. Since the timeliness of existing public health surveillance systems are not currently near real-time, we would encourage U.S. States and territories to contact CDC's Director's Emergency Operations Center as quickly as possible to report or discuss an event.

  Staff from CDC's National Notifiable Diseases Surveillance System (NNDSS) will publish the CSTE-approved revised case definition for initial detections of novel influenza A virus infections (as per CSTE position statement 07-ID-01) on the NNDSS case definitions website and will send a letter to all U.S. State and territorial epidemiologists reminding them of this and other case definition revisions to the nationally notifiable diseases list.

Position Statement Response: 07-ID-06 (continued)

Committee: Infectious Disease

Title: Events that May Constitute a Public Health Emergency of International Concern

- The third statement of desired action indicates CDC and CSTE should review finalized WHO case definitions (for SARS, smallpox, human influenza caused by a new subtype, and poliomyelitis due to wild-type poliovirus) to ascertain whether the current CDC-CSTE case definitions should be revised to align with the WHO case definitions.

  WHO has agreed to send DISSS their finalized case definitions. DISSS will, in turn, share the finalized WHO case definitions with CSTE when they are available and will work with CSTE and CDC Subject Matter Experts to perform a case definition comparison to assess whether changes to the CDC-CSTE national case definitions are warranted to better align with WHO finalized case definitions.

CDC and CSTE share a long history of collaboration on important public health issues. We look forward to continuing our work with you on the revised IHR, NNDSS, and issues involving the integration and interoperability of public health surveillance systems.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director

2007 Position Statement Responses

Position Statement Response: 07-ID-07

Committee: Infectious Disease

Title: Enhancing Disease Control for Cruise Ship Travel

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

RECEIVED SEP 7 2007

SEP 5 2007

Patrick J. McConnon, M.P.H.
Executive Director
2872 Woodstock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

Thank you for forwarding the Council of State and Territorial Epidemiologists' (CSTE) position statement "Enhancing Disease Control for Cruise Ship Travel" for a Centers for Disease Control and Prevention (CDC) response. Addressing public health concerns associated with cruise travel is an essential component of CDC's responsibility to prevent the importation and spread of communicable diseases in the United States. To that end, we support the CSTE resolution and greatly value the opportunity it offers to foster collaboration with CSTE, state and local health departments, and the cruise ship industry in this important public health endeavor.

As you know, Section 361 of the Public Health Service (PHS) Act (42 USC 264) authorizes the Secretary of Health and Human Services to make and enforce regulations necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the United States. Under its delegated authority, CDC's Division of Global Migration and Quarantine (DGMQ) works to fulfill this responsibility through a variety of activities, including the operation of quarantine stations at ports of entry and the administration of interstate and foreign quarantine regulations. Under these regulations, 42 CFR (Code of Federal Regulations) Parts 70 and 71, CDC's quarantine stations and the CDC Vessel Sanitation Program (VSP) carry out surveillance and inspections aboard cruise ships and implement control measures based on the best available scientific evidence and the feasibility of implementing the measures. DGMQ's work requires consultation and collaboration with state and local public health departments, port agencies, and the transportation industry. CSTE's resolution promises to foster and enhance these productive collaborations and further improve the quality of our response to public health concerns on international cruise ships as well as other modes of transportation.

Through our ongoing public health activities on international cruise ships at U.S ports, CDC recognizes the importance of providing consistent, evidence-based public guidance to cruise lines and travelers on preventing and managing communicable diseases. For this reason, several programs within CDC, such as DGMQ and VSP, supported the development of CSTE's resolution. We are grateful to CSTE for introducing this resolution and for convening a workgroup of all the stakeholders to develop public health guidance for cruise ships, their passengers, and crew members. CDC looks forward to the opportunity to participate in this workgroup and write recommendations that will prevent the introduction and spread of communicable diseases in the United States.

Position Statement Response: 07-ID-07 (continued)

Committee: Infectious Disease

Title: Enhancing Disease Control for Cruise Ship Travel

Page 2 – Patrick J. McConnon, M.P.H.

CDC has already made progress in some areas mentioned in the resolution's statement of desired action.

- CDC is continuing to expand and enhance the Quarantine and Migration Health System by increasing CDC's physical presence at U.S. ports of entry and by working to staff each station with a multidisciplinary team of quarantine officers. As part of this process, CDC quarantine stations have been building and expanding partnership activities with state and local health departments, as well as the conveyance industry and other port partners, to prepare for a better-coordinated response to public health threats.
- DGMQ has a travelers' health section on its website that provides guidance on cruise travel and specific destinations: http://wwwn.cdc.gov/travel/yellowBookCh7-CruiseShip.aspx. I am pleased that the resolution proposes to make such guidance more widely available to the public via state and local health departments, as well as travel industry websites.
- DGMQ is also working to develop Standard Operating Procedures for investigating and managing communicable diseases, such as vaccine-preventable diseases and tuberculosis, on maritime modes of transportation. The CSTE-convened workgroup will help gather important input from the stakeholders.
- VSP has provided guidance to prevent gastrointestinal illnesses on cruise ships and regularly updates public and state and local health departments on outbreaks of gastrointestinal illness on cruise ships bound for U.S. ports (http://www.cdc.gov/nceh/vsp).

Again, thank you for sharing CSTE's resolution. Although we have made some progress in addressing this issue, CDC recognizes that much work still lies ahead. We look forward to continued collaboration with CSTE on these efforts.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director

2007 Position Statement Responses

Position Statement Response: 07-ID-08

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville MD 20857

SEP 6 2007

Mr. Patrick J. McConnon
Council of State and Territorial
Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341

Dear Mr. McConnon:

Thank you for the opportunity to respond to the Council of State and Territorial Epidemiologists' (CSTE) position paper on the "Use of HIV/AIDS surveillance data in the future Ryan White HIV/AIDS Treatment Modernization Act funding formula." The Health Resources and Services Administration (HRSA) applauds the efforts of the CSTE to take on this task to ensure that data used for determining grant funding to areas impacted by HIV/AIDS is based on scientifically valid methodologies.

The decision of what data are used for the eligibility and funding formulas does not rest with HRSA; this decision is outlined in the legislation and HRSA is mandated to follow these requirements.

Thank you for your commitment to promoting the effective use of epidemiologic data to guide public health practice and improve health, especially for people living with HIV/AIDS.

Sincerely,

Elizabeth M. Duke

Elizabeth M. Duke
Administrator

Position Statement Response: 07-ID-08 (continued)

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

RECEIVED OCT 1 1 2007

OCT 5 2007

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

I am responding to your letter to Dr. Julie Louise Gerberding regarding the Council of State and Territorial Epidemiologists (CSTE) position statements that provide recommendations around surveillance and recommended changes in current case definitions of several conditions. Enclosed is the Centers for Disease Control and Prevention's (CDC) response to the following CSTE Position Statements:

07-ID-02, Revision of the Surveillance Case Definition for Mumps
07-ID-03, Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)
07-ID-04, Revision of the Surveillance Case Definition for Q fever
07-ID-05, Revision of Surveillance Case Definition for Rocky Mountain spotted fever
07-ID-08, Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formula
07-ID-09, Heterosexual HIV Transmission Classification
07-ID-10, Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months
07-ID-11, Revised National Surveillance Case Definition for Lyme disease
07-ID-12, Establishing Neonatal Herpes Surveillance
07-ID-13, Revision of the Surveillance Case Definition for Coccidioidomycosis
07-ID-14, Influenza-Associated Pediatric Mortality

I appreciate the opportunity to provide a response to CSTE's position statements and applaud your commitment to these important public health issues. We look forward to continued collaboration with CSTE regarding public health issues of mutual concern.

Sincerely,

Mitchell L. Cohen, M.D.
Director, Coordinating Center for
Infectious Diseases

2007 Position Statement Responses

Position Statement Response: 07-ID-08 (continued)

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

The Centers for Disease Control and Prevention's Comments
Regarding the
2007 Council of State and Territorial Epidemiologists'
Position Statements

CSTE Position Statement 07-ID-01
Title: National Reporting for Novel Influenza A Virus Infections"

CDC Comments:
None.

CSTE Position Statement 07-ID-02
Title: "Revision of the Surveillance Case Definition for Mumps"

CSTE recommends modified mumps case definition, case classifications and case classifications of import status for mumps.

CDC Comments:
CDC supports the CSTE recommendations and suggests the following:

- Clarification of the suspected case status by changing the word "testing" to "confirmation." The suspected case would then read "A case with clinically compatible illness or meets the clinical case definition without laboratory confirmation, or a case with laboratory tests suggestive of mumps without clinical information." This change would provide a clear classification for a single clinically compatible case with laboratory testing but without a positive test result.
- Addition of two sentences in the comment section to (1) clarify the meaning of "without laboratory confirmation" in the suspect case classification and to (2) clarify the intent of the term "confirmed case" in the confirmed case classification. Suggested wording for these additions: (1) In the suspect case classification, a case "without laboratory confirmation" would include those not tested as well as those tested but with negative results. (2) To be considered a confirmed case based on epidemiologic linkage, there must be a laboratory confirmed case in the chain of transmission."

CSTE Position Statement 07-ID-03
Title: "Revision of the National Surveillance Case Definition for Ehrlichiosis (Ehrlichiosis/Anaplasmosis)"

CSTE recommends revision of the national surveillance case definition for Ehrlichiosis.

Position Statement Response: 07-ID-08 (continued)

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

CDC Comments:
CDC concurs with and fully supports the CSTE recommendation and would suggest a minor revision to the definition of a suspect case. CDC believes that a "Suspect" case should be defined as "A clinically compatible case but with no supportive laboratory results." As written, a suspect case is defined as having laboratory evidence without clinical information. Laboratory testing on asymptomatic (or non-clinically compatible) individuals is not warranted.

CSTE Position Statement 07-ID-04
Title: "Revision of the Surveillance Case Definition for Q fever"

CSTE recommends revision of the national surveillance case definition for Q Fever.

CDC Comments:
CDC concurs with and fully supports the CSTE recommendation and would suggest adding a definition of a suspect case. As written, the document does not include case definitions for acute or chronic Q fever. For consistency with the other rickettsial case definitions, it would be beneficial to extend the acute case definition for Q fever to include a "suspect case" category. The suggestion by CDC is to add a definition for a suspect case, "A clinically compatible case but with no supportive laboratory results."

CSTE Position Statement 07-ID-05
Title: "Revision of the National Surveillance Case Definition for Rocky Mountain spotted fever"

CSTE recommends revision of the national surveillance case definition for Rocky Mountain Spotted Fever.

CDC Comments:
CDC concurs with and fully supports the CSTE recommendation and would suggest a minor revision to the definition of a suspect case. CDC believes that a "Suspect" case should be defined as "A clinically compatible case but with no supportive laboratory results." As written, a suspect case is defined as having laboratory evidence without clinical information. Laboratory testing on asymptomatic (or non-clinically compatible) individuals is not warranted.

CSTE Position Statement 07-ID-08
Title: "Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas"

Position Statement Response: 07-ID-08 (continued)

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

CSTE recommends that HIV reporting by name is the most viable method for conducting HIV surveillance and deduplicating cases both within and between states. This ensures an equitable measure of HIV disease burden to be used as the basis for determining eligibility and allocating funds for care of HIV-infected persons and for other comparisons of HIV cases between reporting jurisdictions. This position statement reiterates that code based data should not be used as a part of formulas designed either for determining eligibility or for funding future HIV care programs.

CDC Comments:

1. CDC, in collaboration with CSTE, determine the most scientifically valid method for combining data from states that are in various stages of implementing name-based HIV reporting for the purposes of the formulas used to fund care programs.

CDC supports the CSTE recommendation that "CDC, in collaboration with CSTE, determine the most scientifically valid method for combining data from states that are in various stages of implementing name-based HIV reporting for the purposes of the formulas used to fund care programs." During 2007, CDC has worked closely with the Health Resources and Services Administration (HRSA) and HIV/AIDS surveillance coordinators to develop technical guidance for submission of code-based HIV data to HRSA for use in funding formulas. This guidance provides standard criteria for data submissions that enable code-based states to submit data comparable to that of name-based reporting areas, which CDC then submits to HRSA for formula allocations. As the remaining states transition to name-based HIV reporting, CDC will continue to work with HRSA and surveillance coordinators on these issues and provide necessary input as revisions to the formulas are considered.

2. Any future eligibility and funding formulas should include name-based reported cases living with HIV infection (including AIDS), confirmed by CDC, as the basis of the formula(s).

CDC concurs with and supports the CSTE recommendation that future eligibility and funding formulas include name-based reported cases living with HIV infection (including AIDS), as confirmed by CDC.

3. CSTE recommends that CDC should provide technical support to ensure and require that by September 30, 2009 all project areas (states, cities and territories) : a) de-duplicate their HIV/AIDS cases both inside their state as well as with jurisdictions outside of their state within six months of receiving their list of potential interstate duplicates from CDC and, b) perform a match with their state death registry at least annually. Following the death match, CDC should verify that the area uses the results of the match to update vital status of reported cases in the HIV/AIDS registry. They should assure that states have the necessary funding to perform these fundamental activities and should be able to assure and verify that these activities are taking place.

Position Statement Response: 07-ID-08 (continued)

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

CDC supports the CSTE recommendation that CDC provide technical support to ensure areas de-duplicate their HIV/AIDS cases and perform state death registry matches annually. Both de-duplication and death ascertainment activities are part of routine core HIV/AIDS surveillance activities funded under CDC HIV/AIDS Surveillance cooperative agreements. These ongoing activities are currently part of the process standards for evaluation activities outlined in the Technical Guidance for HIV/AIDS Surveillance. In addition, CDC is currently developing standard protocols and procedures for these activities, which it will work with state and local health departments to implement over the next 2 years. As part of these protocols, CDC will work with areas to develop standard report cards to assist with assessing area progress in implementing these activities. Finally, CDC plans to continue technical support for these activities; however, the provision of additional funding, beyond that which is currently available, cannot be guaranteed and will be provided if resources allow.

CSTE Position Statement 07-ID-09
Title: "Heterosexual HIV Transmission Classification"

CDC Comments:

CSTE recommends that:
1. CDC add the category "Presumed Heterosexual" contact (PHC) to the categories used to describe females with HIV infection (including AIDS).

CDC is concerned that recommendation #1, as defined in the CSTE position statement, does not make it clear that a "no" or "unknown" on risk factors other than injection drug use must be documented. Without such a stipulation, it is unclear how to ensure future reported cases are not less valid than those that are currently reported. As surveillance staff may be tempted to report PHC when they are unable to find any risk factor information for an HIV-infected female, PHC could easily become a default category if measures to guard against such practices are not in place.

2. Additional information be collected on female presumed heterosexual cases in areas for which this is feasible in order to better qualify and understand heterosexual HIV transmission. However, this information is not required for classification as presumed heterosexual transmission.

CDC is concerned that state and city surveillance programs will be distracted with collecting additional information, the utility of which is as yet undetermined. Specifically, how will surveillance areas be able to collect more information on behavioral risk factors when they cannot collect what is currently being asked of them? It is problematic to introduce more work when it is unclear who will collect the data sought; how it will be used; and whether such information will even be useful in light of the first recommendation.

Position Statement Response: 07-ID-08 (continued)

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

3. CDC and CSTE convene one or more workgroups to:

a. Select and standardize the data elements listed in recommendation #2 above;
b. Begin the process of changing the current hierarchical system to one that is nonhierarchical and allows for multiple categories of risk factor classification.

Recommendation #3a suggests a workgroup be formed to standardize the data elements for Recommendation #2. Rather than work on issues for supplemental variables that may have limited value to surveillance, CDC thinks that this workgroup should address the definition, as well as implementation and evaluation plans for introducing the new category. Addressing these concerns and issues will help clarify a way to proceed on this topic.

With respect to recommendation #3b, CDC is working on implementation of the exposure category variable to present multiple risk factor categories in a nonhierarchical way. In fact, this variable is already available in eHARS. However, timing of its full implementation will depend on the availability of internal resources.

c. Evaluate the impact of adding this presumed heterosexual category for females;

CDC supports convening a workgroup to develop a definition for a female presumed heterosexual contact category and draft evaluation and implementation plans for the new category. The implementation plan should consider necessary systems changes, training, dissemination, and hardware or software needs at all levels of implementation, as well as other items identified by the workgroup. CDC will convene a workgroup before the end of 2007 to address these three documents (definition, evaluation plan, and implementation plan); execution of the agreed upon plans will follow that meeting.

d. Explore the issues related to, and the feasibility of, creating a presumed heterosexual category for males.

The adoption of a male presumed heterosexual contact category is likely to be far more problematic than it is for females. Therefore, CDC does not think it is appropriate to explore issues related to creation of a male presumed heterosexual contact category until the issues with a female presumed heterosexual contact category have been addressed.

CSTE Position Statement 07-ID-10
Title: "Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among Children age < 18 months"

CSTE recommends that CDC adopt the revised definition for the presumptive uninfected category for HIV infection among children age <18 months.

CDC concurs with, and fully supports, the CSTE recommendation that CDC adopt the revised presumptive uninfected category for HIV infection among children age <18

Position Statement Response: 07-ID-08 (continued)

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

months. Accordingly, the revised case definition will be incorporated into *HIV Infection Among Children Aged <18 Months* and disseminated through official CDC publications (e.g., the *Morbidity and Mortality Weekly Report, Recommendations and Reports*).

To further ensure that all HIV/AIDS surveillance coordinators are aware of this revised definition for categorizing children age <18 months as presumptive uninfected, CDC will immediately implement the revised definition and will update data management software accordingly. The revised definition will then be used in the data analyses of all subsequent papers and presentations.

CSTE Position Statement 07-ID-11
Title: "Revised National Surveillance Case Definition for Lyme disease"

CSTE recommends that CDC revise the national surveillance case definition for Lyme disease.

CDC Comments:
CDC concurs with and fully supports CSTE's recommended revised surveillance case definition. The revised definition provides local and state health departments the flexibility to classify Lyme disease reports as confirmed, probable, or suspect and therefore more effectively capture the public health impact of Lyme disease. CDC expects that this will appreciably increase the number of cases tallied. Therefore, the result of this revision will be to increase the accuracy of reporting while decreasing the burden on state and local health departments.

CDC has worked closely with state health officials and CSTE on the adopted revisions to the Lyme disease surveillance case definition. It is our belief that the changes to Lyme disease reporting proposed by CSTE will result in surveillance that is more consistent, sustainable, accurate, and complete.

CSTE Position Statement 07-ID-12
Title: Establishing Neonatal Herpes Surveillance

CSTE recommends that CDC should convene an expert panel to include those states that currently have neonatal herpes as a reportable condition as well as those states that would like to consider making this a reportable condition, to develop a standard case definition for neonatal herpes surveillance that could be considered for use by those states.

CDC Comments:
CDC appreciates the opportunity to comment on CSTE's position statement on neonatal herpes surveillance. After having worked closely with CSTE on the meeting of the expert panel in March 2007 and attending the CSTE annual meeting in June 2007, at which this issue was discussed, we support a slightly different strategy to further this discussion. The expert panel in March did an excellent job of discussing the relevant

2007 Position Statement Responses

Position Statement Response: 07-ID-08 (continued)

Committee: Infectious Disease

Title: Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment Modernization Act funding formulas

issues and making its recommendations. Instead of convening the expert panel again or convening a second expert panel, CDC supports a process by which CDC and CSTE would approach a number of states that currently have neonatal herpes under surveillance or have an interest in putting it under surveillance to assess these states' interest in adopting the case definition that was developed by the March 2007 Expert Panel. CDC and CSTE would use the March 2007 Expert Panel as advisors for clarification and consultation, as needed, but would do so via phone, conference calls, and e-mail exchanges. Implementing this strategy would assist those states in which neonatal herpes is reportable to improve their surveillance and the quality of their data. Improved data could be a basis for CSTE decision-making on future actions or position statement development.

CSTE Position Statement 07-ID-13
Title: Revision of the Surveillance Case Definition for Coccidioidomycosis

CSTE recommends adoption of the new surveillance case definition for coccidioidomycosis, as presented in Appendix A. In conjunction with this new case definition, CSTE also recommends that state and/or local health departments performing surveillance for coccidioidomycosis have procedures for removing duplicate case-patients, reported within the previous five years.

CDC Comments: CDC is in the process of developing an implementation plan for the revision to the coccidioidomycosis surveillance case definition and any other related changes. The new case definition will be implemented by January 2008.

CSTE Position Statement 07-ID-14
Title: 07-ID-14, Influenza-Associated Pediatric Mortality

CSTE recommends that influenza-associated pediatric death should be maintained on the national reportable disease list and placed under surveillance through the National Notifiable Diseases Surveillance System (NNDSS).

CDC Comments:
CDC supports the continued inclusion of influenza-associated pediatric mortality in the NNDSS and we will work toward integrating the variables needed for this condition into the National Electronic Disease Surveillance System.

2007 Position Statement Responses

Position Statement Response: 07-INJ-01

Committee: ENV/OH/INJ

Title: Improving External Cause Coding in Hospital Discharge Data

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

RECEIVED SEP 13 2007

SEP 10 2007

Patrick McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

Thank you for your letter regarding the Council of State and Territorial Epidemiologists (CSTE) position statement entitled "Improving External Cause Coding in Hospital Discharge Data." The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) and the National Center for Injury Prevention and Control (NCIPC) are very pleased to assume a leadership role in promoting the improvement of external cause coding in hospital discharge and emergency room data. As you know, inadequate external cause coding of hospital discharge data has been a long-standing problem that is seriously limiting injury surveillance efforts. In addition to lack of coding of injury records, as documented in the position statement, the high frequency of unspecified codes is a serious problem.

The Workgroup for External Cause Coding Improvement (WECCI) includes injury data experts from CDC's NCIPC and NCHS. In addition to discussing the CSTE statement, these Centers, along with WECCI and other external injury experts, are working together to prepare a report that provides recommendations for practical strategies for improving E-coding.

The *Morbidity and Mortality Weekly Report (MMWR)* office has approved the preparation of a Reports and Recommendations (*R&R*) article. The *MMWR R&R* is an appropriate publication because it will reach the intended audience of national and state public health professionals, policymakers, professional organizations, insurance industry, and nonprofit organizations who focus on injury and violence prevention. The *R&R* will address the current status of external cause coding in the states; challenges to improving external cause of injury coding; benefits of external-cause-coded data; and recommended strategies for improving coding.

In addition, we plan to work with other federal agencies affected by this issue such as the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the National Highway Traffic Safety Administration, the Public Health Data Standards Consortium, and the National Uniform Billing Committee (of which NCHS is a member) to explore means of improving external cause coding in administrative datasets. Activities could include convening a federal agency summit, creating a federal agency taskforce, facilitating a federal agency workgroup, or contacting appropriate federal agency leadership.

2007 Position Statement Responses

Position Statement Response: 07-INJ-01

Committee: ENV/OH/INJ

Title: Improving External Cause Coding in Hospital Discharge Data

We appreciate your interest and hope this information will be helpful to you.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director