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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, 2008 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, 2008 and the changes in net assets and its cash flows for the year then ended in conformity with generally accepted accounting principals.

In accordance with *Government Auditing Standards*, we have also issued our report dated February 5, 2009, 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, agreements and other matters.

The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and important for assessing 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.

February 5, 2009
Atlanta, Georgia

Financial Statements & Auditors Reports

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC
STATEMENT OF ACTIVITIES
YEAR ENDED SEPTEMBER 30, 2008

CHANGE IN UNRESTRICTED NET ASSETS:	
REVENUES AND GAINS	
Memberships	$ 95,490
Annual Meeting	413,237
Interest Income	24,514
Gain on Disposal of Asset	0
Miscellaneous	1,550
Total Revenues and Gains	534,791
NET ASSETS RELEASED FROM RESTRICTIONS	5,045,721
TOTAL UNRESTRICTED SUPPORT AND RECLASSIFICATION	
EXPENSES	
Program Services	5,201,669
General Supporting Expenses	382,485
Total Expenses	5,584,154
DECREASE IN UNRESTRICTED NET ASSETS	**(3,642)**
TEMPORARILY RESTRICTED NET ASSETS	
Support from Grants	5,037,429
Net Assets Satisfied by Payments	(5,054,011)
Net Assets Released from Restrictions	8,921
DECREASE IN TEMPORARILY RESTRICTED NET ASSETS	**(8,921)**
DECREASE IN NET ASSETS	**(11,933)**
NET ASSETS, BEGINNING OF YEAR	**511,061**
NET ASSETS, END OF YEAR	**$499,128**

See Accompanying Notes to Financial Statements

Financial Statements & Auditors Reports

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
STATEMENT OF FINANCIAL POSITION
SEPTEMBER 30, 2008

ASSETS

CURRENT ASSETS:	
Cash and Cash Equivalents	$ 210,512
Certificates of Deposit	534,197
Accounts Receivable	79,367
Grants Receivable	374,058
Accrued Interest Receivable	3,899
Prepaid Expenses	132,387
TOTAL CURRENT ASSETS	1,334,420
PROPERTY AND EQUIPMENT	
Computers and Software	85,964
Furniture and Equipment	52,705
Less: Accumulated Depreciation	(62,068)
TOTAL PROPERTY AND EQUIPMENT	76,601
OTHER ASSETS	
Deposits	3,153
TOTAL ASSETS	$1,414,174

LIABILITIES AND NET ASSETS

CURRENT LIABILITIES	
Accounts Payable	$ 508,701
Accrued Expenses	240,062
Refundable Advances	161,283
Deferred Revenue	5,000
TOTAL CURRENT LIABILITIES	915,046
NET ASSETS	
Unrestricted	499,128
Temporarily Restricted	0
Permanently Restricted	0
TOTAL NET ASSETS	499,128
TOTAL LIABILITIES AND NET ASSETS	$1,414,174

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, 2008

CASH FLOW FROM OPERATING ACTIVITIES	
Change in Net Asset	$(11,933)
Adjustment to Reconcile Change in Net Assets to Net Cash Provided by Operating Activities:	
Depreciation	19,236
Disposal of Fixed Asset	0
(Increase) Decrease in Operating Assets:	
Grant Funds Receivable	(241,232)
Accounts Receivable	(73,518)
Accrued Interest Receivable	2,371
Prepaid Expenses	174,974
Increase (Decrease) in Operating Liabilities:	
Accounts Payable	101,684
Refundable Advances	161,283
Accrued Expenses	44,765
Deferred Revenue	5,000
NET CASH PROVIDE BY OPERATING ACTIVITIES	182,630
CASH FLOWS FROM INVESTING ACTIVITIES	
Purchase of Certificates of Deposit	(50,123)
Purchase of Property and Equipment	(19,574)
NET CASH (USED) BY INVESTING ACTIVITIES	(69,697)
NET INCREASE IN CASH AND CASH EQUIVALENTS	112,933
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	97,579
CASH AND CASH EQUIVALENTS AT END OF YEAR	$210,512
NON CASH TRANSACTIONS	
Abandonment of fully Depreciated Fixed Assets	$ 29,755
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, 2008

	PROGRAM SERVICES							
	BIRTH DEFECTS	CHRONIC DISEASE	ENVIRONMENTAL HEALTH	INFECTIOUS DISEASE	INJURY	NATIONAL OFFICE	TERROR PREPAREDNESS	CDC FOUNDATION
Annual Meeting Expenses	$0	$0	$0	$0	$0	$0	$0	$0
Consultants	0	(651)	31,500	97,559	0	96,369	0	0
Contracts	0	0	0	400,561	0	15,661	0	0
Fringe	731	5,011	7,442	36,164	1,441	115,020	176	20
General and Administrative	17,776	116,278	94,168	562,205	23,505	251,314	748	920
Other	907	5,838	66,184	828,480	5,255	104,030	0	0
Personnel	3,546	21,559	29,533	123,932	5,777	383,848	1,859	167
Postage and Delivery	0	168	180	1,461	38	2,286	0	9
Printing and Reproduction	0	1,050	195	594	0	13,334	0	0
Staff Travel	1,287	5,233	5,826	19,249	1,731	33,914	296	60
Supplies	4	45	115	16674	9	5,361	0	4
Telephone	0	0	1,327	5,665	0	3,160	0	0
Trainee Expenses	59,215	430,515	183,791	581,955	69,504	8,010	0	3,013
Total Expenses	$83,469	$585,046	$420,260	2,674,499	$107,260	$1,032,309	$3,079	$4,194

	PROGRAM SERVICES							
	OCCUPATIONAL CONFERENCE	NEW YORK CITY	OCCUPATIONAL CAPACITY	RWJF LEGAL	RWJF AWARD	RWJF TRIBAL	NON FEDERAL	TOTAL EXPENSES
Annual Meeting Expenses	$0	$0	$0	$0	$0	$0	$274,563	$274,563
Consultants	0	0	596	40,553	0	0	0	265,927
Contracts	0	0	0	0	0	7	35,000	451,222
Fringe	731	20	5,724	(43)	0	1,499	1,547	173,992
General and Administrative	31	16,061	27,731	1,658	129	11,588	38,878	1,152,903
Other	28,836	0	52,069	0	1,000	63	12,851	1,117,039
Personnel	3,205	173	23,535	0	0	0	10,601	607,796
Postage and Delivery	7	0	1,027	36	0	0	0	5,213
Printing and Reproduction	0	0	0	0	0	0	2,175	17,347
Staff Travel	804	60	8,681	0	0	814	6,433	84,386
Supplies	6,494	4	96	0	67	0	438	29,311
Telephone	719	0	208	0	0	0	0	11,079
Trainee Expenses	0	56,903	470	0	0	0	0	1,393,377
Total Expenses	$40,825	$73,222	$120,137	$42,204	$1,196	$13,971	$382,485	$5,584,154

Financial Statements & Auditors Reports

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
NOTES TO FINANCIAL STATEMENTS
YEAR ENDED SEPTEMBER 30, 2008

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 $4,683,802 for the year ended September 30, 2008. For the year ended September 30, 2008 the Organization received disbursements on these agreements in the amount of $4,646,463.

   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, 2008

3. **Noncancelable Lease Commitments:** The Organization leases its offices and certain equipment under leases that are considered operating leases. Total rent expense was $138,966 for the year ended September 30, 2008. Future minimum lease payments under these noncancelable operating leases as of September 30, 2008 are as follows:

Year Ended September 30,	
2009	$148,222
2010	146,468
2011	144,257
2012	149,488
2013	49,998
Thereafter	0
	$638,433

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, 2008 was $52,867.

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, 2008.

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, 2008

Fed Grantor/Pass-through Grantor Prog Title/Reference#	Federal CFDA Number	Budget Period	Program or Award Amount	Federal 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-WI	93.283	9/30/2007 - 9/29/2008	$4,660,377	$4,906,438
U.S. Dept. of Health & Human Services Center for Disease Control & Prevention Improving Epidemiology Practice Surveillance Systems & Disease Reporting.				
IU 38 8HM000414-01	93.283	6/01/2008 - 5/31/2009	$5,702,651	—
U.S. Dept. of Health & Human Services Center for Disease Control & Prevention State based Occupational Health based Surveillance Meeting.				
IR 13 OH008565-03	93.262	8/01/2007 - 7/31/2008	$39,600	$40,603
IR 13 OH008565-04	93.262	8/01/2008 - 7/31/2009	$59,600	$191
U.S. Dept. of Health & Human Services Center for Disease Control & Prevention State based Occupational Capacity..				
IR 25 OH008802-02	93.262	7/07/2007 - 6/30/2008	$100,000	$92,965
IR 25 OH008802-03	93.262	7/01/2007 - 6/30/2009	$121,403	$27,081

See Accompanying Notes to Financial Statements

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
NOTES TO SCHEDULE OF FEDERAL AWARDS
YEAR ENDED SEPTEMBER 30, 2008

A. BASIS OF PRESENTATION

The accompanying schedule of expenditures of federal awards includes the federal grant activity of Council of State and Territorial Epidemiologists, Inc. and is presented on the accrual basis of accounting. The information in this schedule is presented in accordance with the requirements of OMB Circular 1-333, *Audits of States, Local Governments and Non-Profit Organizations.* Therefore, some amounts presented in this schedule may differ from amount presented in, or used is the preparation of the basis financial statements.

B. AWARD AMOUNT

The Program awarded amounts shown are from information purposes only; they do not represent amounts awarded only in the year ended September 30, 2008.

C. CARRY OVER OF AWARDED AMOUNTS

The Federal expenditures shown for Grant IR 13 OH 008565-03 includes unobligated funds carried over from year 2.

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. (CSTE) (a nonprofit organization) as of and for the year ended September 30, 2008, and have issued our report thereon dated February 5, 2009. 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.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered CSTE's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the effectiveness of CSTE's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Organization's internal control over financial reporting.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the organization's ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles, such that there is more than a remote likelihood that a misstatement of the organization's financial statements that is more than inconsequential will not be prevented or detected by the organization's internal control.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by the organization's internal control.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weakness, as defined above.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Council of State and Territorial Epidemiologist, Inc.'s financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, 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.*

This report is intended for the information of the management, the Executive Board, others within the entity, the Board of Trustees, and federal awarding agencies and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

Cann & Company, P.C.

February 5, 2009
Atlanta, Georgia

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 financial statements of 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, 2008. 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 honour 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.

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, 2008.

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, but not for expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of CSTE's internal control over compliance.

A control deficiency in an entity's internal control over compliance exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect noncompliance with a type of compliance requirement of a federal program on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the entity's ability to administer a federal program such that there is more than a remote likelihood that noncompliance with a type of compliance requirement of a federal program is more than inconsequential will not be prevented or detected by the entity's internal control.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that material noncompliance with a type of compliance requirement of a federal program will not be prevented or detected by the entity's internal control.

Our consideration of the internal control over compliance was for the limited purpose described in the first paragraph of this section and would not necessarily identify all deficiencies in internal control that might be significant deficiencies in internal control over compliance that we consider to be a material weaknesses, as defined above.

**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 solely for the information and use of management, Executive Board, others within the entity, Board of Trustees, and federal awarding agencies and pass-through entities and is not intended to be and should not be used by anyone other than these specified parties.

February 5, 2009
Atlanta, Georgia

Financial Statements & Auditors Reports

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
YEAR ENDED SEPTEMBER 30, 2008

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:
   a) Development of state level surveillance systems and epidemiology training programs. CFDA number 93.283.
   b) State based occupational health surveillance CFDA number 93,262.
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

2008 Jonathan Mann Memorial Lecturer

2008 JONATHAN MANN MEMORIAL LECTURER
CSTE PRESIDENT'S BANQUET
TUESDAY JUNE 10

WILLIAM SCHAFFNER, MD
Professor and Chairman, Department of Preventive Medicine
Professor of Medicine, Division of Infectious Diseases
Vanderbilt University School of Medicine

William Schaffner, MD, is professor and chairman of the Department of Preventive Medicine and professor of Medicine in the Division of Infectious Diseases at Vanderbilt University School of Medicine in Nashville, Tennessee. He has served as Hospital Epidemiologist at Vanderbilt University Hospital for nearly 30 years and is an active member of 20 professional societies.

Dr. Schaffner's work has focused on all aspects of infectious diseases, including epidemiology, infection control and immunizations. In 1996, he was awarded the Society of Healthcare Epidemiology Lecturer Award "in recognition of extraordinary career contributions to infection control and healthcare epidemiology."

Dr. Schaffner is a member of numerous professional societies. He is also a consultant in public health policy and communicable disease control for many national and local institutions, such as the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), the Tennessee Department of Health, the American Hospital Association and the American College of Physicians. He also serves on the board of directors for the National Foundation for Infectious Diseases (NFID).

Dr. Schaffner is active in the field of infectious disease research and has authored or co-authored more than 230 published studies, reviews and book chapters on infectious diseases. He currently serves on the editorial board of a number of scientific journals including Hospital Infection Control, European Journal of Clinical Microbiology and Patient Care.

Dr. Schaffner received his medical degree from Cornell University in Ithaca, New York. He was also a Fulbright Scholar (Albert Ludwigs University, Freiburg, Germany) and received his undergraduate degree from Yale University in New Haven, Connecticut.

2008 Annual Conference Summary

Council of State and Territorial Epidemiologists
2008 Annual Conference Summary

Theme: Public Health Epidemiology: Adapting to a Changing World

Location: Denver, Colorado
Sheraton Denver

Dates: June 8-12, 2008

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

Total Attendees: 950

Program Summary:

Workshops	CSTE Pre-Conference Workshop- Environmental Health Tracking
	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
Day One	Public Health Epidemiology in a Changing World
Day Two	Sharing Public Health Information in the "Information Age"
Day Three	Presenting Epidemiologic Information to the Public

Planning Committee:

Perry Smith	Committee Chair
Beverly Christner	Staff
Shundra Clinton	Staff
Lisa Dwyer	Staff
Kitty Gelberg	Occupational Lead
Gail Hansen	Infectious Disease Chair
Susan Hardman	Injury Committee
Robert Harrison	CSTE Past President
John Horan	Chronic /MCH/Oral Health Committee Chair
Melvin Kohn	Cross cutting Committee
Michael Landen	Cross Cutting Committee Chair
Jennifer Lemmings	Staff
Shao Lin	Environmental Committee Co-Lead
Christopher Maylahn	Chronic/MCH/Oral Health Committee
Karen Mulloy	Occupational Committee

Planning Committee (continued):

Lakesha Robinson	Staff
Jon Roesler	Injury Lead
Tom Safranek	Cross Cutting Committee
C. Mack Sewell	CSTE Past President
Erin Simms	Staff
Martha Stanbury	Environmental/Occupational/ Injury Committee Chair
Faye Sorhage	NASPHV Representative
Thomas Talbot	Environmental Committee Co-Lead
Tanja Walker	Staff

2008 Business Meeting Minutes

Council of State and Territorial Epidemiologists
2008 Business Meeting Minutes
Thursday, June 12, 2008

Roll Call

Present: Alabama, Alaska, Arizona, California, Colorado, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming

Absent: American Samoa, Federated States of Micronesia, Guam, Northern Mariana Island, Arkansas, Connecticut, District of Columbia, Hawaii, Maine, Mississippi, Puerto Rico, Rhode Island, South Dakota, and Virgin Islands

Eddy Bresnitz called the meeting to order at 8:30 a.m.

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

CSTE Final President's Message / State of CSTE
The Annual Conference provides the outgoing President an opportunity to reflect on the accomplishments of the past year. This year has been extremely productive for CSTE. Particularly in four areas – the January 2008 retreat, workforce development, the Annual Conference, and legislative activities – CSTE's successes reflect the collective commitment of its members and consultants.

Retreat on Organization Growth/Change: In January, the Executive Committee convened a two-day Retreat on Organization Growth/Change to discuss the effects of CSTE's rapid membership growth and to determine what, if any, changes the organization needs. The retreat produced recommendations and action items, most of which already have been implemented. Retreat participants recommended major revisions to the CSTE Bylaws and proposed they be adopted at the annual business meeting on June 12. The retreat summary, which includes the status of action items and proposed Bylaws, is available on the CSTE website; please direct any comments to your jurisdiction's representative to the business meeting. Special thanks to Bob Harrison and Mel Kohn, for leading this effort were offered.

Workforce Development: CSTE staff and Executive Committee members finalized and distributed an orientation manual for new State Epidemiologists, produced a soon-to-be-distributed Epidemiology Competencies Toolkit, completed (with CDC and ASPH) and disseminated an Applied Epidemiology Competencies Curriculum and Practitioner Project, and selected a new class of Applied Epidemiology Fellows. As part of the successful application for CDC Cooperative Agreement funding, CSTE developed an impressive list of workforce development objectives. In addition, to assess and improve the nation's capacity to perform epidemiology services, CSTE conducted numerous meetings, surveys, and other activities throughout the year, relating to workforce development.

Annual Conference: The Annual Conference improves each year. Our move from an annual to a two-year planning cycle enables us to secure increasingly larger venues to accommodate our ever-increasing attendance. We have implemented a "CSTE Green" initiative. We accept more abstracts and now offer CME credits. Our new media consultant highlights members' accomplishments through press releases to local and national media. Finally, we established a Robert Wood Johnson Foundation National Award for Outstanding Epidemiology Practice in addressing racial and ethnic disparities. Each year, this award recognizes a state or local epidemiologist (an Annual Conference presenter) whose professional work advances public health knowledge through epidemiology and applied research in racial and ethnic disparities and improves public health practice through effective use of data and epidemiology.

2008 Business Meeting Minutes

Council of State and Territorial Epidemiologists
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Legislative Issues: The CSTE Executive Committee, assisted by our Legislative Liaison Marcia Mabee, helped finalize a bill on Integrated Surveillance and Reportable Conditions, successfully fought the turtle amendment to the Farm Bill, had funds included in CDC's annual budget that will support Applied Epidemiology Fellowship Training, and began modifying the Family Education Rights and Privacy Act.

As we begin this new year, the Executive Committee is undergoing significant changes. Bob Harrison, Gail Hansen and Mel Kohn will complete their terms at the Annual Conference. Allen Craig resigned earlier this year, and John Horan is resigning to focus on his responsibilities as the new Georgia State Epidemiologist. Perry Smith will serve as President; Tom Safranek, Martha Stanbury and Mike Landen will remain on the Executive Committee. Mel Kohn is running for President-Elect, and great candidates are running for the vacant positions. Due to retirement from state government to work as the Medical Director of the adult vaccine unit at Merck, Eddy Bresnitz will not serve as Vice-President.

Discussion and Vote of Proposed Membership Dues Increase: The Executive Committee is proposing an increase in both individual and state dues starting in the 2009 calendar year. The proposed state and individual dues increase would help financially support the work done by the CSTE National Office, including the full cost of providing a Membership Services Coordinator and part-time Washington Liaison.

Below is the proposed increase proposal:

State Dues Proposal

Categories	Current	2009
State Dues: Tier 1 – Territories	$550	$750
State Dues: Tier 2 – States with Populations Less than 1 Million	$800	$1,100
State Dues: Tier 3 – States with Populations 1 to 4 Million	$850	$1,200
State Dues: Tier 4 – States with Populations 4 to 6 Million	$1,250	$1,750
State Dues: Tier 5 – States with Populations More than 6 Million	$1,500	$2,100

Individual Dues Proposal

Membership Categories	Current	2009
Individual Dues: Active	$40	$50
Individual Dues: Associate	$40	$50
Individual Dues: Student	$25	$30

The membership overwhelmingly approved the proposed Membership Dues increase.

2008 Business Meeting Minutes

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Discussion and Vote of Proposed Changes to CSTE Bylaws and Constitution
The document merges the current Constitution and Bylaws together with several major proposed changes. The Executive Committee's primary purpose for the revision is to address recommendations made at the Executive retreat held in January; combine the current governing documents into one unified document; define and update governing procedures, and clarify CSTE's committee structure.

The membership approved the proposed changes to the CSTE Bylaws with a few technical edits that were made by Perry Smith.

Member Comment noted for minutes
Corrine Miller: The policies and procedures needed to be reassessed to align them with changes to the Bylaws. For example, the HIV group holds elections to identify their lead, with the President appointing the person/s. With changes to the Bylaws, the ID chair will now appoint section leads, and we need to make sure that policies and procedures reflect the new communication structure and group activities.

Secretary-Treasurer Report
Melvin Kohn presented the financial statements to the membership. The report was based on the audited financial statements from September 30, 2006 to September 30, 2007, 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 non-compliance 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 30, 2006 to September 30, 2007, was accepted from the floor and seconded. The membership voted to accept the financial statement as record.

Business Meeting Minutes
Minutes from the 2007 Business Meeting were reviewed. A motion to accept the 2007 Atlantic City, New Jersey, Business Meeting minutes was brought from the floor and seconded by the membership. A vote was taken, and the 2007 Business Meeting Minutes were approved.

Review of Voting Rights and Annual Report
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. There are a total of 42 States attending the meeting. A majority vote shall be required to elect board members. If no candidate receives 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.

The Annual Report is now available and contains work done by CSTE in 2007. The Annual Report is available on the CSTE website.

2008 Business Meeting Minutes

Council of State and Territorial Epidemiologists
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Executive Committee Elections

Melvin Kohn called for the election of open positions on the Executive Committee. The appointed tellers were MarySue Shulin, Rick Vogt, Patty Quinlisk and Joe Mclaughlin.

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

Eddy Bresnitz called for the membership to vote for the **President-Elect position**. The name on the ballot was Melvin Kohn. There was a call for additional nominations from the floor. None were put forward. A motion to approve by acclamation and seconded with no discussion; the membership elected **Mel Kohn** to the President-Elect position.

Melvin Kohn called for the membership to vote for the **Past- President position**. The names on the ballot were Jerry Gibson, Patty Quinlisk, Henry Anderson and Richard Hopkins. 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. There was not a majority vote and a run off was required between the top three candidates, Patty Quinlisk, Henry Anderson and Richard Hopkins. A third run off was required between the top two candidates, Richard Hopkins and Patty Quinlisk. **Patty Quinlisk** was elected to the Past-President chair.

Melvin Kohn called for the membership to mark ballots for the **Chronic/MCH/Oral position.** The name on the ballot was Sara Huston. There was a call for additional nominations from the floor. None were put forward. With a motion to approve by acclamation and second with no discussion, the membership elected **Sara Huston** to the Chronic/MCH/Oral Chair.

Melvin Kohn called for the membership to mark ballots for the **Infectious Disease position.** The names placed on the ballot were Jeff Engel and Stephen Ostroff. With no nomination from the floor, a motion was called to close the nomination, and seconded. **Jeff Engel** was elected to the Infectious Disease Chair.

Melvin Kohn called for the membership to mark ballots for the three-year **At-Large position.** The names placed on the ballots were Laurene Mascola and Duc Vugia. With no nominations from the floor, a motion was called to close the nomination, and seconded. **Duc Vugia** was elected to the At-Large Chair.

Melvin Kohn called for the membership to vote for the **Secretary-Treasurer position.** The name placed on the ballot was Steve Ostroff. There was a call for additional nominations from the floor. None were put forward. By a motion to approve by acclamation and second, the membership elected **Steve Ostroff** to the Secretary-Treasurer position.

2008 Business Meeting Minutes

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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 2008 Position Statement consent calendar.

08-ID-06	Revision of the Surveillance Case Definition for Q fever
08-ID-07	Support of and Enhancement of the National Healthcare Safety Network
08-ID-08	Update to Cryptosporidiosis Case Definition
08-ID-10	Influenza Surveillance in the United States
08-EH-01	State-level Environmental Disease Epidemiology Capacity
08-OH-01	State-level Occupational Illness and Injury Epidemiology Capacity
08-INJ-01	State-level Occupational Illness and Injury Epidemiology Capacity

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

08-EC-01	The NASPHV/CSTE resolution on One Health
08-EC-02	Criteria for Inclusion of Conditions on CSTE Nationally Notifiable Condition List and for Categorization as Immediately or Routinely Notifiable (remove from agency for response Jeffrey Engel)
08-EC-03	State-level Substance Abuse Epidemiology Capacity
08-ID-02	Revision of Rubella Case Definition
08-ID-03	Revision of Measles Case Definition

Position Statements that were discussed and amended but not approved at the Business Meeting:

08-ID-04	Revision of Mumps Case Definition

Action items:
- The Mumps position statement will be referred back to Paul Cieslak's workgroup for revisions.
- The position statement will be submitted through the Interim Position Statement process, reviewed by the Executive Board and ratified at the next Annual Business Meeting.

2009 Annual Conference
The next CSTE Annual Meeting will take place in Buffalo, New York.

Adjournment:
The meeting adjourned as President Eddy Bresnitz handed the gavel to President Perry Smith.

2008 Pumphandle Award Winner

RICHARD L. VOGT, M.D.

The Pumphandle Award of the Council of State and Territorial Epidemiologists
is awarded annually for outstanding achievement in the field of applied epidemiology.

The 2008 Pumphandle Award recipient, Richard Vogt, has contributed to public health on many levels over the years, from international to local. Among other positions, he has served as a clinical professor in Colorado, Hawaii and Vermont, as state epidemiologist in Vermont and Hawaii, and as a CDC medical officer advising the Egyptian Ministry of Health for the World Health Organization.

"I've seen public health in many different settings" said Vogt. "And it's always different on different levels and challenging in its own ways." For example, when tackling polio eradication initiatives in Egypt, the language barrier made things more difficult.

As the Executive Director of the Tri-County Health Department in Colorado since 2001, Vogt is enjoying the challenges of working locally again. "One of the great things about working at the local level is that you have a little more control over what programs you want to focus on," he said.

In the Tri-County area, one of the issues they have been working on is improving immunization levels. Colorado was near the bottom of the rankings in the National Immunization Survey in the early 2000s. "We had to look at how to approach this, and decided to focus on children and daycare centers," said Vogt. "We have hundreds of licensed daycare centers in our area, so we could work on making sure the immunizations and records for their kids are up to date."

The department has also become a state resource for other areas, working with elder fall prevention and aging initiatives in Denver. "We are extending our reach beyond just our jurisdiction, where we can be of help," said Vogt. "Our motto this year is 'Innovation' and we're taking that to heart – how we can innovate and help the public."

Vogt believes there are several dynamics at work in public health as his team and officials around the country work on new ways to reach the public. "There's a tremendous push in development of local epidemiologic capacity," he said. "Many more epidemiologists are being trained and assigned to local health departments." While that is very positive, he says that some of this is offset by the fact that epidemiology is already underrepresented in public health agencies. This demand for additional epidemiologic assistance is coming at a time where there are retirements of longtime practitioners in the field.

Another challenge Vogt sees for epidemiology and public health is the need for a more comprehensive approach to research and funding. "Certain areas such as injuries that can cause a large number of potential years of life lost, do not have a lot of prevention funding," he said. "Our support has been fairly categorical in the past, and we really should concentrate on diseases and conditions that cause the greatest amount of morbidity and mortality."

But Vogt says that these challenges can be a positive influence on public health as well. "We're being asked to be able to do more and more, and there is an ever-expanding role for epidemiologists. It will be a growth industry for a while, so it's a great time to go into the field," he said. "And it's very nice to look back and know one has been able to really benefit others."

CSTE congratulates Dr. Richard Vogt on his recognition as the 2008 Pumphandle Award winner.

Executive Board 2007 – 2008

President
Eddy Bresnitz, MD, MS
Deputy Commissioner/State Epidemiologist
New Jersey 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 2008

Past President
Robert Harrison, MD, MPH
Chief, Occupational Health Surveillance
and Evaluation Program
California Department of Health Services
850 Marina May Parkway
Building P, 3rd Floor
Richmond, CA 94804
510/620-5769 Phone
510/620-5743 Fax
Robert.harrison@ucsf.edu
Term Expiration 2008

President Elect
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 Phone
518/473-2301 Fax
Psf01@health.state.ny.us
Term Expiration 2008

Secretary –Treasurer
Melvin Kohn, MD, MPH
State Epidemiologist
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 2008

Environmental /Occupational/Injury Chair
Martha Stanbury, MSPH
State Administrative Manager
Michigan Department of Community Health
201 Townsend St.
P.O. Box 30195
Lansing, MI 48909
517/335-8364 Phone
517/335-9775 Fax
Stanburym@michigan.gov
Term Expiration 2009

Chronic Disease/MCH/Oral Health Chair
John Horan, MD, MPH
Chronic Disease, Injury and Environmental
Epidemiology Section
Georgia Department of Human resources
2 Peachtree Street/ Room 14-392
Atlanta, GA 30303
404/657-2578 Phone
404/463-0780 Fax
johoran@dhr.state.ga.us
Term Expiration 2010

Infectious Disease Chair
Gail Hansen, DVM, MPH
State Epidemiologist
Kansas Department of Health and Environment
1000 SW Jackson
Suite 300
Topeka, KS 66612
785/296-1127 Phone
785/296-1562 Fax
ghansen@kdhe.state.ks.us
Term Expiration 2008

Executive Board 2007 – 2008

Members At-Large

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
*Allen left to do international work

Michael Landen, MD, MPH
Assistant State Epidemiologist
New Mexico Department of Health
1190 St. Francis Dr. N 1320
Santa Fe, NM 87502
505/476-3575 Phone
505/827-0013 Fax
Michael.landen@state.nm.us
Term Expiration 2010

Tom Safranek, MD
State Epidemiologist
Nebraska Department of Health and Human Services
301 Centennial Mall
Lincoln, NE 68509
402/471-0550 Phone
402/471-3601 Fax
Tom.safranek@hhss.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

2008 Ballot and Results

2008 Election of PRESIDENT– ELECT

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

_____ _____

_____ _____

2008 Election of AT-LARGE POSITION (Three Year Term)

_____ **Laurene Mascola, MD, MPH, FAAP**
Chief of the Acute Communicable Disease Control Program, Los Angeles

__X__ **Duc Vugia, MD, MPH**
Chief of the Infectious Diseases Branch, California

2008 Election of INFECTIOUS DISEASE CHAIR (Three Year Term)

__X__ **Jeff Engel, MD**
State Epidemiologist, North Carolina

_____ **Stephen Ostroff, MD**
Director of the Bureau of Epidemiology, Pennsylvania

2008 Election of CHRONIC DISEASE/MCH/ORAL HEALTH CHAIR (Two Year Term)

___X__ **Sara Huston, PhD**
Cardiovascular Epidemiologist, North Carolina

_____ _____

_____ _____

2008 Election of SECRETARY-TREASURER (Three Year Term)

___X__ **Stephen Ostroff, MD**
Director of the Bureau of Epidemiology, Pennsylvania

_____ _____

_____ _____

2008 Ballot and Results

2008 Election of VICE-PRESIDENT (One Year Term)

_____ **Henry Anderson, MD**
Chief Medical Officer and State Environmental and Occupational Epidemiologist, Wisconsin

_____ **James J. Gibson, MD, MPH**
State Epidemiologist, South Carolina

_____ **Richard Hopkins, MD, MSPH**
Acute Disease Epidemiology Section Lead and Interim State Epidemiologist, Florida

__X__ **Patricia Quinlisk, MD, MPH**
State Epidemiologist, Iowa

CSTE Staff September 2007 – 2008

Ed Chao
Associate Research Analyst
Employed since June 2008

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

Amber Leonard
Administrative Assistant
Employed since January 2008

Ryan O'Neil
Information Technology
Employed since April 2007

Patrick McConnon
Executive Director
Employed since August 2002

LaKesha Robinson
Program Director
Employed since January 2001

Lauren Rosenberg
Associate Research Analyst
Employed since June 2008

Erin Simms
Associate Research Analyst
Employed since October 2007

MarySue Shulin
Business Manger
Employed since December 2002

Shannon Whittington
Part-Time Accountant
Employed since February 2007

Molly Wray
Workforce and Fellowship Coordinator
Employed since July 2006

CSTE 2008 State Dues

	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	✔	

2008 Position Statements

08-EC-01

Committee: Executive

Title: NASPHV/CSTE resolution on One Health

Statement of the Problem:
The public health workforce and other health care providers of humans and animals face unprecedented challenges associated with global climate change, emerging pathogens and explosive population growth. More now than ever, an interdisciplinary "One Health" approach is needed involving physicians, veterinarians, public health and environmental health professionals working together to collaboratively address the health concerns associated with these complex problems.

The One Health/ One Medicine concept was first espoused by Rudolf Virchow in the 1800's, and popularized in the 1960s by Dr. Calvin Schwabe, who advocated cooperation between veterinary and human medicine to combat zoonotic diseases. Unfortunately interest in this collaborative approach diminished over time with both human and veterinary medicine becoming divided into specialties with little interaction between the two disciplines. Additionally, there is currently limited opportunity for contact between medical and public health professionals and environmental health scientists such as microbiologists, ecologists or entomologists. In July 2006 Dr. Roger Mahr, then President-elect of the American Veterinary Medical Association (AVMA), outlined his vision of One Health to the organization. The AVMA supported his vision and subsequently convened a One Health Initiative Task Force in July 2007. This Taskforce was charged with articulating a vision to be used by a multi-agency, multi-organizational team working together to promote the One Health problem solving approach. Initiatives to be supported by this group may include, but are not limited to, data sharing efforts among human, animal and environmental agencies; dedicated funding for interdisciplinary research approaches to health problems; integrated medical, veterinary and environmental science training and education efforts; coordinated public education efforts and better coordination between human and veterinary medical practitioners diagnosing and treating zoonotic diseases.

Inspired by Dr. Mahr's leadership, the American Medical Association (AMA) adopted a resolution officially endorsing One Health in June 2007. The American Society of Microbiology (ASM) is anticipated to endorse a similar resolution in April 2008.

CSTE has for many years been a model of One Health by supporting and affiliating closely with NASPHV in public health initiatives and policy. We are asking both organizations to formally recognize the importance of One Health by endorsing the CSTE/NASPHV One Health resolution below.

Statement of the desired action(s) to be taken:
Adoption of a resolution endorsing One Health by the NASPHV/CSTE memberships.

The NASPHV/CSTE One Health Resolution:
Whereas, The majority of recently emerging infectious diseases, including HIV, SARS and agents of bioterrorism, are zoonoses; and
Whereas, Zoonoses can, by definition, infect both animals and humans; and
Whereas, By their very nature, the fields of human medicine and veterinary medicine are complementary and synergistic in confronting, controlling, and preventing zoonotic diseases from infecting across species; and
Whereas, Collaboration and communication between human medicine and veterinary medicine have been limited in recent decades; and
Whereas, An initiative, often called the "One Health" initiative is being developed to improve the lives of all species-human and animals- through the integration of human and veterinary medicine; and
Whereas, "One Health" previously coined as "One Medicine" by Calvin Schwabe, aims to promote and implement close and meaningful collaboration/ communication between human medicine, veterinary medicine, and all allied health scientists with the goal of improving human public health practice effectiveness as well as advanced health care options for humans (and animals) via comparative biomedical research; and
Whereas, The challenges of the 21st Century demand that medical, veterinary and environmental health professions work together; and

2008 Position Statements

(continued)
08-EC-01

Committee: Executive

Title: NASPHV/CSTE resolution on One Health

Whereas, The AVMA has formed an initiative to promote collaboration between human and veterinary medicine; and
Whereas, NASPHV/CSTE recognize the ways in which animals and animal care affect human health and disease through policies on the use of animals in research, medical education and product safety testing; xenotransplanation; and animal-transmissible spongiform encephalopathies in humans; the evaluation of therapeutic and non-therapeutic use of antimicrobials in animals and humans, and the impact on antimicrobial resistance in animals and humans; and effective recognition, prevention and control of zoonoses such as rabies and avian influenza; therefore be it
Resolved, That NASPHV/CSTE support an initiative designed to promote collaboration among human and veterinary medicine and environmental scientists; and be it further
Resolved, That NASPHV/CSTE support joint educational efforts between human medical and veterinary medical schools; and be it further
Resolved, That NASPHV/CSTE encourage joint efforts in clinical care through the assessment, treatment and prevention of cross-species diseases transmission; and be it further
Resolved, That NASPHV/CSTE support joint efforts to promote human, animal and environmental wellness; and be it further
Resolved, That NASPHV/CSTE support cross-species disease surveillance and control efforts in public health; and be it further
Resolved, That NASPHV/CSTE support joint efforts in the development and evaluation of new diagnostic methods, medicines, and vaccines for the prevention and control of diseases across species; and be it further
Resolved, That NASPHV/CSTE endorse this effort and will participate with the AVMA, AMA, American Public Health Association and ASM to discuss strategies for enhancing collaboration between the medical and veterinary medical professions in medical education, clinical care, public health and biomedical research.

Public Health Impact:
Improved public health outcome through a more integrated approach to medical education, practice and research.

2008 Position Statements

(continued)
08-EC-01

Committee: Executive

Title: NASPHV/CSTE resolution on One Health

Coordination:

Agencies for Response:

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

(2) Dr. Cindy Smith
Director
USDA, APHIS
Jamie L Whitten Federal Building, Room 320 E
1400 Independence Ave SW, AG Box 3491
Washington, DC 20250-3491
202-720-4171
Cindy.Smith@aphis.usda.gov

(3) Dr. Leslie Dierauf
Director
National Wildlife Health Center
USGS, Department of Interior
6006 Schroeder Road
Madison, WI, 53711-6223
608-270-2401
ldierauf@usgs.gov

Agencies for Information:

(1) Dr. Hugh Mainzer
Supervisory Prev. Med. Officer
U.S. Centers for Disease Control and Prevention
NCEH, Division of Emergency and Environmental Health Services
4770 Bedford Highway, NE, Mailstop F28
Atlanta, GA, 30341
770-488-3138
HMainzer@cdc.gov

(2) Dr. Lonnie King
Director, NCZVED
Centers for Disease Control and Prevention
1600 Clifton Road, Mailstop D76
Atlanta, GA
404-639-7380
ljk8@cdc.gov

2008 Position Statements

(continued)
08-EC-01

Committee: Executive

Title: NASPHV/CSTE resolution on One Health

Coordination:

Submitting Author:

(1) Carina Blackmore, DVM, PhD
State Public Health Veterinarian, State Environmental Epidemiologist
Florida Department of Health
4052 Bald Cypress Way, Bin A08
Tallahassee, FL 32330
850-245-4732
Carina_Blackmore@doh.state.fl.us

Co-Author:

(1) Active Member
Tim F Jones, MD
State Epidemiologist
Tennessee Department of Health
425 5th Ave, North
Nashville, TN, 37243
615.741.7247
Tim.F.Jones@state.tn.us

2008 Position Statements

08-EC-02

Committee: Executive Committee

Title: Criteria for Inclusion of Conditions on CSTE Nationally Notifiable Condition List and for Categorization as Immediately or Routinely Notifiable

Statement of the Problem:

In 2007, CSTE adopted the position statement, "CSTE official list of nationally notifiable conditions." In response to the adoption of the International Health Regulations (IHR) by the US and recommendations by the American Health Information Community (AHIC), CSTE will modify the Nationally Notifiable Conditions definitions to be consistent with the IHR requirements and AHIC recommendations.

A reportable/notifiable condition is one for which regular, frequent, and timely information regarding individual cases is considered necessary for the prevention and control of the disease. Within states and territories, the term "reportable condition" generally refers to conditions that physicians, laboratories, or other entities are required under state law to report to local or state public health authorities. Nationally, the term "notifiable condition" refers to conditions that state health departments agree to voluntary report to CDC.

The definition of a "nationally notifiable condition" (NNC) is that the condition should be under surveillance using population-based case ascertainment by reports of individual cases from reporting sources (e.g., clinicians, labs, hospitals) to governmental public health agencies acting under state/territorial statutory or regulatory authority. State laws generally require that case reports include the name and other identifying information of the person with the condition and the entity making the report. CSTE recognizes that public health surveillance for NNC can include infectious diseases, chronic conditions, injuries, and occupational and environmental injuries and diseases.

Conditions that are under surveillance using only secondary analysis of administrative data without accessing personal identifying information (e.g., case counts from vital statistics or hospital discharge data), or only survey data based on sampling (e.g., BRFSS), are not included as NNCs.

Notifiable condition reporting at the local level protects the public's health by ensuring the proper identification and follow-up of cases. The authority to mandate that certain conditions are reportable by law rests with states or territories. Public health workers follow up on reported cases to ensure that persons who are already ill receive appropriate treatment; trace contacts who need vaccines, treatment, quarantine, or education; investigate and halt outbreaks; eliminate environmental or occupational hazards; and close premises where appropriate.

Surveillance based on notifiable condition reports shares objectives of surveillance systems based on other data sources (e.g., vital records, BRFSS): Estimating the magnitude of the health problem, measuring disease trends, assessing the effectiveness of control and prevention measures, identifying populations or geographic areas at high risk, allocating resources appropriately, formulating prevention strategies, and developing public health policies. Monitoring surveillance data enables public health authorities to detect changes in disease occurrence and distribution, identify changes in disease agents and host factors, and detect changes in healthcare practices.

Public health surveillance for nationally notifiable conditions is part of the larger public health surveillance system that operates largely at the state and local level. Some health conditions have primarily local or regional public health importance, and surveillance for many conditions of public health importance, particularly chronic diseases, injuries, and those related to work or environmental exposures, is not always practical through reporting by traditional partners. Surveillance for conditions of public health importance that are not included in the NNC list may also be defined through development of CSTE Position Statements using the CSTE Position Statement Template and become part of CSTE's National Public Health Surveillance System.

Electronic health records can potentially provide a single information source that can meet both clinical and public health needs. As electronic health record system requirements are developed, the need for capturing all diseases/conditions of public health importance, not just those which are Nationally Notifiable Conditions, must be recognized.

2008 Position Statements

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08-EC-02

Committee: Executive Committee

Title: Criteria for Inclusion of Conditions on CSTE Nationally Notifiable Condition List and for Categorization as Immediately or Routinely Notifiable

CSTE and CDC annually review the list of nationally notifiable conditions that state health departments agree to voluntarily report to CDC. Because CDC is not responsible for follow-up or investigation of individual people with cases of notifiable conditions, notifiable condition reports from states to CDC do not include patient or provider names or other personally identifying information.

In early 2007, CSTE conducted a comprehensive review of its adopted position statements which call for a specified disease/condition to be nationally notifiable. This review also documented which position statement contains the most current version of the case definition. The resultant list contains 73 diseases/conditions, nine of which are non-infectious.

In order to aid production of its weekly tables in *MMWR* and the annual publication *Summary of Notifiable Diseases*, CDC NNDSS has conducted annual surveys of each state's reporting requirements for infectious diseases. CSTE has surveyed state epidemiologists on reporting requirements periodically, roughly every other year in the current decade. The CSTE assessment has asked about infectious diseases and non-infectious conditions, as well as specified whether reporting was to be from clinicians, laboratories, or other specified entities. Starting in 2007, CSTE and CDC have jointly conducted the State Reportable Conditions Assessment.

In addition, there has been interest from Congress and the Department of Homeland Security in there being a national system for which immediate notification of national authorities whenever certain diseases of concern occur. Further, CDC has asked states to immediately report specified conditions to them following the algorithm in the International Health Regulations defining a public health emergency of international concern. At present, there is no formal list of conditions that are designated as immediately reportable from states to the national level.

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

1) CSTE shall establish a Nationally Notifiable Condition List with two categories of notifiable conditions: conditions notifiable immediately on strong suspicion from states to CDC, and all other conditions, notifiable routinely to CDC.

2) A) The following criteria for inclusion of a condition on the CSTE NNC **Immediately** Notifiable List shall be adopted:

- The condition has special importance for international health regulations [i.e., a public health event that may constitute a "public health emergency of international concern" as defined in IHR 2005 including, but not limited to: smallpox, novel influenza, wild-type polio, Severe Acute Respiratory Syndrome (SARS)];

OR

- The condition is included on the list of Category A possible bioterrorism agents and toxins.

OR

- The condition or disease has been declared eliminated (absence of endemic disease transmission) in the United States or eradicated globally.

OR

- CSTE position statement has been adopted pursuant to 07-EC-02, which specifically calls for the condition to be immediately nationally notifiable, and
- Law/rule requiring immediate reporting for the condition exists in a majority of state and territorial jurisdictions, or in a combination of state/territorial jurisdictions that taken together comprise 50% or more of the US population, and

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Committee: Executive Committee

Title: Criteria for Inclusion of Conditions on CSTE Nationally Notifiable Condition List and for Categorization as Immediately or Routinely Notifiable

- The CDC requests immediate notification of the condition, and has adopted condition-specific policies and practices that describe:
  - Why immediate notification to the national level is necessary;
  - What purposes, goals and objectives will be met by immediate notification to the national level;
  - How CDC will respond to the notification;
  - What are the uses to which the cumulative or aggregate case data will be put, including both routine analyses of nationally-compiled data and anticipated ad-hoc analyses;
  - The frequency of information provided to the states and territories of the results of analyses of the compiled case data;
  - The anticipated schedule of release of published data based on notifications, as well as any rules for restrictions on the printing of counts of case data; and
  - Re-release of case data, including re-release to WHO or other parties.

B) CSTE and CDC jointly will determine the specifics of immediately notifiable conditions including the timeframe and methods of notification.

C) All states will be encouraged to require immediate reporting to them of all conditions on this list and to establish procedures to notify CDC when the state receives a report of the conditions on the NNC list. CSTE encourages coordination with CDC to make joint recommendations on these procedures.

3) The following criteria for inclusion of a condition on the CSTE NNC **Routinely** Notifiable List shall be adopted:

- CSTE position statement has been adopted pursuant to 07-EC-02, which specifically calls for the condition to be routinely nationally notifiable, and
- Law/rule requiring routinely reporting for the condition exists in a majority of state and territorial jurisdictions, or in a combination of state/territorial jurisdictions that taken together comprise 50% or more of the US population, and
- The CDC has requested that the condition be notifiable to federal authorities (CDC), and has adopted condition-specific policies and practices which describe:
  - What purposes, goals and objectives will be met by routine notification to the national level;
  - What are the uses to which the cumulative or aggregate case data will be put, including both routine analyses of nationally-compiled data and anticipated ad-hoc analyses;
  - The frequency of information provided to the states and territories of the results of analyses of the compiled case data;
  - The anticipated schedule of release of published data based on notifications, as well as any rules for restrictions on the printing of counts of case data; and
  - Re-release of case data, including re-release to WHO or other parties.

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Committee: Executive Committee

Title: Criteria for Inclusion of Conditions on CSTE Nationally Notifiable Condition List and for Categorization as Immediately or Routinely Notifiable

4) In keeping with precedent of state and federal uses of notifications, states will continue to notify CDC of cases of nationally notifiable conditions without names or other personal identifiers. Also, in keeping with precedent, if CDC recognizes that notifications merit further investigation, state or territorial health departments (with delegation to local health departments in some instances) would have primary responsibility for conducting these investigations, with CDC guidance, support, or technical assistance. This may include states invoking formal requests for on-site involvement and assistance from CDC staff.
5) The list of NNCs will also form the basis for inclusion of reports in the *MMWR* weekly disease reporting tables and the annual *Summary of Notifiable Diseases.*

Public Health Impact:

Having a clearly defined list of immediately notifiable conditions at the national level will eliminate current ambiguity and enable more timely response to conditions that may constitute a public health emergency or bioterrorism event at the national level. Standardizing the list of routinely notifiable conditions will improve consistency.

References

1. CSTE Position Statement 07-EC-02, "CSTE official list of nationally notifiable conditions". http://www.cste.org/PS/2007ps/2007psfinal/EC/07-EC-02.pdf, accessed March 26, 2008.
2. World Health Organization International Health Regulations (2005). http://www.who.int/csr/ihr/WHA58-en.pdf, accessed March 26, 2008.
3. Meriwether RA. Blueprint for a national public health surveillance system for the 21st century. J Public Health Manag Pract. 1996;2(4):16-23. Available at: http://www.cste.org/pdffiles/Blueprint.pdf.
4. Centers for Disease Control and Prevention. Bioterrorism Agents and Diseases by Category, accessed June 11, 2008. Available at: http://emergency.cdc.gov/agent/agentlist-category.asp
5. Orenstein WA, Papania MJ, Wharton ME. Measles elimination in the United States. J Infect Dis. 2004 May 1;189 Suppl 1.
6. Centers for Disease Control and Prevention. Achievements in public health: elimination of rubella and congenital rubella syndrome. *MMWR Morb Mortal Wkly Rep.* 2005;54 :279.

2008 Position Statements

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08-EC-02

Committee: Executive Committee

Title: Criteria for Inclusion of Conditions on CSTE Nationally Notifiable Condition List and for Categorization as Immediately or Routinely Notifiable

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
jyg2@cdc.gov

Agencies for Information:

(1) Jeffrey Engel, NC State Epidemiologist
NC DHHS, Division of Public Health
Mail Service Center 1902
Raleigh, NC 27699-1902
919-715-7394
jeffrey.engel@ncmail.net

2008 Position Statements

08-EC-03

Committee: Executive

Title: State-level Substance Abuse Epidemiology Capacity

Statement of the Problem:
Substance abuse, defined as the abuse of substances such as alcohol and pharmaceuticals, and the use of illegal drugs, has long been recognized as a social and law enforcement problem, but more recently has begun to be considered in the context of public health. Recent reports in the MMWR (1) and from National Center for Health Statistics (NCHS) (2) have documented the major impact of prescription narcotics in the explosive increase in mortality due to fatal poisonings in the US. Alcohol consumption has been estimated to contribute to 75,000 deaths and $184 billion in economic costs per year in the United States. Impact on youth is also of concern. For example, binge drinking among youth is associated with poor school performance and involvement in health risk behaviors including riding with a driver who had been drinking, being currently sexually active, smoking cigarettes or cigars, being a victim of dating violence, attempting suicide and using illicit drugs (3).

Identification and quantification of the determinants and human health consequences of use and abuse of these substances is an essential first step in prevention. Epidemiology, as the core science of public health, is the basis for public health surveillance and, as such, is essential for the detection, control and prevention of adverse health effects in the population. Substance Abuse and Mental Health Services Administration (SAMHSA) has recently recognized the importance of epidemiology in directing prevention by creating the State Epidemiological Data System (SEDS) https://www.epidcc.samhsa.gov/.

The core functions and mandates of public health surveillance, including tracking of adverse health effects from substance abuse, reside principally in states. Unfortunately, state funding to support epidemiologists working on substance abuse is minimal or none in most states. CDC has provided limited support in the area of alcohol use epidemiology by funding two state-level epidemiologists to track alcohol abuse, and has developed tools such as the Alcohol and Public Health website www.cdc.gov/alcohol; the web-based Alcohol-Related Disease Impact (ARDI) software for calculating state-specific disease burden; funding alcohol consumption questions and modules in the Behavioral Risk Factor Survey (BRFS); and development of a chapter on alcohol in the Guide to Community Preventive Services. In other areas of substance abuse, CDC has been even more limited in its activities, with only one CDC-level epidemiologist in the National Center for Injury Prevention and Control focused in this area, although there appear to be some activities addressing substance abuse related to HIV. A search of the CDC web site revealed no centralized information resources devoted to substance abuse excluding alcohol. SAMHSA has been funding state level epidemiologic work through its Strategic Prevention Framework; however this activity has largely been operating outside the framework of state health departments. The National Institute on Drug Abuse (NIDA) also operates mainly outside state health departments, maintaining its own surveillance system through the Community Epidemiology Work Group (CEWG) http://www.nida.nih.gov/about/organization/CEWG/, a network of researchers from major metropolitan areas of the United States and selected foreign countries who "provide ongoing community-level surveillance of drug abuse through analysis of quantitative and qualitative research data. Through this program the CEWG provides current descriptive and analytical information regarding the nature and patterns of drug abuse, emerging trends, characteristics of vulnerable populations and social and health consequences."

Similar to the situation at CDC, substance abuse has no usual 'home' in the traditional CSTE categories of epidemiology, as it is a topic equally related to chronic diseases, injury, and risky behaviors such as HIV, STDs, and school/youth concerns. The 2006 National Assessment of Epidemiologic Capacity did not address this topic (4).

2008 Position Statements

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Committee: Executive

Title: State-level Substance Abuse Epidemiology Capacity

Statement of the desired action(s) to be taken:
CDC, SAMHSA, the Association of State and Territorial Health Officials (ASTHO) and other partner organizations should advocate on behalf of states in their efforts to train, recruit and retain adequate numbers of substance abuse epidemiologists needed to carry out essential surveillance functions. CDC and SAMHSA will work with its Federal partners and with CSTE to develop a coherent focus for substance abuse information, surveillance activities and resources which will be made available to state and local health departments.

Specific steps to achieve these outcomes should include the following:

- CDC and SAMHSA should encourage all states to achieve a minimum workforce of at least one substance abuse epidemiologist in every state public health agency through establishment and expansion of cooperative agreements to fund state substance abuse surveillance programs.
- CDC and SAMHSA should include language in other/related cooperative agreements that explicitly encourages support for substance abuse epidemiologists and provides mechanisms and opportunities to give states greater flexibility in using categorical funding, including resources from multiple grants, to support these positions. In particular, CDC should encourage collaboration between state programs in chronic disease, maternal and child health, injury control, communicable diseases, and others which address aspects of substance abuse in their mission.
- Mechanisms for capacity development such as, the CDC/CSTE Applied Epidemiology Fellowship Program, Epidemic Intelligence Service, Public Health Prevention Service, and state-based epidemiology training programs should be supported as part of the grant programs using both direct assistance and financial assistance to accomplish the objective of minimum substance abuse epidemiology workforce in each state within five years.
- CDC and SAMHSA should establish performance measures such that, by 2015, all states will meet the minimum workforce requirement of one substance abuse epidemiologist for every state public health department.
- ASTHO and its affiliates (e.g., CSTE) should work for and with states to ensure hiring of needed substance abuse epidemiologists by promoting and maximizing use of funding flexibility and other resources.
- CDC and SAMHSA should reach out to other Federal agencies such as NIDA and NIAAA with common missions in substance abuse surveillance and epidemiology, with the goal of identifying and sharing information and resources that can be used by state public health departments to address substance abuse.
- CDC should develop a central focus or point of contact within the agency for substance abuse information, surveillance activities and resources.
- The voluntary national accreditation program for state and local health departments under development by the Public Health Accreditation Board (www.exploringaccreditation.org/index.html) should address substance abuse epidemiology capacity.

Public Health Impact:
Support of substance abuse epidemiology will enhance the ability of states to prioritize, plan, promote, implement and evaluate evidence-based interventions. This will prevent development of and reduce diseases, injuries and other adverse outcomes associated with substance abuse.

(continued)
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Committee: Executive

Title: State-level Substance Abuse Epidemiology Capacity

References

1. Unintentional Poisoning Deaths: United States, 1999-2004. MMWR February 9, 2007/ 56(05);93-96 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5605a1.htm
2. Fingerhut LA. NCHS Health E-stats. Increases in Poisoning and Methadone-Related Deaths: United States, 1999-2005. http://198.246.98.21/nchs/products/pubs/pubd/hestats/poisoning/poisoning.htm
3. Miller, JW, Naimi TS, Brewer RD, Jones SE. Binge Drinking and Associated Health Risk Behaviors Among High School Students. Pediatrics. January 2007; 119 (1): 76-85.
4. CSTE. 2006 National Assessment of Epidemiologic Capacity: Findings and Recommendations. Available at www.cste.org

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
jvg2@cdc.gov

(2) Terry Cline, Ph.D.
Administrator
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857
(240) 276-2000
terry.cline@samhsa.hhs.gov

(3) Paul E Jarris, MD, MBA
Executive Director
Association of State and Territorial Health Officials
2231 Crystal Dr, Suite 450
Arlington, VA 22202
(202) 371-9090
pjarris@astho.org

(4) Albert Gray, PhD
Public Health Accreditation Board
Executive Director
1600 Duke Street, Suite 440
Alexandria, VA 22314
(703) 778-4549

2008 Position Statements

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08-EC-03

Committee: Executive

Title: State-level Substance Abuse Epidemiology Capacity

Coordination:

Agencies for Information:

(1) Ting-Kai Li, MD
Director
National Institute on Alcohol Abuse and Alcoholism
National Institutes of Health
5635 Fischers Lane, MSC 9304
Bethesda, MD 20892-9304

(2) Nora D. Volkow, M.D.
Director
National Institute on Drug Abuse
National Institutes of Health
6001 Executive Boulevard, Room 5213
Bethesda, MD 20892-9561
(301) 443-6480
nv29q@nih.gov

Submitting Author:

(1) Corinne Miller, DDS, PhD
State Epidemiologist and
Director, Bureau of Epidemiology
Michigan Department of Community Health
PO Box 30195
Lansing MI 48909
517-335-8900
MillerCori@michigan.gov

Co-Author:

(1) Michael Landen, MD, MPH
Deputy State Epidemiologist
New Mexico Department of Health
PO Box 26110
Santa Fe , NM 87505
505-476-3575
Michael.landen@state.nm.us

(2) Lorraine Cameron, PhD, MPH
Chief, Environmental Epidemiology Section
Michigan Department of Community Health
PO Box 30195
Lansing, MI 48909
517-335-8342
CameronL@michigan.gov

2008 Position Statements

08-EH-01

Committee: Occupational/Environmental Health

Title: State-level Environmental Disease Epidemiology Capacity

Statement of the Problem:
CSTE has long recognized that environmental conditions and hazards have substantial impacts on morbidity and mortality in the US. Although the actual burden of environmentally-related disease, disability and death is not known, some studies have estimated the environmentally attributable fraction to the cause of number of chronic diseases including lead poisoning (100%),[1] childhood asthma (10-35%),[1] cardiovascular disease (7-23%),[2] cardiovascular disease to due to air pollution alone (4-9%),[3] childhood cancer (2-10%),[1] all cancer (1-5%),[4] and neurobehavioral disorders in children (5-20%).[1] One study estimated the costs of environmentally attributable fractions of asthma, cancer, lead poisoning and neurobehavioral disorders in children to be approximately $55 billion nationwide.[1] The State of Oregon estimated the costs of the environmentally attributable fraction of these diseases in children and adults, plus cardiovascular disease to be $1.57 billion in Oregon.[2] Diseases caused by exposures to environmental pollutants are potentially preventable through the application of traditional approaches of public health and pollution prevention. Identification and quantification of the human health impacts of environmental exposures are the essential first steps in prevention.

Epidemiology, as the core science of public health, is the basis for public health surveillance and, as such, is essential for the detection, control and prevention of environmental diseases. The Pew Environmental Health Commission pointed out in 2000 that there is a lack of information to document possible links between environmental hazards and chronic disease. The Commission noted the urgent need to track exposures and the distribution of disease and its relationship to the environment.[5]

The core functions and mandates of public health surveillance, including tracking of adverse health effects from environmental exposures, reside principally in states. Unfortunately, state funding to support environmental epidemiologists is minimal or none in most states. Although federal funding was identified to develop collection of disease and environmental data subsequent to the Pew Environmental Health Commission report, currently only 16 states and one city are funded by the CDC to support epidemiologists for environmental disease tracking. The CSTE 2006 National Assessment of Epidemiologic Capacity found that 8% of state health departments reported no environmental epidemiology capacity at all, and only 33% of states reported substantial or almost full capacity. By contrast, all states reported partial to full capacity in infectious disease.[6] CSTE concluded that there was a gap of 28% between current and needed capacity for environmental epidemiologists.[7] Training of environmental epidemiologists and funding of state environmental epidemiology programs are critical to filling this gap.

Statement of the desired action(s) to be taken:
CDC, the Association of State and Territorial Health Officials (ASTHO) and other partner organizations including the US Environmental Protection Agency (EPA) should work with CSTE to advocate on behalf of states in their efforts to train, recruit and retain adequate numbers of trained and experienced environmental epidemiologists to carry out the needed functions described in the Pew Environmental Health Commission report.[5]

States should identify state resources to support environmental epidemiology capacity. State public health agencies should deploy environmental epidemiologists in an organizational structure that maximizes their ability to coordinate environmental health activities throughout their agency and among other agencies.

2008 Position Statements

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08-EH-01

Committee: Occupational/Environmental Health

Title: State-level Environmental Disease Epidemiology Capacity

Specific steps to achieve these outcomes should include the following:

- CDC should encourage all states to achieve minimum environmental epidemiology workforce of at least one environmental epidemiologist in every state public health agency through establishment and expansion of cooperative agreements to fund state environmental health tracking programs.
- CDC should include language in other/related cooperative agreements that explicitly encourages support for environmental epidemiologists and provides mechanisms and opportunities to give states greater flexibility in using categorical funding, including resources from multiple grants, to support these positions. In particular, CDC should encourage collaboration between state programs for "Environmental Public Health Tracking," "Hazardous Substance Emergency Events Surveillance" (HSEES), ATSDR's "Program to Conduct and Coordinate Site-Specific Activities", "Core and Enhanced Programs in Occupational Health Surveillance," and "Public Health Emergency Preparedness".
- CDC should establish performance measures such that, by 2015, all states will meet the minimum workforce requirement of one environmental epidemiologist for every state public health department.
- ASTHO and its affiliates (e.g., CSTE) should work with states to ensure hiring of needed environmental epidemiologists by promoting and maximizing use of funding flexibility and other resources.
- CDC should continue to support CSTE to sustain and promote the work of the CSTE State Environmental Health Indicator Collaborative (SEHIC) and related environmental health surveillance programs.
- CDC should continue to support surveillance research efforts to generate information for state-based environmental epidemiologists to apply to public health practice.
- CSTE should disseminate standards for and strongly encourage the development of competency-based Epidemiology Job series in state personnel systems.
- Mechanisms for capacity development such as the CDC/CSTE Applied Epidemiology Fellowship Program, Epidemic Intelligence Service, Public Health Prevention Service, and state-based epidemiology training programs should be supported as part of grant programs using both direct assistance and financial assistance to accomplish the objective of minimum epidemiology workforce in each state within five years.
- The voluntary national accreditation program for state and local health departments under development by the Public Health Accreditation Board (www.exploringaccreditation.org/index.html) should address environmental epidemiology capacity.

Public Health Impact:
Support of environmental epidemiology functions will enhance the ability of states to prioritize, plan, promote, implement and evaluate evidence-based interventions. This will prevent development of and reduce diseases associated with on-going and emergent environmentallyrelated exposures and conditions, including toxic contamination, global warming, and the built environment.

References

1. Landrigan PJ, Schechter CB, Lipton JM, Fahs M, Schwartz J. Environmental pollutants and disease in American Children: Estimates of morbidity, mortality, and costs for lead poisoning, asthma, cancer, and developmental disabilities. Environ Health Perspect 2002. 110:721-728.
2. Pruss-Ustun A, Corvalan C. *Preventing Disease through Healthy Environments: Towards and Estimate of the Environmental Burden of Disease*. World Health Organization 2006. Available at http://www.who.int/quantifying_ehimpacts/publications/preventingdisease/en/index.html
3. Oregon Environmental Council. The Price of Pollution: cost estimates of environmentallyrelated disease in Oregon. February 2008. Available at http://www.oeconline.org/kidshealth/priceofpollution/index
4. Doll R. Muir C. Estimating avoidable causes of cancer. Environ Health Perspect 1995. 103:301-6.

(continued)
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Committee: Occupational/Environmental Health

Title: State-level Environmental Disease Epidemiology Capacity

5. Pew Environmental Health Commission. America's Environmental health Gap: Why the Country Needs a Nationwide Health Tracking Network. September 2000. Available at http://healthyamericans.org/reports/files/healthgap.pdf
6. CSTE. 2006 National Assessment of Epidemiologic Capacity: Findings and Recommendations. Available at www.cste.org
7. CSTE. *Special Report: Workforce Development Initiative*. June 2007. Available at www.cste.org.

Coordination:

Agencies for Response:

(1) Julie Gerberding, MD, MPH, Director
Centers for Disease Control and Prevention
1600 Clifton Road MS D14
Atlanta, GA 30333
404-639-7000
jvg@cdc.gov

(2) Paul E Jarvis, MD, MBA
Executive Director
Association of State and Territorial Health Officials
2231 Crystal Dr, Suite 450
Arlington, VA 22202
(202) 371-9090
pjarris@astho.org

(3) Harold Zenick, PhD.
Director
National Health and Environmental Effects Research Laboratory
U.S. Environmental Protection Agency
Mail Code B305-01
Research Triangle Park
North Carolina 27711
(919) 541-2281
zenick.hal@epa.gov

Agencies for Information

(1) Howard Frumkin, MD, MPH
Director, National Center for Environmental Health/
Agency for Toxic Substances and Disease Registry
Centers for Disease Control and Prevention
4770 Buford Highway NE
Mailstop F-61
Atlanta, GA 30341-3717
(770) 488-0604
howard.frumkin@cdc.hhs.gov

(continued)
08-EH-01

Committee: Occupational/Environmental Health

Title: State-level Environmental Disease Epidemiology Capacity

(2) Nelson Fabian
Executive Director
National Environmental Health Association
720 S. Colorado Blvd
Suite 1000-N
Denver, CO 80246

(3) Albert C. Gray, PhD, CAE
Executive Director
Public Health Accreditation Board
1600 Duke Street, Suite 440
Alexandria, VA 22314
(703) 778 - 4549

Submitting Author:

(1) Martha Stanbury, MSPH
State Administrative Manager
Division of Environmental Health
Michigan Department of Community Health
PO Box 30195
Lansing MI 48909
517-335-8364
stanburym@michigan.gov

Co-Author:

(1) Henry Anderson, MD
Wisconsin Department of Health
One W. Wilson St
PO Box 309
Madison, WI
(608) 266-1253
anderha@dhfs.state.wi.us

2008 Position Statements

08-ID-02 (revised 6/11/2008 10AM)

Committee: Infectious Disease

Title: Revision of Rubella Case Definition and Enhancing Timeliness of Reporting to NNDSS

Statement of the Problem:
The laboratory criteria for diagnosis of rubella do not include PCR testing, which has been shown to be specific for rubella virus.

Background and Justification:
1. Because of successful implementation of rubella vaccination programs, endemic rubella transmission was declared eliminated in the United States in 2004. Despite significant advances in global rubella control, the US remains at risk for rubella importations and rubella outbreaks, especially if importations occur into unvaccinated communities. To maintain rubella elimination and prevent re-establishment of endemic disease transmission, sustained high vaccine coverage and sensitive rubella surveillance with rapid and robust public health response to every rubella case is needed. All rubella cases in the U.S. are a cause for concern. Delayed reporting of rubella cases to NNDSS does not allow timely reporting of current rubella cases to state, national and international partners.
2. Rubella is currently nationally notifiable, with laboratory criteria for diagnosis including isolation of the virus, significant rise in IgG titer, or positive IgM titer — but not a positive PCR test, which is also a reliable indicator of rubella virus.

Statement of the desired action(s) to be taken:
Modify the laboratory criteria for rubella to read as follows:
- Isolation of rubella virus from a clinical specimen, or
- Detection of rubella-virus-specific nucleic acid by polymerase chain reaction, or
- Significant rise in serum rubella immunoglobulin G antibody level between acute- and convalescent-phase specimens, by any standard serologic assay, or
- Positive serologic test for rubella immunoglobulin M antibody.

Goals of Surveillance:
(unchanged)

Methods for Surveillance:
(unchanged)

Criteria for Reporting
If the method for surveillance described in the previous section includes case ascertainment by reports of individual cases from traditional partners (e.g., clinicians, labs, hospitals) to governmental public health agencies, then **describe the reporting criteria which trigger the case reports**. [If the case ascertainment method is not based on reporting of individual cases, leave the "Reporting" subsections blank.] This section should specify the criteria to be used by both humans (described below under "Narrative") and machines (described below under "Tables"). "Human-based" criteria are applied by medical care providers (i.e., based on clinical judgment and clinical diagnosis) and laboratory staff. Machine-based criteria are applied using computerized algorithms which operate in electronic health record systems, including computerized lab test orders and lab test results.

A. Narrative:
If the method for surveillance described in the previous section includes case ascertainment by reports of individual cases from traditional partner
1. Timely reporting of rubella cases is important to allow appropriate reporting of rubella cases to state, national and international partners.
2. In addition to current reporting criteria, clinicians and laboratories should report positive PCR results.

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Committee: Infectious Disease

Title: Revision of Rubella Case Definition and Enhancing Timeliness of Reporting to NNDSS

B. Tables:
In this subsection, use two-column tables to express the criteria for reporting as machine-based criteria appropriate to guide development of computerized algorithms for electronic case-reporting processes. The machine-based criteria, where appropriate, should follow the human-based criteria in the above subsection: place each human-based criterion in the left column and the corresponding machine-based criterion in the right column.

C. Reporting disease-specific data elements:
(unchanged)

Case Definition

A. Narrative:
As noted in §III above, only the laboratory criteria are being changed — viz., adding positive PCR tests.

B. Classification Tables::
(unchanged)

Period of Surveillance:
(unchanged)

Data sharing/release and Print criteria:
(unchanged)

References:

Current rubella case definition:
http://www.cdc.gov/ncphi/disss/nndss/casedef/measles_current.htm

Coordination

Agencies for Response:

(1) Julie L. Gerberding, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Rd., MS D-12
Atlanta, GA 30333
404-639-7000
julie.gerberding@cdc.hhs.gov

Submitting Author:

(1) Paul R. Cieslak, MD
Manager, Acute & Communicable Disease Prevention
Oregon Public Health Division
800 NE Oregon St., Ste. 772
Portland, OR 97232
971-673-1111
paul.r.cieslak@state.or.us

(continued)
08-ID-02 (revised 6/11/2008 10AM)

Committee: Infectious Disease

Title: Revision of Rubella Case Definition and Enhancing Timeliness of Reporting to NNDSS

Table 1. Common core data elements for case reporting to a public health agency from a healthcare provider: To be included in the initial case report.

	Non Condition Specific Data Elements	Core Data Set
Reporting Information		
	Date of report	X
	Reporter name	X
Reporter Contact Information		
	Telephone	X
	Address	X
Health Care Provider Information		
	Health care provider name	X
	Facility Name	X
Facility/Provider Contact Information		
	Phone number	X
	Address	X
Subject Information		
	First Name	X
	Middle Name	X
	Last Name	X
	Street	X
	City	X
	State	X
	ZIP	X
	Telephone	X
	Age	X
	Date of birth	X
	Gender	X
Clinical Information		
	Name of Condition	X
	Date of onset	X

2008 Position Statements

08-ID-03 (revised 6/11/2008 10AM)

Committee: Infectious Disease

Title: Revision of Measles Case Definition and Enhancing Timeliness of Reporting to NNDSS

Statement of the Problem:

The laboratory criteria for diagnosis of measles do not include PCR testing, which has been shown to be specific for measles virus.

Background and Justification:

1. Because of successful implementation of measles vaccination programs, endemic measles transmission was declared eliminated in the United States in 2000 and in the World Health Organization (WHO) Region of the Americas in 2002. Despite significant advances in global measles control, the US remains at risk for measles importations and measles outbreaks, especially if importations occur into unvaccinated communities. To maintain measles elimination and prevent re-establishment of endemic disease transmission, sustained high vaccine coverage and sensitive measles surveillance with rapid and robust public health response to every measles case is needed. All measles cases in the Americas are a cause for concern. Delayed reporting of measles cases to NNDSS does not allow timely reporting of current measles cases to state, national and international partners.
2. Measles is currently nationally notifiable, with laboratory criteria for diagnosis including isolation of the virus, significant rise in IgG titer, or positive IgM titer — but not a positive PCR test, which is also a reliable indicator of measles virus.

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

Modify the laboratory criteria for measles to read as follows:

- Isolation of measles virus from a clinical specimen, or
- Detection of measles-virus-specific nucleic acid by polymerase chain reaction, or
- Significant rise in serum measles immunoglobulin G antibody level between acute- and convalescent-phase specimens, by any standard serologic assay, or
- Positive serologic test for measles immunoglobulin M antibody.

Goals of Surveillance:

(unchanged)

Methods for Surveillance:

(unchanged)

Criteria for Reporting

A. Narrative:

1. Timely reporting of measles cases is important to allow appropriate reporting of measles cases to state, national and international partners.
2. In addition to current reporting criteria, clinicians and laboratories should report positive PCR results.

B. Tables:

In this subsection, use two-column tables to express the criteria for reporting as machine-based criteria appropriate to guide development of computerized algorithms for electronic case-reporting processes. The machine-based criteria, where appropriate, should follow the human-based criteria in the above subsection: place each human-based criterion in the left column and the corresponding machine-based criterion in the right column.

2008 Position Statements

(continued)
08-ID-03 (revised 6/11/2008 10AM)

Committee: Infectious Disease

Title: Revision of Measles Case Definition and Enhancing Timeliness of Reporting to NNDSS

C. Reporting disease-specific data elements::

(unchanged)

Case Definition

A. Narrative:

As noted in §III above, only the laboratory criteria are being changed — viz., adding positive PCR tests.

B. Classification Tables:

(unchanged)

Period of Surveillance:

(unchanged)

Data sharing/release and Print criteria:

(unchanged)

References:

Current measles case definition: http://www.cdc.gov/ncphi/disss/nndss/casedef/measles_current.htm

Coordination

Agencies for Response:

(1) Julie L. Gerberding, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Rd., MS D-12
Atlanta, GA 30333
404-639-7000
julie.gerberding@cdc.hhs.gov

Submitting Author:

(1) Paul R. Cieslak, MD
Manager, Acute & Communicable Disease Prevention
Oregon Public Health Division
800 NE Oregon St., Ste. 772
Portland, OR 97232
971-673-1111
paul.r.cieslak@state.or.us

(continued)
08-ID-03 (revised 6/11/2008 10AM)

Committee: Infectious Disease

Title: Revision of Measles Case Definition and Enhancing Timeliness of Reporting to NNDSS

Table 1. Common core data elements for case reporting to a public health agency from a healthcare provider: To be included in the initial case report.

	Non Condition Specific Data Elements	Core Data Set
Reporting Information		
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	Address	X
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Subject Information		
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	Last Name	X
	Street	X
	City	X
	State	X
	ZIP	X
	Telephone	X
	Age	X
	Date of birth	X
	Gender	X
Clinical Information		
	Name of Condition	X
	Date of onset	X

2008 Position Statements

08-ID-06

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

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 Response 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.

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.

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

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.

2008 Position Statements

(continued)
08-ID-06

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

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.

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 phase II IgG or IgM antibody reactive with C. burnetii antigen by enzyme-linked immunosorbent assay (ELISA), dot-ELISA, or latex agglutination.

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.

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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.

References:
- 1999 Case Definition

Coordination:

Agencies for Response:

(1) Julie Gerberding, MD, MPH
Director
Centers for Disease Control and Prevention
1600 Clifton Road MS D14
Atlanta, GA 30333
404-639-7000
jvg2@cdc.hhs.gov

(continued)
08-ID-06

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

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

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

(continued)
08-ID-06

Committee: Infectious Disease

Title: Revision of the Surveillance Case Definition for Q fever

(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
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

2008 Position Statements

08-ID-07

Committee: Infectious Disease

Title: Support of and Enhancement of the National Healthcare Safety Network (NHSN)

Statement of the Problem:
Methicillin-resistant Staphylococcus aureus (MRSA) and mandatory public reporting of selected healthcare associated infections are topics that have received intensive media coverage and attention by Congress and state legislatures. Use of the National Healthcare Safety Network (NHSN) for mandatory public reporting of such infections and other adverse events has been very helpful for States that have chosen to use it, especially in those states where reporting requirements to state agencies have been imposed with little or no money appropriated for the purpose.

The standardized methodology, protocols and definitions are invaluable; it would be prohibitively labor intensive and redundant for state health departments to develop these. Using NHSN definitions, software and methodology allows facilities to compare themselves to their own rates over time as well as national rate data. Many more states are considering or planning to use NHSN to comply with mandatory reporting of outcome and process measures related to healthcare acquired infections. NHSN can also be used as a way for hospitals to report hospitalized cases of infections such as MRSA.

Constraints to the wider adoption of NHSN modules by hospitals, whether for voluntary performance measurement or mandated state reporting, include limited numbers of infection control personnel, training requirements, time required for data capture and data keying. Adoption of electronic medical record systems and provider order entry systems by hospitals offer the possibility of cost savings through automated data capture for the purposes of on-site performance measurement and data export to NHSN. Such systems continue to be developed, but are not yet widely adopted, and often do not follow a common architecture that allows for interoperability and data sharing across institutions.

There are tremendous opportunities to take advantage of electronic data exchange to support current and future modules within NHSN. Clinical document architecture specifications and implementation guidance for events and process measures such as central line insertion practices will avoid duplicate data entry and collisions with vendor developed systems. An example of one of the numerous applications and opportunities is importing existing Surgical Care Improvement Project (SCIP) data from the Centers for Medicare and Medicaid Services (CMS) at a patient level and coupling of surgical site infection (SSI) outcome and process measures to assist in the prevention of SSI. Other opportunities for electronic data exchange will allow collection of data in a much smarter, effective manner. This would obviate duplicate data entry and allow infection control professionals to spend time preventing infections and evaluating the impact of prevention measures instead of just counting infections and entering data. CSTE and States place a high priority on the commitment of Federal resources for NHSN system development in conjunction with State resources that are committed to use of NHSN as the infrastructure for mandatory reporting of healthcare-associated infections.

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

(1) CDC should allocate sufficient resources to NHSN to achieve the following:

   a. CDC should implement existing standards to allow for electronic data exchange from healthcare information systems and clinical microbiology laboratories to NHSN. These standards should be closely coordinated with the electronic laboratory reporting standards being created. These include microbiology data, pharmacy data and admission, and discharge and transfer (ADT) messages to populate data fields within NHSN.

   b. CDC should work with public and private sector partners to develop standards if they do not yet exist.

   c. CDC and partners should develop clinical document architecture specifications and implementation guidance for healthcare-associated events, and for process measures such as central line insertion practices.

(continued)
08-ID-07

Committee: Infectious Disease

Title: Support of and Enhancement of the National Healthcare Safety Network (NHSN)

d. CDC and partners, including CSTE, CMS, the Food and Drug Administration (FDA) and the Agency for Healthcare Research and Quality (AHRQ) should work to implement a change management process to assist in prioritizing NHSN change requests to meet State and federal partner requirements and to operationalize those requests in an effective manner.

e. CDC should develop and provide online training and competency modules for both hospitals and public health staff.

f. CDC should support "train the trainer" sessions for key staff within States.

(2) CSTE, state and local health departments should work with CDC and organizations active in hospital epidemiology and infection control in a manner analogous to the National Notifiable Disease Surveillance System process to further develop case definitions for healthcare-associated infections and processes for uniformity.

(3) CDC and CSTE should work on the joint development of methods for data validation. States and hospitals would make primary use of those methods to ensure data quality.

(4) CDC, CSTE and other organizations should support development of health care organizations' capability to transfer selected data through well-defined messaging systems from electronic health record systems, including laboratory information systems, to both notifiable disease surveillance systems and NHSN.

(5) CDC, CSTE and other organizations should assess the possible utility of NHSN as an option for transmittal of electronic case reports of hospitalized cases of all notifiable diseases between participating hospitals and the appropriate local and state public health agencies. This would require NHSN to be able to generate and send standard public health notification messages to public health surveillance applications.

Public Health Impact:

Adoption of these recommendations will:

(1) Strengthen surveillance of hospital acquired infections and multi-drug resistant organisms and enable a tighter coupling between surveillance and prevention activities resulting in a reduction of hospital acquired infections and multi-drug resistant organisms.

(2) Enable States to define and fulfill their state-specific roles and responsibilities in infection control and healthcare-acquired infections. These roles and responsibilities may be broader than the pure collection and reporting of data and may include responding to high rates of infection. This is achieved by stabilizing the infrastructure for collection and reporting of data.

(3) Maximize the return on investment at a Federal and State level. This will allow States to use available resources to further develop their roles and responsibilities as public health agencies and to use and respond to collected data.

(4) Ensure standardization of definitions and data collection. This will allow hospitals to compare their own rates over time as well as to national rate data, thereby encouraging them to use these comparisons to provide an impetus for further prevention activities.

(5) Support the capacity for evaluating the impact of interventions and legislation.

(6) Provide greater population wide coverage and more comprehensive surveillance data for public health analysis and evaluation.

(continued)
08-ID-07

Committee: Infectious Disease

Title: Support of and Enhancement of the National Healthcare Safety Network (NHSN)

Coordination

Agencies for Response:

Julie L. Gerberding, MD, MPH
Director
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
pjarris@astho.org

(3) Pat Libbey
Executive Director
National Association of City and County Health Officials
1100 17th Street, NW, Second Floor
Washington, DC 20036
Ph: (202) 783-5550
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

(continued)
08-ID-07

Committee: Infectious Disease

Title: Support of and Enhancement of the National Healthcare Safety Network (NHSN)

(5) Andrew C. von Eschenbach, M.D.
Commissioner
Food and Drug Administration
5600 Fishers Land
Room 14-71
Rockville, MD 20857
(301) 827-2410

(6) Kerry M. Weems
Acting Director
Centers for Medicare and Medicaid)
7500 Security Boulevard
Baltimore, MD 21244
202-690-6726
Kerry.Weems@CMS.hhs.gov

(7) Carolyn Clancy, M.D.
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850
301-427-1364
Carolyn.Clancy@ahrq.hhs.gov

(8) Robert M. Kolodner, MD
National Coordinator
Office of the National Coordinator for Health Information Technology
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
202-690-7151
robert.kolodner@hhs.gov

Submitting Author

Marion A. 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

(continued)
08-ID-07

Committee: Infectious Disease

Title: Support of and Enhancement of the National Healthcare Safety Network (NHSN)

Co-Author

Gail R. Hansen
State Epidemiologist
Kansas Department of Health and Environment
1000 SW Jackson, Suite 300
Topeka, KS 66612
785-296-1127
ghansen@kdhe.state.ks.us

Richard S. Hopkins, MD, MSPH
Medical Epidemiologist
Acute Disease Epidemiology Section
Bureau of Epidemiology
Florida Department of Health
4052 Bald Cypress Way, Bin # A-12, Tallahassee, FL 32399
850-245-4412
Cell: 850-251-5857
Fax: 850-922-9299
Richard_Hopkins@doh.state.fl.us

Kirk Smith, DVM, PhD
Supervisor, Foodborne, Vectorborne, and Zoonotic Disease Unit
Acute Disease Investigation and Control Section
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-5240
Fax: 651-201-5743
kirk.smith@state.mn.us

(Street address for deliveries)
625 Robert Street North
St. Paul, MN 55155-2538

2008 Position Statements

08-ID-08

Committee: Infectious Disease

Title: Revision of Cryptosporidiosis Case Definition

Statement of the Problem:
The case definition of cryptosporidiosis, a disease under public health surveillance, is in need of a case classification for reporting of probable cases of cryptosporidiosis.

Background and Justification:
Protozoan parasites of the genus *Cryptosporidium* can cause severe diarrheal illness, and are an increasingly recognized cause of recreational water-associated outbreaks. Monitoring of surveillance data has been very useful in delineating the epidemiology of cryptosporidiosis at the state and national levels. This information is useful in designing further studies to assess risk factors that might be associated with changes in transmission patterns, as well as to assess current policies, both at the state and local levels and at the national level. These data may guide development of policy in the area of design and construction of recreational water facilities.

Statement of the desired action(s) to be taken:
1) add a probable case classification; 2) delete the asymptomatic confirmed case classification; and 3) broaden the case definition beyond *C. parvum* to increase understanding of the epidemiology of other *Cryptosporidium* species.

Goals of Surveillance:
The last modification to the cryptosporidiosis case definition was a response to the public health risks associated with the finding of *Cryptosporidium* oocysts in source water or tap water under EPA's "Information Collection Rule" (that requires utilities to test source water for Cryptosporidiosis oocysts) and focused on the detection of human disease associated with public water supplies. Since 1998, *Cryptosporidium* has been increasingly recognized as the etiologic agent involved in recreational water outbreaks. In addition, molecular analysis of *Cryptosporidium* has shown that the species *Cryptosporidium parvum* is actually a mixture of various species that differ in infectivity for humans. The goal of this change to the case definition would be to accurately capture not only the number of confirmed, but the number of probable cases of cryptosporidiosis caused by any species of *Cryptosporidium*. Public health officials will need to respond to these findings. Continued surveillance for cryptosporidiosis in humans can provide information that may be useful in formulating an appropriate response.

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

Criteria for Reporting

A. Tables:
   To be developed.

B. Reporting disease-specific data elements:
   To be developed.

Case Definition

A. Narrative:

   Clinical description
   An illness characterized by watery diarrhea, abdominal cramps, loss of appetite, low-grade fever, nausea and vomiting. The disease can be prolonged and life-threatening in severely immunocompromised persons.

(continued)
08-ID-08

Committee: Infectious Disease

Title: Revision of Cryptosporidiosis Case Definition

Laboratory evidence
Laboratory-confirmed cryptosporidiosis is defined as the detection of a member of the genus *Cryptosporidium* by one of the following methods:

Case classification

Confirmed: a case that meets the clinical description and at least one of the criteria for laboratory confirmation as described above. When available, species designation and molecular characterization should be reported.

Probable: a case that meets the clinical description and that is epidemiologically linked to a confirmed case.

Period of Surveillance:

Ongoing. This revision of the surveillance case definition will be effective January 1, 2009.

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.

References:

Position Statement 1998-ID 5. Continuation of Cryptosporidiosis Under National Surveillance.
Position Statement 1994-ID. National Surveillance for Cryptosporidiosis.

(continued)
08-ID-08

Committee: Infectious Disease

Title: Revision of Cryptosporidiosis Case Definition

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) Lauri Smithee
Chief, Acute Disease Services
Oklahoma State Department of Health
1000 NE 10th St
Oklahoma City, OK 73117-1299
(405) 271-4060
LauriS@health.ok.gov

(2) Michael Beach
Centers for Disease Control and Prevention
4770 Buford Highway, NE
Atlanta, GA 30341
770-488-7763
mbeach@cdc.gov

Submitting Author:

(1) Lauri Smithee
Chief, Acute Disease Service
Oklahoma State Department of Health
1000 NE 10th St
Oklahoma City, OK 73117-1299
(405) 271-4060 LauriS@health.ok.gov

Co-Author:

(1) Michael Beach
Centers for Disease Control and Prevention
4770 Buford Highway, NE
Atlanta, GA 30341
770-488-7763
mbeach@cdc.gov

(continued)
08-ID-08

Committee: Infectious Disease

Title: Revision of Cryptosporidiosis Case Definition

Table 1. Common core data elements for case reporting to a public health agency from a healthcare provider: To be included in the initial case report.

	Non Condition Specific Data Elements	Core Data Set
Reporting Information		
	Date of report	X
	Reporter name	X
Reporter Contact Information		
	Telephone	X
	Address	X
Health Care Provider Information		
	Health care provider name	X
	Facility Name	X
Facility/Provider Contact Information		
	Phone number	X
	Address	X
Subject Information		
	First Name	X
	Middle Name	X
	Last Name	X
	Street	X
	City	X
	State	X
	ZIP	X
	Telephone	X
	Age	X
	Date of birth	X
	Gender	X
Clinical Information		
	Name of Condition	X
	Date of onset	X

2008 Position Statements

08-ID-10

Committee: Infectious Disease

Title: Influenza Surveillance in the United States

Statement of the Problem:

Influenza is a major public health issue in the United States, causing an estimated 200,000 hospitalizations (1) and 36,000 deaths each year in the United States (2). Substantial public health resources are committed to prevention of influenza and influenza-associated morbidity and mortality, primarily through influenza vaccination, but also including promotion of respiratory hygiene and use of antiviral medications. During the past several years, influenza has received heightened attention because of:

- Increased pediatric mortality during the 2003-4 influenza season (3);
- Widespread resistance of influenza A (H3N2) to adamantanes detected during the 2005-2006 season (7); and resistance to Oseltamivir detected in H1N1 isolates during the 2007-08 influenza season;
- Increased concerns raised during pandemic influenza planning efforts at the local, state and national level with respect to varying surveillance needs at all levels of government.

Information from public health surveillance is needed to assess the public health burden of seasonal influenza, inform policy makers and the public, promote vaccination efforts, evaluate vaccination strategies, vaccine strain selection , detect changes in influenza viruses including detection of novel viruses with pandemic potential, and to guide public health interventions to limit morbidity and mortality.

The emergence of avian influenza A (H5N1) as a widespread epizootic disease capable of causing severe human disease has increased both the importance of seasonal influenza surveillance and public interest in both seasonal and pandemic influenza. Surveillance systems for seasonal influenza should serve as a foundation for pandemic surveillance. Currently, United States influenza surveillance includes several components (8):

1. World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) Collaborating Laboratories.
2. U.S. Influenza Sentinel Providers Surveillance Network.
3. 122 Cities Mortality Reporting System.
4. State and Territorial Epidemiologists Reports.
5. Influenza-associated pediatric mortality.
6. Emerging Infections Program (EIP) - laboratory-confirmed influenza related hospitalizations
7. New Vaccine Surveillance Network (NVSN) -- laboratory-confirmed influenza hospitalization in children less than 5 years old and outpatients 0– 12 years old.

In addition, other methods are being used in some states, including:

- Influenza-associated hospitalizations (9); syndromic surveillance using emergency department chief complaints (respiratory, systemic/febrile illness); hospitalizations for pneumonia; and over-the-counter sales of medicines. (10-12)

Although the current influenza surveillance system has provided useful information, in 2006, CSTE passed a position statement urging CDC to convene an expert panel to conduct an evaluation of influenza surveillance in the United States. It was requested that such a panel would:

a) include representatives of local, state, and federal public health agencies and individuals with expertise in influenza, public health surveillance, pandemic preparedness, virology and laboratory testing, immunizations, vaccine development, hospital infection control (i.e., infection control practitioners, hospital epidemiologists), medical and public health informatics, and risk communications.

b) consider the objectives, uses and value of the components of influenza surveillance at national, state, and local levels for both seasonal epidemics of influenza and during an influenza pandemic. The interaction of U.S. surveillance with global needs should also be considered.

2008 Position Statements

(continued)
08-ID-10

Committee: Infectious Disease

Title: Influenza Surveillance in the United States

c) issue recommendations for influenza surveillance in the United States that balance local, state, and national needs with available resources.
d) issue recommendations that would setting priorities for improvement or change; listing of the resources needed to accomplish any recommended changes; addressing surveillance needs for seasonal influenza and assessing the ability of the surveillance system to serve as a basis for surveillance during an influenza pandemic.
e) issue recommendations for research and evaluation to guide future surveillance system development should be included.

In response to this position statement, CDC's Influenza Division convened an expert consultation in November 2006 to initiate the process. The main recommendations of the meeting were:

Facilitate implementation of electronic death reporting as a means for improving reporting of pneumonia and influenza related deaths.

Develop methods for timely assessment of severe influenza disease and health care resource demands including developing standards and definitions for case reporting.

Develop methods for expanding laboratory networks within states, electronic laboratory reporting, and data feedback mechanism within states.

Develop flexible yet consistent systems for capturing outpatient ILI, specifically focused on expanded use of alternative electronic data sources.

Develop standardized definitions for influenza activity including a measure of intensity for the State and Territorial Epidemiologists' Report.

Following the meeting workgroups were established that met throughout 2007 to determine how to implement the recommendations. These groups reported their recommendations to the larger expert consultation panel during a second meeting convened in December 2007.

The expert consultation panel acknowledged that several factors impact influenza surveillance strategies. These include:

1) Currently, the approaches to and resources dedicated to influenza surveillance vary markedly from state to state.
2) Some components of influenza surveillance work well at the national and international level, but provide little useful information at state and local levels (e.g., influenza mortality, pediatric influenza hospitalizations). Heightened interest in influenza has increased the need for information at state and local levels. In addition, it is unlikely that current surveillance methods would be sustainable or satisfy information needs at state and local levels during an influenza pandemic.
3) The current classification system used in the State and Territorial Epidemiologist Reports is problematic in several ways. First, it continues to be very challenging to implement in a standardized manner across states. Secondly, it is potentially confusing to media and policymakers, as it may be interpreted to both describe the seriousness of the seasonal epidemic (i.e., from a mild to a severe flu season) the distribution of cases across different geographical areas...
4) The role of syndromic surveillance methods for .tracking influenza and in particular the potential redundancy between ILI surveillance and chief complaint surveillance deserves attention.
5) Collection of viral isolates is becoming increasingly difficult as practitioners increasingly rely on rapid influenza tests that provide them with real-time clinical information but don't provide a source of information on the types of viruses that are circulating.
6) Consideration should be given to integrating seasonal and pandemic influenza surveillance with local, state, and federal surveillance computer systems and surveillance system standards (e.g., NEDSS, PHIN, and the PHIN Preparedness Functional Requirements). Plans should be made to assure that surveillance applications are prepared to manage surveillance data during a pandemic.

2008 Position Statements

(continued)
08-ID-10

Committee: Infectious Disease

Title: Influenza Surveillance in the United States

The 2007 expert consultation concluded that CDC and CSTE need to have a national surveillance system that moves surveillance toward a unified system versus a piecemeal approach to disease reporting activities. The recommendations of the 2007 consultation are stated in the "Statement of desired actions to be taken" below:

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

1. CDC should publish formal influenza surveillance guidelines derived from the recommendations made in the two CSTE/ CDC Consultations (in the form of R&R or other).
2. CDC should work with states to foster development of standardized surveillance systems for influenza associated hospitalization, and influenza associated electronic death reporting. Those states with current, or in the process of developing systems, should work with CDC to develop standards for data format and transmission.
3. CDC should establish a mechanism to accept data in a standardized format for those states able to send influenza associated hospitalization data, influenza mortality data, and laboratory data. This mechanism should include the ability to accept data according to PHIN standards for those states able to transfer it according to those standards.
4. The Influenza Division should provide adequate funding for states to enhance surveillance activities and resources should be provided to the Influenza Division by CDC to fund influenza surveillance activities.

Public Health Impact:

Influenza is a major public health issue causing substantial disease and death during seasonal epidemics and with the potential for pandemics of historic magnitude. As stated in Institute of Medicine report, *Emerging Infections: Microbial Threats to Health in the United States* "The importance of surveillance to the detection and control of emerging microbial threats cannot be overemphasized " (14). What is needed is a national approach to influenza surveillance that can move this nation from a piecemeal to a more unified and standardized system of disease surveillance.

References

1. Thompson WW, Shay DK, Weintraub E, et al. Influenza-associated hospitalizations in the United States. JAMA 2004;292:1333-1340.
2. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP. MMWR 2004;53(No.RR-6).
3. Bhat N, Wright JG, Broder KR, et al. Influenza-associated deaths among children in the United States, 2003-2004. N Engl J Med 2005;353:2559.
4. CDC. High Levels of Adamantane Resistance Among Influenza A (H3N2) Viruses and Interim Guidelines for Use of Antiviral Agents --- United States, 2005--06 Influenza Season. MMWR 2006; 55(02);44-46.
5. CDC. Overview of influenza surveillance in the United States. http://www.cdc.gov/flu/weekly/fluactivity.htm (accessed on March 9, 2006).
6. CDC. Surveillance for Laboratory-Confirmed, Influenza-Associated Hospitalizations -- Colorado, 2004--05 Influenza Season. MMWR 2005;54(21):535-537.
7. CDC. Hospital Admissions Syndromic Surveillance --Connecticut, October 2001-- June 2004. MMWR 2005; 54(Suppl);169-173.
8. CDC. Comparison of Syndromic Surveillance and a Sentinel Provider System in Detecting an Influenza Outbreak --- Denver, Colorado, 2003. MMWR 2005; 54(Suppl);151-156.
9. Vergu E, Grais RF, Sarter H, et al. Medication sales and syndromic surveillance, France. Emerg Infect Dis [serial on the Internet]. 2006 Mar [accessed March 28, 2006]. Available from http://www.cdc.gov/ncidod/EID/vol12no03/05-0573.htm
10. Institute of Medicine. *The Future of the Public's Health in the 21st Century*. The National Academies Press, 2003; Washington, DC.
11. Institute of Medicine. Emerging Infections: *Microbial Threats to Health in the United States*. National Academy Press, 1992; Washington, DC.

(continued)
08-ID-10

Committee: Infectious Disease

Title: Influenza Surveillance in the United States

Coordination:

Agencies for Response:

(1) Julie L. Gerberding, MD
Director
Centers for Disease Control and Prevention
1600 Clifton Road, NE, MS D-14
Atlanta, GA 30333
404-639-7000
jyg2@cdc.gov

Agencies for Information:

(1) Paul E. Jarris, MD, MBA
Executive Director, Association of State and Territorial Health Officers
1275 K Street NW, Suite 800
Washington, DC 20005
(202) 371-9090
pjarris@astho.org

(2) Scott Becker
Executive Director
Association of Public Health Laboratories
2025 M Street NW, #550
Washington, DC 20036-3320
(202) 822-5227
Sbecker@aphl.org

(3) Patrick Libbey
Executive Director
National Association of City and County Health Officers
1100 17th Street 2nd floor
Washington, D.C. 20036
202-783-5550
plibbey@naccho.org

(4) Rex Archer, MD, MPH
President, National Association of County and City Health Officials
Director of Health
Kansas City Health Department
2400 Troost Avenue, Suite 4000
Kansas City, MO 64108
(816) 513-6252
rex_archer@kcmo.org

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08-ID-10

Committee: Infectious Disease

Title: Influenza Surveillance in the United States

(5) Bruce Gellin, MD, MPH
Director, National Vaccine Program Office
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 690-5566
BGellin@OSOPHS.DHHS.GOV

Submitting Authors:

(1) Kathleen F. Gensheimer, MD, MPH
State Epidemiologist
Maine CDC, Maine Dept. of Health and Human Services
State House #11, Key Plaza
Augusta, Maine 04333
207 287 5183
Kathleen.F.Gensheimer@Maine.gov

(2) Lyn Finelli, DrPH, MS
Influenza Division
CDC

Co-Authors:

(1) Ken Gershman, MD, MPH
Chief, Communicable Disease Epidemiology
Colorado Department of Public Health
4300 Cherry Creek Drive South
Denver, Colorado 80246
(303) 692-2657
ken.gershman@state.co.us

(2) Robert Rolfs, MD, MPH
Utah Dept of Health
801-538-6191
rrolfs@utah.gov

2008 Position Statements

08-OH-01
08-INJ-01

Committee: Environmental/Occupational/Injury

Title: State-level Occupational Illness and Injury Epidemiology Capacity

Statement of the Problem:
CSTE has long recognized that occupational illnesses and injuries are important causes of morbidity and mortality in the US. Approximately 6500 job-related deaths from injury, 13.2 million nonfatal injuries, 60,300 deaths from disease, and 862,200 illnesses are estimated to occur annually in the civilian workforce. The total direct ($65 billion) plus indirect ($106 billion) costs have been estimated to be $171 billion.[1]

Epidemiology, as the core science of public health, is the basis for public health surveillance and, as such, is essential for the detection, control and prevention of occupational illnesses and injuries. In spite of the magnitude of occupational illness and injury, relatively few states employ occupational epidemiologists in part because of the perception that public health surveillance for occupational diseases and injuries is being addressed adequately by the annual occupational injury and illness survey conducted by the Bureau of Labor Statistics (BLS). Recently published studies have continued to document the inadequacy of the BLS survey for surveillance of occupational injuries and illnesses.[2,3,4] These studies demonstrate the importance of alternate and complementary occupational disease and injury surveillance systems that are integrated into traditional public health systems. It is also noteworthy that occupational epidemiology has a place in a variety of public health surveillance programs, including infectious disease (e.g., blood borne pathogens, needlestick injuries), chronic disease (e.g., work-related asthma), injury control, cancer, and others.

The CSTE 2006 National Assessment of Epidemiologic Capacity found that 42% of state health departments had no epidemiologic capacity at all in occupational health and only 13% had substantial or almost full capacity. By contrast, 33% reported substantial or almost full capacity in environmental health epidemiology, and all states reported partial to full capacity in infectious disease.5 CSTE concluded that there was a 192% gap between current and needed capacity for occupational epidemiologists.[8]

In 1995, the National Institute for Occupational Safety and Health (NIOSH), an agency in the Centers for Disease Control and Prevention (CDC), recommended that, at a minimum, every state should have one epidemiologist assigned to occupational health to carry out public health surveillance functions.[6] A CSTE Workgroup then developed a strategic plan for state-based public health surveillance of occupational illnesses and injuries. One outcome of that planning process was a document entitled *The Role of the States in a Nationwide, Comprehensive Surveillance system for Work-Related Diseases, Injuries, and Hazards*.[7] This document reinforced the fundamental importance of public health surveillance, based on principles of epidemiology, to the practice of occupational disease and injury prevention.

Statement of the desired action(s) to be taken:
CSTE will work with CDC/NIOSH, the Association of State and Territorial Health Officials (ASTHO) and other partner organizations to advocate on behalf of states in their efforts to recruit and retain adequate numbers of trained and experienced occupational epidemiologists to carry out the functions described by NIOSH 6 and CSTE.[7]

States should identify state resources to support occupational epidemiology capacity. They should deploy occupational epidemiologists in an organizational structure that maximizes their ability to coordinate occupational health activities throughout their agency and among other agencies.

(continued)
08-OH-01
08-INJ-01

Committee: Environmental/Occupational/Injury

Title: State-level Occupational Illness and Injury Epidemiology Capacity

Specific steps to achieve these outcomes should include the following:

- CDC/NIOSH should encourage all states to achieve the recommended minimum occupational epidemiology workforce through establishment and expansion of cooperative agreements to fund state occupational health surveillance programs.
- CDC should include language in other/related cooperative agreements that explicitly encourages support for occupational epidemiologists and provides mechanisms and opportunities to give states greater flexibility in using categorical funding, including resources from multiple grants, to support these positions. In particular, CDC should encourage collaboration between state occupational health surveillance, Environmental Public Health Tracking, and Public Health Preparedness programs.
- CDC/NIOSH should establish performance measures such that, by 2012, 20 state programs will meet the minimum workforce requirement of one occupational epidemiologist for state based activities in occupational public health6 and by 2020 all states will meet this minimum workforce requirement.
- ASTHO and its affiliates (e.g., CSTE) should work for and with states to ensure hiring of needed occupational epidemiologists by promoting and maximizing use of funding flexibility and other resources.
- CDC/NIOSH should continue to support CSTE to continue the work of the CSTE Occupational Health Surveillance Workgroup so that states can advance the programmatic goals set by CDC/NIOSH for state-based occupational health surveillance.
- CDC/NIOSH should continue to support surveillance research efforts to generate information for state-based occupational epidemiologists to apply to public health practice.
- CSTE should disseminate standards for and strongly encourage the development of competency-based Epidemiology Job series in state personnel systems.
- Mechanisms for capacity development such as the CDC/CSTE Applied Epidemiology Fellowship Program, Epidemic Intelligence Service, Public Health Prevention Service, and state-based epidemiology training programs should be supported as part of grant programs using both direct assistance and financial assistance to accomplish the objective of minimum epidemiology workforce in each state within five years.
- The voluntary national accreditation program for state and local health departments under development by the Public Health Accreditation Board (www.exploringaccreditation.org/index.html) should address occupational epidemiology capacity.

Public Health Impact:
Support of occupational epidemiology functions will enhance the ability of states to prioritize, plan, promote, implement and evaluate evidence-based interventions. This will prevent development of and reduce disability from work-related conditions.

References

1. Leigh JP, Markowitz SB, Fahs M, Shin C, Landrigan PJ. Occupational injury and illness in the United States. Estimates of costs, morbidity, and mortality. Arch Intern Med. 1997 Jul 28;157(14):1557-68.
2. Rosenman KD, Kalush A, Reilly MJ, Gardiner JC, Reeves M, Luo Z. How much work-related injury and illness is missed by the current national surveillance system? J Occup Environ Med. 2006 48:357-65.
3. Leigh JP, Marcin JP, Miller TR. An estimate of the U.S. government's undercount of nonfatal occupational injuries. J Occup Environ Med. 2004;46:10-18.
4. Azaroff LS, Levenstein C, Wegman DH. Occupational injury and illness surveillance: Conceptual filters explain underreporting. Am J Public Health. 2002 92:1421-1429.

(continued)
08-OH-01
08-INJ-01

Committee: Environmental/Occupational/Injury

Title: State-level Occupational Illness and Injury Epidemiology Capacity

5. CSTE. 2006 National Assessment of Epidemiologic Capacity: Findings as Recommendations. Available at www.cste.org
6. Stanbury M, Rosenman KD, Anderson HA. *Guidelines: Minimum and Comprehensive State- Based Activities in Occupational Safety and Health.* DHHS (NIOSH) Publication No. 95-107. June 1995. This document is under revision and is expected to be published by NIOSH in 2008.
7. *The Role of the States in a Nationwide Comprehensive Surveillance System for Work-related Diseases, Injuries, and Hazards.* Council of State and Territorial Epidemiologists, July 2001. Available at www.cste.org.
8. CSTE. Special Report: Workforce Development Initiative. June 2007. Available at www.cste.org.

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

(2) Paul E Jarvis, MD, MBA
Executive Director
Association of State and Territorial Health Officials
2231 Crystal Dr, Suite 450
Arlington, VA 22202
(202) 371-9090
pjarris@astho.org

(3) John Howard, MD, MPH, JD, LLM
Director,
National Institute for Occupational Safety and Health
395 E Street, S.W.
Suite 9200
Patriots Plaza Building
Washington, DC 20201
(202) 245-0625
John.howard@cdc.hhs.gov

Agencies for Information:

(1) John Howard, MD, MPH, JD, LLM
Director,
National Institute for Occupational Safety and Health
395 E Street, S.W.
Suite 9200
Patriots Plaza Building
Washington, DC 20201
(202) 245-0625
John.howard@cdc.hhs.gov

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08-OH-01
08-INJ-01

Committee: Environmental/Occupational/Injury

Title: State-level Occupational Illness and Injury Epidemiology Capacity

(2) Edwin G. Foulke, Jr.
Assistant Secretary of Labor for OSHA
U.S. Department of Labor
Occupational Safety & Health Administration
200 Constitution Avenue
Washington, D.C. 20210
1-800-321-6742

(3) Elaine L. Chao,
Secretary of Labor
U.S. Bureau of Labor Statistics
Postal Square Building
2 Massachusetts Avenue, NE
Washington, DC 20212-0001
(202) 691-5200

(4) Albert C. Gray, PhD, CAE
Executive Director
Public Health Accreditation Board
1600 Duke Street, Suite 440
Alexandria, VA 22314
(703) 778 - 4549

Submitting Author:
(1) Martha Stanbury, MSPH
State Administrative Manager
Division of Environmental Health
Michigan Department of Community Health
PO Box 30195
Lansing MI 48909
517-335-8364
stanburym@michigan.gov

Co-Author:
(1) Letitia Davis, ScD, EdM
Director, Occupational Health Surveillance Program
Massachusetts Department of Public Health
250 Washington Street, 6th Floor
Boston, MA 02108
617-624-5626
Letitia.Davis@state.ma.us

2008 Position Statement Author Progress Report

Author Progress Report: 08-EC-01

Committee: Executive

Title: NASPHV/CSTE resolution on One Health

Position Statement Progress Report:
08-EC-01 "NASPHV/CSTE resolution on One Health"

April 10, 2009

Lekesha Robinson, Deputy Director
Council of State and Territorial Epidemiologists
2872 Woodcock boulevard, Suite 303
Atlanta, GA 30341

Dear Ms Robinson,

Thank you for your inquire regarding the impact of position statement 08-EC-01 entitled "NASPHV/CSTE resolution on One Health".

Since the resolution was passed in June, 2008, the American Veterinary Medical Association's One health Initiative Taskforce published a report, which recommended that a One Health Commission be formed to lead the effort of promoting the One Health concept to policy makers, scientists, educational institutions, governmental agencies and other interest groups in the United States over the next few years. The complete Taskforce report can be found at http://www.avma.org/onehelath/default.asp. An interim One Health Joint Steering Committee was formed last fall to help launch the Commission. There are currently 16 member organizations on the Committee, including the agencies responding to the CSTE resolution.

The One Health Commission will be launched in July 2009. The Commission will have an advisory team of experts and sponsoring organizations and a guiding coalition with additional supporters and champions. My hope is that CSTE will serve the One Health Commission i one of these advisory capacities.

I would also like to encourage CSTE to continue working with CDC and other partners to foster an interdisciplinary approach to disease prevention and control whenever appropriate. CSTE can do this by advocating for multi-disciplinary funding, educational, and leadership training opportunities. The recent joint CDC/CSTE meeting on influenza at the animal-human interface and the cooperative agreement being discussed between CDC and CSTE to further interagency cooperation among research institutions, public health and agriculture agencies in the states are good examples of such efforts.

Please don't hesitate to call on me if I can be of assistance in this effort.

Sincerely,

Carina Blackmore, DVM, PhD
State Public health Veterinarian
State Environmental Epidemiologist
Chief, Bureau of Environmental Public Health Medicine
Florida Department of Health.

2008 Position Statement Author Progress Report

Author Progress Report: 08-EC-02

Committee: Executive

Title: Criteria for Inclusion of Conditions on CSTE Nationally Notifiable Condition List and for Categorization as Immediately or Routinely Notifiable

Position Statement Progress Report:
08-EC-02 "Criteria for Inclusion of Conditions on CSTE Nationally Notifiable Condition List and for Categorization as Immediately or Routinely Notifiable"

We are requesting an author progress report to the 2008 position statement **08-EC-02** entitled ***"Criteria for Inclusion of Conditions on CSTE Nationally Notifiable Condition List and for Categorization as Immediately or Routinely Notifiable"*** authored by you for inclusion in the CSTE Annual Report that will be available at the 2009 CSTE Annual Conference. Please provide a progress report to the CSTE National Office by May 2, 2009 addressing the following in regards to the position statements.

1. **Please summarize what, if anything, has happened since the resolution was passed.**
   Beginning in July 2008, CSTE contracted with a team of medical epidemiologists and a medical informatician to reformat (without modifying the case definition) into an approved format that was developed by the CSTE Surveillance Coordination Subcommittee led by Steve Macdonald and approved by the CSTE Executive Board. There are essentially three phases to accomplish the reformatting of over 70 position statements.

   Phase I:
   The position statements were reformatted by the contractors and submitted for CSTE epidemiology and CDC and APHL subject matter expert (SME) review between July and November 2008. CSTE SMEs were authors of position statements related to the disease being reformatted and CDC and APHL SMEs were identified by their respective organizations. To aid in this process, CSTE created several documents that depict exactly how to submit a new or revised position statement including a step-by-step guide to completing each of the required sections. A guide was also published on how to submit a completed statement online.

   Phase II:
   After each position statement was revised by the contractors for the final time in November 2008, the position statements were posted to the CSTE Position Statement Revision Forum in January 2009 for membership review and verification of content. Guides were made available describing exactly how to revise previously submitted position statements online. CSTE hosted numerous conference calls, webinars and discussions to clarify the process and encourage cross-agency collaboration. During this process, CDC submitted Case Notification Requests (CNRs) that included information for the notification process from state health departments to CDC (either immediate or standard notification).

   Phase III:
   Position statements undergoing further revisions to the content and case definitions need to be submitted to CSTE electronically on the CSTE website (members only section) by April 2, 2009. As of April 5, 15 reformatted nationally notifiable condition position statements were submitted as new position statements along with 37 position statements with no major changes made. There are 21 position statements currently outstanding. CSTE National Office staff is working with the authors of the outstanding position statements to have them submitted by the Expedited handling deadline.

2008 Position Statement Author Progress Report

Author Progress Report: 08-EC-02 (continued)

Committee: CSTE Executive Committee

Title: Criteria for Inclusion of Conditions on CSTE Nationally Notifiable Condition List and for Categorization as Immediately or Routinely Notifiable

2. **Has there been any positive action or outcome due to the resolution? If so, please summarize.**
   Increased collaboration and communication between CSTE authors and CDC program area subject matter experts was a result of the position statement. It also brought attention to the way in which CSTE position statements are created, maintained and modified. Future projects will spring forth in other areas as electronic health records, laboratory reporting and other work affects how epidemiology and surveillance are conducted.

3. **Is there any action needed by CSTE at this time to assist in further implementation?**
   Further action from CSTE and collaboration with CDC will be required to complete the Technical Implementation Guides for all of the approved final position statements by September 2009. Also, further work in standardizing the data elements of all of the nationally notifiable conditions may be another project for CSTE to lead.

   CDC SMEs are currently working on the mechanisms for immediate vs. routine notification of nationally notifiable conditions. CSTE will work with CDC to finalize this process.

4. **Were any partners mobilized because of the resolution?**
   CSTE collaborated with the Association of Public Health Laboratories (APHL) and various program areas at CDC.

5. **Please include any other comments or suggestions.**
   All position statements that underwent the reformatting process will be discussed at the Sunday preconference workshop at the June CSTE Annual Conference in Buffalo. The submitted position statements (with significant changes to the case definition) will be open for discussion at the individual steering committee sessions at the Annual Conference.

Jeffery Engel

2008 Position Statement Author Progress Report

Author Progress Report: 08-EC-03

Committee: Executive

Title: State-level Substance Abuse Epidemiology Capacity

Position Statement Progress Report:
08-EC-03 "State-level Substance Abuse Epidemiology Capacity"

April 6, 2009

Lekesha Robinson, Deputy Director
Council of State and Territorial Epidemiologists
2872 Woodcock boulevard, Suite 303
Atlanta, GA 30341

Dear Ms Robinson,

This is in response to progress related to the 2008 position statement 08-EC-03 entitled "State-level Substance Abuse Epidemiology Capacity.

There have been positive actions since the resolution was passed. CSTE members have formed three new substance abuse subcommittees: alcohol, drug overdoses and substance abuse indicators. These are in addition to the overarching substance abuse subcommittee that is focused on building collaborations and epidemiology capacity in states. These subcommittees have brought new members to CSTE as well as re-engaged members whose membership had lapsed. To develop a baseline measure of substance abuse epidemiology capacity, questions on substance abuse epidemiology have been added to the new CSTE epidemiology capacity assessment.

Mr. Ed Chao of CSTE was assigned as staff support to the substance abuse subcommittees. Substance abuse has been added to the forum area of the CSTE Website and currently two of the three subcommittees have posted work plans to their respective areas. The overdose subcommittee has actively planned for presentations at the 2009 CSTE meeting in buffalo, New York. The alcohol and indicator subcommittees recently held organizational discussions and will be seeking ways to promote their work.

Initial funding for a CSTE substance abuse fellow was received from CDC for proof of concept. This position is based at the Georgia's public health agency under the guidance of Dr. John Horan, Georgia"s State Epidemiologist. In addition, at least two otehr states have submitted billets for a substance abuse epidemiology CSTE fellow from the incoming class.

CSTE members continue to promote collaborations with CDC and SAMHSA. A member of the CSTE Executive Committee viseted SAMHSA to advocate for the continued focus SAMHSA has had on public health methods that relate to surveillance and public health practice. Other members have promoted CSTE at SAMHSA-sponsored meetings over the past year, particularly those meetings that are focused on population-level data and data methods.

Members involved with the substance abuse epidemiology subcommittees appreciate CSTE's support in the assignment of staff support to the subcommittees and the support for CSTE fellows interested in substance abuse epidemiology

2008 Position Statement
Author Progress Report

Author Progress Report: 08-EC-03 (continued)

Committee: Executive

Title: State-level Substance Abuse Epidemiology Capacity

Lakesha Robinson, Deputy Director
Page 2
April 6, 2009

National attention is being focused on the surveillance of alcohol and other drugs. The rising morbidity and mortality related to overdoses from prescription drugs has raised considerable awareness among substance abuse agencies, law enforcement and public health agencies. Journal articles by CSTE members and others have also highlighted the continuing problem of alcohol misuse and abuse including youth and college-age binge drinking. The need for substance abuse data that is reliable, routinely collected, and disseminated has become very clear to policy makers as well.

In summary, the interest in substance abuse epidemiology is growing. The CSTE effort has attracted individuals from state public health agencies as well as those working in the substance abuse field. Students are recognizing it as an area of interest due to the scope of the problem and its multi-disciplinary nature.

CSTE is well poised to bring cohesion to the practice of substance abuse epidemiology nationally, due to its relationship with federal agencies, its leadership in the area of state-based surveillance and its collaborations with public health training programs in academia.

Sincerely,

Corinne Miller, Ph.D.
State Epidemiologist and Director, Bureau of Epidemiology

CM
cc: Dr. Steve Ostroff

2008 Position Statement Author Progress Report

Author Progress Report: 08-EH-01

Committee: Occupational/Environmental Health

Title: State-level Environmental Disease Epidemiology Capacity

Prepared by: Martha Stanbury, Michigan Department of Community Health

Date: April 27, 2009

The lead recommendation of this position statement was to strengthen environmental epidemiology capacity in states. Since the resolution was passed in June 2008, five activities have occurred at CDC/National Center for Environmental Health (NCEH) and CSTE which support this recommendation, although they cannot necessarily be attributed directly to the Position Statement itself. (It should be noted that there was no written response provided by CDC to CSTE.)

1) The level of interaction between the CSTE environmental subcommittee leadership and environmental epidemiology leadership at NCEH has increased, including a face-to-face meeting in July 2008, conference calls, a planned webinar, and enhanced plans for the environmental part of the CSTE annual meeting in June 2009.

2) Following the July 2008 meeting, NCEH identified some additional funds to promote environmental work at CSTE. In part, these funds have supported continuation of the development and piloting of environmental public health indicators, most notably indicators for "climate change". A manuscript describing the climate change indicators has been accepted for publication pending revisions. A workshop on the indicators and on the Environmental Public Health Tracking (EPHT) program has been scheduled on the Sunday before the CSTE 2009 annual meeting.

3) Funds were identified to add one CSTE epidemiology fellow in environmental epidemiology to the two already funded for the class starting in 2009.

4) Additional funds were obtained from Congress to increase funding (FY '09 funds)to states for Environmental Public Health Tracking (EPHT), both to add funds to existing EPHT states and to add five new states. The RFA for new states is expected to be announced shortly. (There may also be "stimulus funds" for more EPHT activities, but this has not been determined at this point.)

5) CSTE is increasingly being seen as an important partner in strategic planning for environmental health, resulting in 8 consultancy invitations with CDC/NCEH, including disaster/radiation epidemiology and the "National Conversation on Public Health and Chemical Exposures."

CSTE needs to continue to maintain the communications with NCEH in order to promote support for state-based environmental epidemiology initiatives. The role of CSTE and the CSTE Environmental Epidemiology Subcommittee in the EPHT initiative is still not clear; it is hoped that on-going communications and activities will help to clarify this issue. Another CSTE/NCEH leadership meeting is being considered for July 2009.

2008 Position Statement
Author Progress Report

Author Progress Report: 08-ID-07

Committee: Infectious Diseases

Title: Support and Enhancement of the National Healthcare Safety Network

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

1. CDC should allocate sufficient resources to NHSN to achieve the following:
   a. CDC should implement existing standards to allow for electronic data exchange from healthcare information systems and clinical microbiology laboratories to NHSN. These standards should be closely coordinated with the electronic laboratory reporting standards being created. These include microbiology data, pharmacy data and admission, and discharge and transfer (ADT) messages to populate data fields within NHSN.
   b. CDC should work with public and private sector partners to develop standards if they do not yet exist.
   c. CDC and partners should develop clinical document architecture specifications and implementation guidance for healthcare-associated events, and for process measures such as central line insertion practices.
   d. CDC and partners, including CSTE, CMS, the Food and Drug Administration (FDA) and the Agency for Healthcare Research and Quality (AHRQ) should work to implement a change management process to assist in prioritizing NHSN change requests to meet State and federal partner requirements and to operationalize those requests in an effective manner.
   e. CDC should develop and provide online training and competency modules for both hospitals and public health staff.
   f. CDC should support "train the trainer" sessions for key staff within States.

2. CSTE, state and local health departments should work with CDC and organizations active in hospital epidemiology and infection control in a manner analogous to the National Notifiable Disease Surveillance System process to further develop case definitions for healthcare-associated infections and processes for uniformity.

3. CDC and CSTE should work on the joint development of methods for data validation. States and hospitals would make primary use of those methods to ensure data quality.

4. CDC, CSTE and other organizations should support development of health care organizations' capability to transfer selected data through well-defined messaging systems from electronic health record systems, including laboratory information systems, to both notifiable disease surveillance systems and NHSN.

5. CDC, CSTE and other organizations should assess the possible utility of NHSN as an option for transmittal of electronic case reports of hospitalized cases of all notifiable diseases between participating hospitals and the appropriate local and state public health agencies. This would require NHSN to be able to generate and send standard public health notification messages to public health surveillance applications.

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

1. The 2009FY Omnibus Appropriations Act includes $10 million dollars to support and enhance NHSN. See: http://www.rules.house.gov/111/LegText/111_omni2009.htm. This money is available as a result of the Act being signed into law on March 11, 2009. With this increased funding for NHSN, CDC is directed in the Act to:
   - Expand the number of hospitals and other healthcare facilities participating in NHSN.
   - Increase the types of infections for which data are collected by each facility
   - Accelerate the transition from manual to electronic HAI reporting

2008 Position Statement
Author Progress Report

Author Progress Report: 08-ID-07 (continued)

Committee: Infectious Diseases

Title: Support and Enhancement of the National Healthcare Safety Network

CDC staff within the Division of Healthcare Quality Promotion [DHQP] is committed to:

- Using healthcare data standards for electronic HAI reporting, including Health Level Seven (HL7) messages for laboratory results, admission/discharge/transfer, and pharmacy data and Clinical Document Architecture (CDA) specifications for HAI events, all of which are under development and have been field tested
- Implementing online, interactive training for NHSN, several modules of which have been developed by CDC with more to follow as a result of new NHSN funding before the training is launched
- In addition, CDC DHQP staff continues to develop plans for a train the trainer program for NHSN. These plans are at a preliminary stage and the pace of further planning and development is likely to accelerate with the new resources available to CDC.

2. CDC staff is moving forward with plans for an NHSN Steering Group and a NHSN change management process in which CSTE and individual States using NHSN will be represented. The Steering Group and change management process are expected to be launched this calendar year. CDC staff is planning to seek input from CSTE and States prior to implementation.

3. A little progress on this has been made; a lot of additional work will need to be performed.

4. CDC/DHQP is supporting support development of health care organizations' capability to transfer selected data through well-defined messaging systems from electronic health record systems, including laboratory information systems, to both notifiable disease surveillance systems and NHSN. CSTE (at the time of this response) has not discussed the dual messaging component in detail; this topic is on the agenda for discussion.

5. This topic needs to be explored is greater detail by both CDC and CSTE.

B. Has there been any positive action or outcome due to the resolution?

- Please see refer to 1.A. for details on the omnibus/ FY2009 Appropriations Act, that includes $10 million for NHSN enhancements.
- The American Recovery and Reinvestment Act [ARRA] includes $50 million allocation for healthcare associated infections; $40 million of which will go to States for prevention of healthcare associated infections. http://www.whitehouse.gov/the_press_office/ARRA_public_review/. Details on this are expected to be released in early May; at present some information on how this money is expected to be allocated can be found in the testimony by Dr Richard Besser to the House Appropriation's committee on April 1, 2009: http://appropriations.house.gov/Witness_testimony/LHHS/Richard_Besser_04_01_09.pdf

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

- Letters to thank the sponsors that promoted the inclusion of the $50 million for healthcare associated infections in the ARRA
- Letters to thank the person(s) that included the additional funding for NHSN within the omnibus FY09 spending bill that will allow CDC to implement many of the actions recommended by this CSTE position statement
- Continue to monitor actions by CDC to ensure that further implementation is achieved

2008 Position Statement Author Progress Report

Author Progress Report: 08-ID-07 (continued)

Committee: Infectious Diseases

Title: Support and Enhancement of the National Healthcare Safety Network

D. Were any partners mobilized because of the resolution?

- CDC, HICPAC, SHEA, APIC

Author:

Marion A. Kainer MD, MPH
Medical Epidemiologist
Tennessee Department of Health
425 5th Avenue
Cordell Hull Building
Nashville, 37243
(615) 741-7247
marion.kainer@tn.gov

2008 Position Statement
Author Progress Report

Author Progress Report: 08-ID-10:

Committee: Infectious Diseases

Title: Influenza Surveillance in the United States

April 07, 2009

I think the components of the position statement regarding influenza surveillance are covered by ongoing activities as carried out by the influenza branch, CDC. The one exception to all of this is the CDC development of surveillance guidelines which has not yet been started. I understand from the Influenza Branch that they have no plans to do so until the pandemic surveillance guidelines are finalized, as they can only do one activity at a time due to limited resources.

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

1. CDC did indeed publish formal influenza surveillance guidelines by CDC derived from the recommendations made in the two CSTE/CDC Consultations

2. CDC should encourage states to develop surveillance systems for influenza associated hospitalization, and influenza associated electronic death reporting. Those states with current, or in the process of developing systems, should work with CDC to develop standards for data format and transmission. The influenza branch is in the middle of three pilot projects for hospitalization surveillance, EDR and laboratory reporting so they are making some progress regarding developing prototypes for that recommendation.

3. By the 20008-09 influenza season, CDC should establish a mechanism to accept data in a standardized format for those states able to send influenza associated hospitalization data and influenza mortality data. EDR and Hospitalization pilots are working on standardization of reporting which will allow the Influenza Branch to evaluate this process at the end of this year's influenza season.

4. The Influenza Division should provide adequate funding for states to enhance surveillance activities and resources should be provided to the Influenza Division by CDC to fund influenza surveillance. Financial support continues through the ELC grants.

I hope this addresses the issues related to the 2008 Influenza Surveillance position statement.

Kathleen Gensheimer
Maine

2008 Position Statement Author Progress Report

Author Progress Report: 08-OH-01 and 08-INJ-01

Committee: Environmental/Occupational/Injury

Title: State-level Occupational Disease Epidemiology Capacity

Prepared by: Martha Stanbury, Michigan Department of Community Health

Date: April 27, 2009

The lead recommendation of this position statement was to strengthen occupational epidemiology capacity in states. Responses to the Position Statement, which are posted on the CSTE website, are from the Director of CDC and from the Director of OSHA.
The NIOSH Acting Director acknowledged in a 3/3/2009 letter to Martha Stanbury in response to a letter from the CSTE Occupational Health Workgroup about stimulus funds that funding from NIOSH would be needed to increase state capacity in occupational epidemiology as well as funding a robust CSTE occupational epidemiology fellowship program.

Since the resolution was passed in June 2008, a number of activities supporting this recommendation have occurred at CDC/National Institute for Occupational Safety and Health CSTE, although they cannot necessarily be attributed directly to the Position Statement itself.

1. With extra funding support from NIOSH, CSTE hosted a two-day conference on state-based occupational health for states in the western U.S. (the Western Occupational Network – WestON). This conference brought states with considerable experience in occupational health surveillance together with those states that have not had programs, in an effort to encourage inexperienced states to become more active in this public health arena. A Conference Grant proposal has been submitted to fund a follow-up conference.

2. The Occupational Health Surveillance Workgroup (the occupational subcommittee of CSTE) has been active in promoting strategies to improve occupational illness and injury surveillance. As a result, the Bureau of Labor Statistics is funding some pilot programs to address issues in the undercounting of occupational illnesses and injuries in their survey, and in April '09 CSTE hosted an important meeting of states, NIOSH, BLS, OSHA, academics, labor union representatives and other groups to do some strategic thinking about how to address the undercount, including enhancing state-based surveillance.

3. The Acting Director of NIOSH has demonstrated an interest in increased interactions with CSTE and the Occupational Health Surveillance Workgroup. Here interests were expressed both in person when she met with the CSTE Executive Board on March 3, 2009, and in a lengthy letter to Martha Stanbury that was a response to a letter to her from the Workgroup about stimulus funds and state occupational epidemiology priorities.

4. One '09 class CSTE epidemiology fellow has been placed in an occupational epidemiology program. This is the first time CSTE has been able to fill an occupational billet.

5. The Workgroup has been active in the Position Statement process, including revisions to three Position Statements relevant to occupational health (lead, silicosis, and pesticides). In addition, the Workgroup and its NIOSH partners have been concerned about the omission of occupational data elements in all of the proposed revised position statements and have responded by initiating discussions with the Infectious Disease Committee of CSTE and related activities at CDC and the federal level. These data elements are critical for occupational epidemiologists.

2008 Position Statement Responses

Position Statement Response: 08-EC-01

Committee: Executive

Title: NASPHV/CSTE resolution on One Health

RECEIVED AUG 1 8 2008

United States Department of the Interior
U.S. GEOLOGICAL SURVEY
National Wildlife Health Center
6006 Schroeder Road
Madison, Wisconsin 53711-6223

August 14, 2008

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

Dear Mr. McConnon:

I am pleased to be asked by the Executive Committee of the Council of State and Territorial Epidemiologists (CSTE) to respond to the position statement entitled "NASPHV/CSTE Resolution on One Health" (08-EC-01) adopted at your annual conference held on June 12, 2008. As Director of the U.S. Geological Survey's National Wildlife Health Center (NWHC) in Madison, Wisconsin, I enthusiastically support the One Health concept and the CSTE resolution. For nearly 35 years, the NWHC has investigated disease in and intoxications of wildlife in the U.S. and around the world. With the increasing recognition that wildlife can serve as reservoirs of zoonotic pathogens of humans and domestic animals, such as West Nile Virus or Highly Pathogenic Avian Influenza, our experience has guided us to work closely with public health, veterinary medical, and environmental health practitioners and specialists. Our experience includes:

- Demonstration of the relationship between lead poisoning of wild birds, particularly waterfowl, and the use of lead shot and lead fishing weights. This has contributed to control efforts in lead-contaminated wetland and upland areas from lead shot and the banning of small lead fishing weights by some states in the U.S..
- Conducting surveillance for the West Nile Virus epizootic in the U.S. through diagnostic testing of dead birds and mapping of the occurrence of the virus in humans, domestic animals, and other surveillance species. USGS scientists are conducting research on the potential use of WNV vaccines on wild birds in an effort to reduce the risk of the disease to humans, and domestic and wild animals.
- Conducting surveillance, diagnostic, genetic, and experimental studies on the Highly Pathogenic Avian Influenza (A H5N1) virus that has to date affected millions of domestic and wild birds and has affected and killed several hundred people.

Position Statement Response: 08-EC-01 (continued)

Committee: Executive

Title: NASPHV/CSTE resolution on One Health

- Establishment of the Wildlife Disease Information Node (WDIN) that provides an entry point to wildlife disease information contained in the National Biological Information Infrastructure [http://wildlifedisease.nbii.gov]. This Web-based wildlife disease monitoring and reporting system provides state and federal resource managers, animal disease specialists, veterinary diagnostic laboratories, physicians, public health workers, educators, and the general public with access to standardized and quality-controlled data on wildlife diseases, mortality events, and other critical related information.
- Providing field and laboratory diagnostic and management support to wildlife resource managers and animal disease specialists to identify and manage animal disease outbreaks in the U.S.

In conclusion, I appreciate you taking the time to seek our input and support. If you have questions or comments regarding this letter, please don't hesitate to contact me.

Most Sincerely,

Leslie A. Dierauf, VMD
USGS National Wildlife Health Center
Center Director

2008 Position Statement Responses

Position Statement Response: 08-EC-01 (continued)

Committee: Executive

Title: NASPHV/CSTE resolution on One Health

RECEIVED AUG 1 1 2008

United States Department of Agriculture

Animal and Plant Health Inspection Service

Veterinary Services

Washington, DC 20250

Patrick J. McConnon, MPH
Executive Director
Council of State and Territorial Epidemiologists (CSTE)
National Headquarters
2872 Woodcock Boulevard I Suite 303
Atlanta, Georgia 30341

AUG 8 2008

Dear Mr. McConnon:

Thank you for your letter of July 21, 2008, and the copy of your resolution on the One Health Initiative. Cindy Smith, Administrator of the Animal and Plant Health Inspection Service, asked me to respond on her behalf.

Veterinary Services (VS) applauds the One-Health Initiative. As you know, our mission is to safeguard animal health, and we consider our mission and the One Health Initiative to be interlinked. More and more, VS programs are utilizing this approach by working with our partners in public health, food safety, and wildlife management. We recently pledged our support for the One Health concept by joining the One Health Joint Steering Committee of the American Veterinary Medical Association.

VS is committed to the One Health Initiative. Thank you again for writing.

Sincerely,

Andrew M. Morgan DVM
for

John R. Clifford
Deputy Administrator
Veterinary Services

2008 Position Statement Responses

Position Statement Response: 08-EC-01 (continued)

Committee: Executive

Title: NASPHV/CSTE resolution on One Health

SEP 19 2008

RECEIVED SEP 23 2008

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 08-EC-01 entitled "NASPHV/CSTE resolution on One Health." Please excuse the delay of this response.

Following is the Centers for Disease Control and Prevention's (CDC) response to the CSTE position statements: 08-EC-01.

CDC concurs with and fully supports the CSTE recommendation of the adoption of the resolution endorsing One Health and would suggest the changes noted below. CDC believes that a holistic, comprehensive, and multi-disciplinary approach is needed to effectively address the existing, emerging, and re-emerging infectious disease threats to our world today. Active engagement with disease, not only as it exists within the human domain, but also as it relates to the animal and physical domains, is essential.

Suggested changes:

1) Resolved, That NASPHV/CSTE support an initiative designed to promote collaboration among human and veterinary medicine **and public health professionals in other scientific disciplines (i.e., including but not limited to environmental scientists, mammologists, entomologists, and pathologists)**.

2) Resolved That NASPHV/CSTE support joint educational efforts between **medical and veterinary medical schools and other pertinent scientific disciplines (i.e., including but not limited to environmental scientists, mammologists, and entomologists)**.

6) Resolved, That NASPHV/CSTE support joint efforts in the development and evaluation of new diagnostic methods, medicines, and vaccines for the prevention and control of diseases; (deleting "across species").

2008 Position Statement Responses

Position Statement Response: 08-EC-01 (continued)

Committee: Executive

Title: NASPHV/CSTE resolution on One Health

Public Health Impact:
Improved public health outcome through a more integrated approach to **education, practice, and research across all species;** (and deleting "medical").

I appreciate the opportunity to provide a response to CSTE's position statement and applaud your commitment to these important public health issues. I look forward to continued collaboration with CSTE regarding public health issues of mutual concern.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director

2008 Position Statement Responses

Position Statement Response: 08-EC-02

Committee: Executive

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

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

RECEIVED SEP 8 2008

SEP 2 2008

Mr. Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341

Dear Mr. McConnon:

Thank you for your letter regarding the Council of State and Territorial Epidemiologists' (CSTE) position statement 08-EC-02 entitled "Criteria for Inclusion of Conditions on CSTE Nationally Notifiable Condition List and for Categorization as Immediately or Routinely Notifiable." Please excuse the delay of this response.

The Centers for Disease Control and Prevention (CDC) supports position statement 08-EC-02 and believes this action will support implementation of the revised International Health Regulations and recommendations issued by the American Health Information Community (AHIC). CDC's National Center for Public Health Informatics (NCPHI) can serve as an intermediary between CSTE and CDC programs with prevention and control responsibilities for nationally notifiable conditions (NNC) to help plan, facilitate, and coordinate activities needed to implement this position statement.

We assume the list of conditions included in the enclosed Appendix of the CSTE Request for Proposal titled "Reformatting Reportable Diseases/Conditions into 2009 Case Definition Position Statement Template" will form the basis of the initial CSTE official NNC list. We are in the process of identifying CDC Subject Matter Experts (SME) who can review the reformatted 2009 CSTE position statements for the CSTE NNC list. We believe these CDC SMEs will play a major role in preparing the revised 2009 CSTE position statements.

Position statement 08-EC-02 indicates "the list of NNCs will also form the basis for inclusion of reports in the *MMWR* weekly disease reporting tables and the annual *Summary of Notifiable Diseases*." CDC's NCPHI notes that the conditions and events on the initial CSTE NNC list are much more diverse than the list of nationally notifiable infectious diseases that currently form the basis of the National Notifiable Diseases Surveillance System (NNDSS). Therefore, NCPHI will need to engage the CDC programs with programmatic responsibility for non-NNDSS conditions in discussions to assess the feasibility of implementing this desired action. An implementation plan to address this aspect of the position statement will be developed that takes into account the availability of resources and the feasibility assessment.

I appreciate the opportunity to provide a response to CSTE's position statement and applaud your commitment to this important public health issue. We look forward to continued collaboration with CSTE regarding public health issues of mutual concern.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director

2008 Position Statement Responses

Position Statement Response: 08-EC-02 (continued)

Committee: Executive

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

REQUEST FOR PROPOSAL

Re-Formatting Reportable Diseases/Conditions Into 2009 Case Definition Position Statement Template

Introduction and Purpose

The purpose of this request for proposal is to obtain assistance to update the case definition position statements used to support position statements: 07-EC-02 and 08-EC-02 (available at: http://www.cste.org/PS/2007ps/2007psfinal/EC/07-EC-02.pdf and http://www.cste.org/PS/2008/2008psfinal/08-EC-02.pdf). This effort should result in standardizing the formatting and technical vocabulary so that case definitions used for state and local reporting and notifications to CDC can be accomplished electronically from and among contributors and users of these systems. CSTE is responsible for maintaining and updating a list of reportable diseases/conditions for each state and territory as determined by the states and territories. In late 2007 and early 2008, CSTE conducted a review of states websites of reportable conditions and compiled a listing of such conditions found online. CSTE National Office Staff have reviewed each state's reportable conditions websites and have listed them in order of most frequently "immediately" reported to local or state health departments. This information was prioritized to be reformatted according to the 2009 CSTE Position Statement Template.

Source of Funds

CSTE receives funding for this project through the Centers for Disease Control and Prevention (CDC) cooperative agreement number U60/CCU007277. Funds awarded to applicants under this announcement are subject to the laws, regulations and policies governing the U.S. Public Health Service grant awards.

Eligible Applicants

Public health organizations, individual consultants, or academically affiliated individuals or organizations operating in the United States are eligible to submit a proposal for this project. Applications must demonstrate familiarity with state reportable disease/conditions and surveillance methodology and must have participants with background and expertise in epidemiology, reporting requirements, case definitions, case classifications, and standardized vocabularies (including LOINC and SNOMED). Applicants must also have familiarity with disease reporting systems and methods - from health care providers to local and state health departments, electronic laboratory reporting, case notification of notifiable conditions to CDC from the state level, and the emerging technology of identification of potential cases of reportable diseases in electronic health records.

It is anticipated that this project will require a team, not a single person. Therefore, it is not necessary that one team member possess all of the above knowledge and skills but that the entire team have the skills required to complete the project. Only one proposal per team is necessary.

2008 Position Statement Responses

Position Statement Response: 08-EC-02 (continued)

Committee: Executive

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

Availability of Funds

Award funds up to $200,000 will be available to the successful applicant qualified to undertake the tasks necessary for completion of this project. The awardees will be notified on or about **July 17, 2008**. CSTE's support for this activity is on a one-time basis. The award period will be from the award date to September 30, 2008. A limited no-cost extension may be available to complete the work if delays are experienced with CDC or CSTE input/approval if satisfactory progress can otherwise be demonstrated for the overall project.

Project Requirements

The awarded entity will carry out the following tasks for the diseases/conditions categorized in the appendix (below) as Phase I, II, III, and IV diseases, starting with Phase I:
a) Compose revised position statements for all diseases/conditions in each phase using the 2009 CSTE Position Statement Template.
b) Circulate completed drafts to CSTE and CDC subject matter experts for their review and comment.
c) Finalize proposed position statements for the diseases/conditions in each phase, for review by CSTE.

Outcome/Deliverable: The final report consists of the finalized position statements of all three phases. The amount of awarded funds will be dependent on the number of disease/conditions completed within the timeline of the agreement.

Required Proposal Content

Proposals should be single-spaced, typed with 12-point font character, printed on one-sided 8 ½ by 11-inch paper with one-inch margins, and should not exceed 3 pages in length (plus an attached cover letter). Please follow the sequence and format described below and adhere to the page limits indicated for each section.

1. Cover letter (1 page maximum):
   a) Overview of the proposal and the amount requested.
   b) Full contact information (name/title/address/phone/email/fax) of project coordinator and participants with estimate of % of time involved in the project..

   Background and Qualifications:
   c) Existing and past experience with state reportable conditions, nationally notifiable conditions, and surveillance methodology.
   d) Background in epidemiology, reportable conditions, standardized vocabularies (including LOINC and SNOMED), and management ability regarding the oversight of the entire process.
   e) Proposed timeline for completion of the project phases.
2. Proposed Activities
   a) Describe how the team will accomplish the project requirements. Please address each phase.
   b) Circulate position statements to CSTE and CDC subject matter experts for finalization.

Position Statement Response: 08-EC-02 (continued)

Committee: Executive

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

c) Finalize and collate proposed position statements for each reportable condition listed in each phase.

Evaluation

CSTE's Surveillance Coordination Group, including CSTE National Office Staff will evaluate proposals. Funding awards will be made based upon the extent to which the respondent addresses the required proposal content above and qualifications of the team submitting the proposal.

Proposal Submission and Deadline

Applicants must submit two original copies of their proposal to:
LaKesha Robinson, Director of Programs
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341

Proposals must be received at CSTE by close of business on **July 15, 2008.**

Additional Information

For additional information on this program, please contact:

Lisa Dwyer, Associate Research Analyst
ldwyer@cste.org
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015
Phone: (770) 458-3811, Fax (770) 458-8516

Appendix:

Phase I (IHR-2005 or BT category A or designated "eliminated")
Anthrax
Botulism
Influenza, novel
Measles
Plague
Polio
Rubella
SARS
Smallpox
Tularemia
Viral hemorrhagic fevers
Phase II (Immediately reportable [50% rule])
Brucellosis
Diptheria
Haemophilus influenzae
Lead, elevated blood level
Meningococcal Disease (Neisseria meningitidis)
Rabies
Vibrio cholera

2008 Position Statement Responses

Position Statement Response: 08-EC-02 (continued)

Committee: Executive

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

Phase III (Reportable in all states [2007])
Arboviral: West Nile Virus
Chlamydia trachomatis
Cryptosporidiosis
Gonorrhea
Hepatitis A
Hepatitis B
Legionellosis
Malaria
Mumps
Pertussis
Salmonellosis
Shigellosis
Syphilis
Tetanus
Tuberculosis
Typhoid fever
Phase IV (Routinely notifiable conditions likely to meet 50% rule)
Foodborne Disease Outbreak
Yellow Fever
Staphylococcus
Q fever
Waterborne Disease Outbreak
Hantavirus pulmonary syndrome
Hemolytic Uremic Syndrome, Post-diarrheal
Influenza
Listeriosis
Psittacosis
Escherichia coli, Shiga toxin-producing (STEC)
Trichinellosis (Trichinosis)
Varicella (Chickenpox)
Arboviral Disease, Eastern equine
Arboviral Disease, St. Louis
Arboviral Disease, Western equine
Chancroid
Creutzfeldt-Jakob and other Prion Diseases
Coccidioidomycosis
Cyclosporiasis
Giardiasis
Lyme disease
Hansen's Disease (Leprosy)
Hepatitis C
HIV
Streptococcus
Arboviral Disease, Calif. Serogroup
Carbon monoxide poisoning
Rocky Mountain Spotted Fever

2008 Position Statement Responses

Position Statement Response: 08-EC-02 (continued)

Committee: Executive

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

Toxic-shock syndrome (other than streptococcal)
Arboviral Disease, Powassan
Cancer
Disaster casualty
Ehrlichiosis
Pesticide-related Illness
Silicosis
Spinal cord injury
Vaccine-Related Adverse Events

2008 Position Statement Responses

Position Statement Response: 08-EC-03

Committee: Executive

Title: State-level Substance Abuse Epidemiology Capacity

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

AUG 27 2008

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

Dear Mr. McConnon:

Thank you for your July 1 letter on behalf of the Executive Committee for the Council of State and Territorial Epidemiologists (CSTE). I applaud the Committee's recent efforts in developing a position statement on "Criteria State-level Substance Abuse Epidemiology Capacity."

As you know, the Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes the importance of state-level epidemiologic work in substance abuse, and has been supporting such work through the allocation of funds within SAMHSA's Strategic Prevention Framework activities. Pending Congressional support, these activities will remain a priority within SAMHSA.

The CSTE position statement outlines potential areas of collaboration among your organization and relevant Federal agencies. The current realities of limited Federal funding underscore even more strongly the importance of considering such collaborations in order to maximize these resources. SAMHSA welcomes the opportunity to participate with our Federal partners and others in discussions of these and other potential priorities.

Thank you sharing the CSTE position statement.

Sincerely,

Terry L. Cline

Terry L. Cline, Ph.D.
Administrator

Position Statement Response: 08-EC-03 (continued)

Committee: Executive

Title: State-level Substance Abuse Epidemiology Capacity

DEPARTMENT OF HEALTH & HUMAN SERVICES

RECEIVED OCT 10 2008 Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

OCT 7 2008

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341

Dear Mr. McConnon:

Thank you for sharing a copy of the Council of State and Territorial Epidemiologists' (CSTE) position statement 08-EC-03 entitled "Criteria State-level Substance Abuse Epidemiology Capacity." Please excuse the delay of this response.

Substance abuse is an important public health issue that has a great impact on our nation's health and safety. Efforts to address this broad issue span across the research and practice of several programs within the Centers for Disease Control and Prevention (CDC). As an agency, we support efforts to build capacity to work on substance abuse surveillance and other epidemiology issues in state health agencies.

Specifically, CDC's National Center for Injury Prevention and Control is dedicated to reducing the number and severity of unintentional injuries related to substance abuse through a science-based public health approach. Currently, in addition to ongoing research and surveillance activities, efforts are underway to develop a broad strategy to address unintentional drug overdoses by building state capacity.

We welcome the opportunity to further discuss and coordinate ways to enhance the ability of states to address substance abuse. For further information, please contact Dr. Robert D. Brewer, Alcohol Team Leader at CDC's National Center for Chronic Disease Prevention and Health Promotion, at (770) 488-5920, or Ms. Sara Schmit, Office of Planning, Policy, and Evaluation, at (770) 488-1429.

I thank you and CSTE for your commitment and national leadership to the field of epidemiology. We look forward to continued collaboration with CSTE regarding public health issues of mutual concern.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director

2008 Position Statement Responses

Position Statement Response: 08-ID-02, 08-ID-03, 08-ID-06 and 08-ID-08

Committee: Infectious Disease

Title: Revision of Rubella Case Definition; Revision of Measles Case Definition; Revision of the Surveillance Case Definition for Q Fever; and Update to Cryptosporidiosis Case Definition

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

SEP 25 2008

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
National Headquarters
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 statements that provide recommendations around surveillance and recommended changes in current case definitions of several conditions. Please excuse the delay of this response. Enclosed are the Centers for Disease Control and Prevention's response to the following CSTE Position Statements:

- 08-ID-02 "Revision of Rubella Case Definition"
- 08-ID-03 "Revision of Measles Case Definition"
- 08-ID-06 "Revision of the Surveillance Case Definition for Q fever"
- 08-ID-08 "Update to Cryptosporidiosis Case Definition"

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,

Julie Louise Gerberding, M.D., M.P.H.
Director

Enclosures

2008 Position Statement Responses

Position Statement Response: 08-ID-02, 08-ID-03, 08-ID-06 and 08-ID-08 (continued)

Committee: Infectious Disease

Title: Revision of Rubella Case Definition; Revision of Measles Case Definition; Revision of the Surveillance Case Definition for Q Fever; and Update to Cryptosporidiosis Case Definition

The Centers for Disease Control and Prevention's (CDC) Comments Regarding the 2008 Council of State and Territorial Epidemiologists' (CSTE) Position Statements

CSTE Position Statement 08-ID-02

Title: Revision of the Rubella Case Definition and Enhancing Timeliness of Reporting to NNDSS

Statement of desired action:

The purpose of this position statement is to revise the rubella national case definition by modifying the laboratory criteria for diagnosis of rubella to include detection of rubella-virus specific nucleic acid by polymerase chain reaction and to enhance timeliness of notification of rubella cases to the National Notifiable Disease Surveillance System (NNDSS).

CDC Comments:

CDC concurs with and fully supports CSTE's recommendation to revise the laboratory criteria for diagnosis of rubella to include reverse transcriptase-polymerase chain reaction (RT-PCR). CDC worked with state health officials and CSTE on this revision to the laboratory diagnostic criteria for rubella. CDC will provide necessary guidance as well as standard protocols for RT-PCR to public health laboratories who wish to implement such assays as part of their rubella surveillance program. Because of rubella's post-elimination status, CDC supports more timely reporting and notification of rubella and Congenital Rubella Syndrome cases and understands that specifics with respect to the enhanced timeliness of reporting and notification for measles, rubella, and polio were addressed under CSTE position statement 08-EC-02.

CSTE Position Statement 08-ID-03

Title: Revision of the Measles Case Definition and Enhancing Timeliness of Reporting to NNDSS

Statement of desired action:

The purpose of this position statement is to revise the measles national case definition by modifying the laboratory criteria for diagnosis of measles to include detection of measles-virus-specific nucleic acid by polymerase chain reaction and to enhance timeliness of notification of measles cases to NNDSS.

CDC Comments:

CDC concurs with and fully supports CSTE's recommendation to revise the laboratory criteria for diagnosis of measles to include reverse transcriptase-polymerase chain reaction (RT-PCR).

2008 Position Statement Responses

Position Statement Response: 08-ID-02, 08-ID-03, 08-ID-06 and 08-ID-08 (continued)

Committee: Infectious Disease

Title: Revision of Rubella Case Definition; Revision of Measles Case Definition; Revision of the Surveillance Case Definition for Q Fever; and Update to Cryptosporidiosis Case Definition

CDC worked with state health officials and CSTE on this revision to the laboratory diagnostic criteria for measles. CDC will provide necessary guidance as well as standard protocols for RT-PCR to public health laboratories who wish to implement such assays as part of their measles surveillance program. Because of measles' post-elimination status, CDC supports more timely notification of measles cases and understands that specifics with respect to the enhanced timeliness of notification for measles, rubella, and polio were addressed under CSTE position statement 08-EC-02.

CSTE Position Statement 08-ID-06

Title: Revision of the Surveillance Case Definition for Q fever

Statement of desired action:

Revise the national surveillance case definition for Q fever.

CDC Comments:

CDC concurs with and fully supports the CSTE recommendation.

CSTE Position Statement 08-ID-08

Title: Revision of Cryptosporidiosis Case Definition

Statement of desired action:

The purpose of this position statement is to revise the cryptosporidiosis national surveillance case definition. This revision permits states and territories to report confirmed and probable cases of cryptosporidiosis to NNDSS, updates the laboratory evidence section to reflect current testing practices, and encourages reporting of species designation and molecular characterization when available.

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 cryptosporidiosis case reports as confirmed or probable and therefore more effectively captures the public health impact of cryptosporidiosis. CDC expects that this will increase the number of cases reported while improving the accuracy of case classification.

CDC has worked closely with state health officials and CSTE on the adopted revisions to the cryptosporidiosis surveillance case definition. It is our belief that CSTE's proposed changes to cryptosporidiosis reporting will result in more consistent, sustainable, accurate, and complete surveillance.

2008 Position Statement Responses

Position Statement Response: 08-ID-07

Committee: Infectious Disease

Title: Support and Enhancement of the National Heaalthcare Safety Network (NHSN)

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

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SEP 1 6 2008

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341

Dear Mr. McConnon:

Thank you for your letter regarding the Council of State and Territorial Epidemiologists (CSTE) position statement entitled "Support and Enhancement of the National Healthcare Safety Network (NHSN)." The Centers for Disease Control and Prevention (CDC) strongly supports working with CSTE to improve NHSN, and we look forward to collaborating with CSTE on these issues. Expanding and improving NHSN is a CDC priority.

With respect to financial support, as you know, NHSN receives funding from several budgetary lines, including the Emerging Infectious Disease (EID) line. The EID budget line provides critical support to programs across the Coordinating Center for Infectious Diseases (CCID). As CDC has not received its fiscal year 2009 Congressional appropriation, we cannot make a determination at present what resources will be available for the EID line or the NHSN.

The increasing availability of healthcare data in electronic form and recent advances in information technology provide new opportunities to accelerate the transition from manual healthcare-associated infections (HAI) case finding and reporting to computer-based algorithmic case detection and electronic reporting to NHSN. Accelerating the pace of this transition will reduce data collection burden on hospitals, streamline the processes of case finding and reporting, and enhance the extent of HAI coverage using NHSN.

CDC recognizes the need to promote the development of well-defined messaging systems at healthcare organizations to improve their ability to transfer data. In an effort to foster this development, CDC is focusing on standards-based solutions for conveying healthcare data and validation processes to confirm that the data received at CDC accurately reflect the data transmitted by healthcare facilities, including HL7 Clinical Document Architecture (CDA) solutions. CSTE and other partners are important collaborators in the development of these systems.

Future plans regarding NHSN messaging systems include use of microbiology results, admit-discharge transfer (ADT) administrative data, and pharmacy messages to populate the NHSN database and to algorithmically detect bloodstream and other infections. CDC also plans to

Position Statement Response: 08-ID-07 (continued)

Committee: Infectious Disease

Title: Support and Enhancement of the National Heaalthcare Safety Network (NHSN)

enable data reported via CDA documents to be imported into NHSN. An integral component of supporting data transfer is the further development of case definitions. CDC looks forward to opportunities to work with CSTE and other partners in this process.

The development of methods for data validation is an important step in ensuring that data submitted to NHSN continue to be of high quality. CDC is working with states within the scope of our current resources to develop new data validation methods and welcomes the involvement of CSTE in the process.

NHSN currently includes online training for individuals registering for NHSN. CDC will soon begin implementation of new interactive training modules with a pilot group. The new training modules will enable tracking of usage, include quizzes to assess knowledge, and enable users to obtain continuing education credit for completing training. CDC recognizes the need to consider additional training mechanisms in the future, including "train the trainer" sessions.

CDC is establishing a NHSN steering group governance charter. The governance system includes representatives from state health departments. It is anticipated that prioritization of NHSN change requests would fall under this group's activities.

Again, we thank you for your letter and your support of NHSN. Investing in tracking and surveillance activities, such as those provided by NHSN, is integral to the mission of CDC. We look forward to the opportunity to work with CSTE to strengthen and expand the NHSN surveillance system and to continue to monitor the impact of HAI, monitor trends, and increase the effectiveness of prevention efforts.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director

2008 Position Statement Responses

Position Statement Response: 08-INJ-01

Committee: Environmental/Occupational/Injury

Title: State-level Occupational Illness and Injury Epidemiology Capacity

RECEIVED AUG 18 2008

U.S. Department of Labor

Assistant Secretary for
Occupational Safety and Health
Washington, D.C. 20210

AUG 12 2008

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

Dear Mr. McConnon:

This letter is in response to your correspondence of July 1, 2008 regarding the Council of State and Territorial Epidemiologists' position statement entitled, "*State-level Occupational Illness and Injury Epidemiology Capacity.*" The position statement outlines the important role that epidemiologists play in public health surveillance and in the prevention of occupational illnesses and injuries.

I appreciate receiving your informational copy of the position statement. I have reviewed its findings and shared it with appropriate OSHA staff.

Thank you for your interest in occupational safety and health.

Sincerely,

Edwin G. Foulke, Jr.

2008 Position Statement Responses

Position Statement Response: 08-OH-01

Committee: Environmental/Occupational/Injury

Title: State-level Occupational Illness and Injury Epidemiology Capacity

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

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AUG 1 4 2008

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341

Dear Mr. McConnon:

Thank you for sharing the position statement "State-level Occupational Illness and Injury Epidemiology Capacity," recently adopted at the Council of State and Territorial Epidemiologists' (CSTE) Annual Conference on June 12, 2008. I see from your correspondence that many agencies, including the Centers for Disease Control and Prevention's (CDC) National Institute for Occupational Safety and Health (NIOSH), have been contacted. I believe NIOSH will provide a separate response focused on occupational safety and health. My comments in this letter will address the CSTE statements that focus on partnership between CDC and state health departments.

Successes in both the recruitment and retention of occupational epidemiologists in state health departments are important to CDC. In addition to their roles in describing and identifying occupational illness and injury problems, these epidemiologists expand state-based capacity that may be applied to other public health domains such as injury prevention, environmental health, and chronic disease prevention. CDC has a long-standing commitment to occupational illness and injury surveillance capacity building in state health department. I expect that future cooperative solicitations from CDC will continue to support the establishment and expansion of state occupational health surveillance programs.

CSTE's position statement identifies nine steps to advance occupational illness and injury epidemiology capacity building. This letter addresses CDC's role in the following two steps identified in achieving the functions to enhance the abilities of states to prioritize, plan, promote, implement, and evaluate evidence-based interventions.

> *CDC should include language in other/related cooperative agreements that explicitly encourages support for occupational epidemiologists and provides mechanisms and opportunities to give states greater flexibility in using categorical funding, including resources from multiple grants, to support these positions. In particular, CDC should encourage collaboration between state occupational health surveillance, Environmental Public Health Tracking, and Public Health Preparedness programs.*

Position Statement Response: 08-OH-01 (continued)

Committee: Environmental/Occupational/Injury

Title: State-level Occupational Illness and Injury Epidemiology Capacity

Page 2 - Patrick J. McConnon, M.P.H.

Many CDC programs have categorical funding that targets surveillance and prevention programs. CDC's support of state-based surveillance activities comes through a number of such discrete funding streams. Our stewardship of these programs must be sensitive to legislative and other fiscal mandates. As new programs or funding opportunity announcements are developed, CDC will explore potential synergies that might result through collaboration among CDC centers.

> *Mechanisms for capacity development such as the CDC/CSTE Applied Epidemiology Fellowship Program, Epidemic Intelligence Service, Public Health Prevention Service, and state-based epidemiology training programs should be supported as part of grant programs using both direct assistance and financial assistance to accomplish the objective of minimum epidemiology workforce in each state within five years.*

CDC has a long history of providing direct assistance and financial support to state health departments. The Epidemic Intelligence and the Public Health Prevention Services are important fellowship programs to both CDC and the states. Since their inception, these programs have assigned Epidemiologic Intelligence Service Officers and Public Health Prevention Services Fellows to state for one- and two-year assignments. In addition to providing state with epidemiologic and program management capacity through these assignments, many of these officers and fellows are offered and accept permanent employment by their host state programs. These CDC-state partnerships advance our shared goal of building state-based epidemiologic capacity.

The CSTE and its member states are essential prevention partners to CDC. I look forward to continued collaboration between CSTE and CDC as we build the nation's future epidemiologic workforce.

Sincerely,

Julie Louise Gerberding, M.D., M.P.H.
Director