2010-2011

ANNUAL REPORT

CSTE

Alaska
Hawaii
Territories
Puerto Rico
U.S. Virgin Islands

Council of State and Territorial Epidemiologists

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS

TABLE OF CONTENTS

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, 2011 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 the standards applicable to financial audits contained in *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, 2011 and the changes in net assets and its cash flows for the year then ended in conformity with generally accepted accounting principles.

In accordance with *Government Auditing Standards*, we have also issued our report on the same date, 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 should be considered in 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-I33, "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.

Coun & Company, LLC

February 2, 2012
Atlanta., Georgia

2010-2011

FINANCIAL STATEMENTS & AUDITORS REPORTS

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
STATEMENT OF FINANCIAL POSITION
SEPTEMBER 30, 2011

ASSETS	
CURRENT ASSETS	
Cash and Cash Equivalents	$ 551,878
Certificates of Deposit	651,396
Accounts Receivable	73,347
Grants Receivable	607,074
Accrued Interest Receivable	6,019
Prepaid Expenses	54,481
TOTAL CURRENT ASSETS	1,944,195
PROPERTY AND EQUIPMENT	
Computers and Software	91,528
Furniture and Equipment	115,640
Less: Accumulated Depreciation	(118,003)
TOTAL PROPERTY AND EQUIPMENT	89,165
OTHER ASSETS	
Deposits	3,153
TOTAL ASSETS	$2,036,513
LIABILITIES AND NET ASSETS	
CURRENT LIABILITIES	
Accounts Payable	$ 339,993
Accrued Expenses	649,405
TOTAL CURRENT LIABILITIES	989,398
NET ASSETS	
Unrestricted	1,047,115
Temporarily Restricted	-0-
Permanently Restricted	-0-
TOTAL NET ASSETS	1,047,115
TOTAL LIABILITIES AND NET ASSETS	$2,036,513

See Accompanying Notes to Financial Statements

FINANCIAL STATEMENTS & AUDITORS REPORTS

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
STATEMENT OF FINANCIAL ACTIVITIES
YEAR ENDED SEPTEMBER 30, 2011

CHANGE IN UNRESTRICTED NET ASSETS:	
Revenues and Gains	
Support from Grants	$8,964,118
Memberships	121,300
Annual Meeting	473,192
Interest Income	14,063
Miscellaneous	1,280
Total Revenues and Gains	9,573,953
Expenses	
Program Services	8,969,794
General Supporting Expenses	539,745
Total Expenses	9,509,539
INCREASE IN UNRESTRICTED NET ASSETS	64,414
NET ASSETS, BEGINNING OF YEAR	982,701
NET ASSETS, END OF YEAR	$1,047,115

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, 2011

CASH FLOW FROM OPERATING ACTIVITIES	
Change in Net Assets	$ 64,414
Adjustment to Reconcile Change in Net Assets to Net Cash Provided by Operating Activities:	
Depreciation	36,033
(Increase) Decrease in Operating Assets:	
Grant Funds Receivable	287,176
Accounts Receivable	(73,347)
Accrued Interest Receivable	(59)
Prepaid Expenses	261,979
Increase (Decrease) in Operating Liabilities:	
Accounts Payable	(611,393)
Accrued Expenses	178,802
NET CASH PROVIDED BY OPERATING ACTIVITIES	143,605
CASH FLOWS FROM INVESTING ACTIVITIES	
Purchase of Certificates of Deposit	(6,507)
Purchase of Property and Equipment	(76,404)
NET CASH (USED) BY INVESTING ACTIVITIES	(82,911)
NET INCREASE IN CASH AND CASH EQUIVALENTS	60,694
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	491,184
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 551,878
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 FINANCIAL ACTIVITIES
YEAR ENDED SEPTEMBER 30, 2011

Program Services

	5U38HM000414 Focus Areas									
	Chronic	Core	Environmenta	Epidemiology	FoodSafety	HIV	Infectious	ACA	ASTHO	NYC
Annual Meeting Expense	-	-	-	-	-	-	-	-	-	-
Bank Service Charges	-	84	-	553	-	-	-	-	-	-
Consultants	-	76,651	25,500	60,165	30,487	5,000	62,407	-	7,200	-
Contracts	-	-	-	61,663	35,027	44,802	-	-	-	-
Fringe	13,515	101,635	17,665	75,527	11,738	6,281	17,627	6,556	398	942
General & Administrative	47,402	234,682	81,738	493,242	70,181	28,096	173,040	159,566	3,333	10,090
Internet	-	-	-	-	-	-	-	-	-	-
Other	72,588	170,295	94,927	2,328,134	130,346	44,374	153,580	360	5,741	-
Personnel	47,968	327,982	68,262	243,491	43,597	23,212	62,234	23,632	1,460	3,457
Postage and Delivery	1,082	2,181	227	706	3,124	2	170	81	-	24
Printing and Reproduction	90	13,932	166	2,306	23,094	-	318	137	-	79
Software	1,113	1,146	1,433	4,942	320	15	3,264	4,909	-	318
Staff Travel	3,847	73,908	3,132	20,358	4,484	1,938	2,573	10	149	1
Supplies	1,533	1,807	570	395	719	-	242	1,022	-	19
Telephone	397	4,384	768	1,823	-	6,918	6,951	237	-	2
Trainee Expenses	142,369	334,020	176,908	704,188	60,622	-	516,844	754,301	-	69,704
Total Expense	331,904	1,342,707	471,296	3,997,493	413,739	160,638	999,250	950,811	18,281	84,636

Program Services

	Occupational Capacity	Occupational Capacity 2012	Occupational Conference	RWJF Award	Weston	Nonfed	Total Expenses
Annual Meeting Expense	-	-	-	-	-	353,345	353,345
Bank Service Charges	-	-	-	-	-	19,397	20,034
Consultants	-	-	-	-	-	-	267,410
Contracts	-	14,000	-	-	-	14,000	169,492
Fringe	9,787	(158)	559	(323)	1,249	4,142	267,140
General & Administrative	36,052	327	(69)	290	(52)	55,284	1,393,202
Internet	-	-	-	-	-	8,641	8,641
Other	69,047	-	14,113	1,000	9,967	18,351	3,112,823
Personnel	30,513	1,169	4,913	-	3,758	12,305	897,953
Postage and Delivery	84	-	-	-	155	746	8,582
Printing and Reproduction	-	-	-	-	-	25,685	65,807
Software	-	-	-	-	-	1,731	19,191
Staff Travel	3,160	-	200	-	210	8,383	122,353
Supplies	-	-	-	99	22	16,846	23,274
Telephone	224	-	-	-	-	-	21,704
Trainee Expenses	-	-	-	-	(368)	-	2,758,588
Total Expense	148,867	15,338	19,716	1,066	14,941	538,856	9,509,539

FINANCIAL STATEMENTS & AUDITORS REPORTS

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
NOTES TO FINANCIAL STATEMENTS
YEAR ENDED SEPTEMBER 30, 2010

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 oilier 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 $17,095,381 for the year ended September 30, 2011. For the year ended September 30,2011 the Organization received disbursements on these agreements in the amount of$8,866,618.

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.

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
NOTES TO FINANCIAL STATEMENTS
YEAR ENDED SEPTEMBER 30, 2010

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 of 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.

3. NONCANCELABLE LEASE COMMITMENTS

The Organization leases its offices and certain equipment under leases that are considered operating leases. Total rent expense was $142,361 and equipment rent was $27,825 the year ended September 30, 2011 Future minimum lease payments under these noncancelable operating leases as of September 30, 2011 are as follows:

Year Ended September 30,	
2012	171,880
2013	67,562
2014	8,103
Thereafter	0
	$247,545

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
NOTES TO FINANCIAL STATEMENTS
YEAR ENDED SEPTEMBER 30, 2011

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, 2011 was $72,028.

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-three percent (93%) of the Organization's support was from federal governmental grant assistance for the year ended September 30, 2011.

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.

7. SUBSEQUENT EVENTS:

Subsequent events were evaluated thru February 2,2012, the issuance date of this report.

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
SCHEDULE OF FEDERAL AWARDS
YEAR ENDED SEPTEMBER 30, 2011

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/				
5U38HM000414-003	93.524	6/1/2010-5/31/2011	$ 7,552,558	$ 6,994,997
5U38HM000414-004	93.524	6/1/2011-5/31/2012	$ 9,130,847	$ 1,685,151
U.S. Dept. of Health & Human Services/ Center for Disease Control & Prevention/Building Capacity for State-Based Occupational Health Surveillance/				
1R01OH010094-01	93.262	7/1/2011-6/30/2012	$ 190,000	$ -
U.S. Dept. of Health & Human Services/ Center for Disease Control & Prevention/Building Capacity for State-Based Occupational Health Surveillance/				
5R25OH008802-04	93.262	7/1/2009-6/30/2010	$ 62,776	$ 62,776
5R25OH008802-05	93.262	7/1/2010-12/31/2011	$ 100,000	$ 99,964
U.S. Dept. of Health & Human Services/ Center for Disease Control & Prevention/ Western States Occupational Network Meeting/ 1R13OH009925-01	93.262	8/1/2010-07/31/2011	$ 20,000	$ 15,997
1R130H009925-02	93.262	8/1/2011-07/31/2012	$ 19,200	$ 7,733
U.S. Dept. of Health & Human Services/ Center for Disease Control & Prevention/ State-Based Occupational Health Surveillance Meeting				
1R130H009930-01	93.262	4/1/11-3/31/12	$ 20,000	$ -
				$ 8,866,618

See Accompanying Notes to Financial Statements

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
NOTES TO SCHEDULE OF FEDERAL AWARDS
YEAR ENDED SEPTEMBER 30, 2011

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 A-133, *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.

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, 2011, and have issued our report thereon dated February 2, 2012. We conducted our audit in accordance with generally accepted auditing standards 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.

2010-2011

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

COMPLIANCE AND OTHER MATTERS

As part of obtaining reasonable assurance about whether Council of State and Territorial Epidemiologists, Inc.' s financial statements are free of material misstatement, we performed tests or 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 and use of 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.

Coun & Company, LLC

February 2,2012
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 compliance of the Council of State and Territorial Epidemiologists, Inc. (CSTE) (a nonprofit organization) with the types of compliance requirements described in the "U.S. Office of Management and Budget (OMB) Circular A-133 Compliance Supplement" that are applicable to each of its major federal programs for the year ended September 30, 2011. CSTE's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs. Compliance with the requirements of laws, regulations, contracts, and grants applicable to each of its major federal programs is the responsibility of CSTE's management. Our responsibility is to express an opinion on CSTE's compliance based on our audit.

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

In our opinion, CSTE complied, in all material respects, with the requirements referred to above that are applicable to each of its major federal programs for the year ended September 30, 2011.

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.

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

A control deficiency in an entity's internal control over compliance exists when the design Of 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.

Out 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.

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.

Coun & Company, LLC

February 2, 2012
Atlanta, Georgia

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS, INC.
SCHEDULE OF FINDINGS AND QUESTIONED COSTS
YEAR ENDED SEPTEMBER 30, 2011

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.
7. The threshold for distinguishing types A and B programs was $300,000.
8. Council of State and Territorial Epidemiologists, Inc. qualified as 11 high risk auditee because of the size of their largest grant.

FINDINGS-FINANCIAL STATEMENTS AUDIT

None

FINDINGS AND QUESTIONED COSTS-MAJOR FEDERAL AWARD PROGRAMS AUDIT

None

2010-2011

EXECUTIVE BOARD

PRESIDENT

Stephen Ostroff, MD
Director, Bureau of Epidemiology
Pennsylvania Department of Health
Health and Welfare Building Room 933
625 Foster Street
Harrisburg, PA 17120
717-787-3550 Phone
717-787-6975 Fax
808-428-1750 Cell
sostroff@state.pa.us

Term Expiration 2011

VICE PRESIDENT
MELVIN KOHN, MD, MPH

Public Health Director
Oregon Department of Human Services
800 NE Oregon Street
Suite 730
Portland, OR 97232
971-673-1300 Phone
971-673-1361 Fax
503-572-7621 Cell
Melvin.a.kohn@state.or.us

Term Expiration 2011

PRESIDENT ELECT

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
402-440-5729 Cell
Tom.Safranek@nebraska.gov

Term Expiration 2011

SECRETARY-TREASURER

Tim Jones, MD
State Epidemiologist
Tennessee Department of Health
CEDS, 1st Fl. Cordell Hull Bldg.
425 5th Ave. N.
Nashville, TN 37243
615-741-7247 Phone
612-741-3847 Fax
tim.f.jones@tn.gov

Term Expiration 2011

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
517-974-3034 Cell
Stanburym@michigan.gov

Term Expiration 2012

2010-2011

EXECUTIVE BOARD

CHRONIC DISEASE/MCH/ ORAL CHAIR

SARA HUSTON, PHD
Chronic Disease Epidemiologist
Maine Center for Disease Control and Prevention
244 Water St., 2nd Floor
Augusta, Maine 04333
207-287-1968 Phone
919-924-1306 Cell
Sara.Huston@maine.gov

Term Expiration 2013

INFECTIOUS DISEASE CHAIR

LAURENE MASCOLA, MD, MPH
Chief of Acute Communicable Disease Control Program
Los Angeles County Department of Public Health
313 N. Figueroa Street, Room 212
Los Angeles, CA 90012
213- 240-7941 Phone
213-482-4856 Fax
213-793-9407 Cell
lmascola@ph.lacounty.gov

Term Expiration 2011

MEMBER AT-LARGE

DUC VUGIA, MD, MPH
Chief, Infectious Disease Branch
California Department of Public Health
850 Marina Bay Parkway
Building P, 2nd Floor
Richmond, CA 94804
510-620-3434 Phone
510-620-3425 Fax
510-520-9409 Cell
Duc.vugia@cdph.ca.gov

Term Expiration 2011

ROBERT ROLFS, MD, MPH
State Epidemiologist
Utah Department of Health
P.O. Box 142104
Salt Lake City, UT 84114
801- 538-6386 Phone
801- 538-9923 Fax
801-971-5481 Cell
rrolfs@utah.gov

Term Expiration 2012

KATRINA HEDBERG, MD, MPH
Interim State Epidemiologist
Oregon Department of Human Services
800 Northeast Oregon Street
Suite 730
Portland, OR 97232
971-673-0982 Phone
971-673-0994 Fax
katrina.hedberg@state.or.us

Term Expiration 2013

SEPTEMBER 2010-2011

CSTE STAFF

Ashlyn Beavor
Workforce and Fellowship Administrator
Employed since 2009

Angie Blocksom
Part-Time Accountant
Employed Since September 2010

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

Tarajee Curry
Administrative Assistant
Employed since August 2003

Elizabeth Dunbar
Associate Research Analyst
Employed since June 2011

Kevin Gibbs
Applications Programmer
Employed since October 2003

Andrea Giorgi
Associate Research Analyst
Employed since June 2011

Monica Huang
Associate Research Analyst
Employed Since June 2010

Robert Jones
Information Technology
Employed since August 2009

Jennifer Lemmings
Epidemiology Program Director
Employed since January 2004

Amber Leonard
Administrative Assistant
Employed since January 2008

Patrick McConnon
Executive Director
Employed since August 2002

Amanda Masters
Workforce and Fellowship Coordinator
Employed since November 2008

Lauren Rosenberg
Associate Research Analyst
Employed since June 2008

LaKesha Robinson
Deputy Director
Employed since January 2001

Erin Simms
Associate Research Analyst
Employed since October 2007

MarySue Shulin
Business Manger
Employed since December 2002

Annie Tran
Associate Research Analyst
Employed since December 2010

Shannon Whittington
Part Time Accountant
Employed since February 2007

2011

ANNUAL CONFERENCE SUMMARY

THEME ▸ THE CHANGING HEALTHCARE LANDSCAPE: NEW OPPORTUNITIES FOR IMPROVING POPULATION HEALTH

LOCATION ▸ PITTSBURGH, PENNSYLVANIA

DATES ▸ JUNE 12-16

TOTAL ATTENDEES ▸ 1045

PROGRAM SUMMARY

WORKSHOPS

- Epidemiology Training Workshop
- Joint National Meeting of Environmental Health and Occupational Health Epidemiologists
- NASPHV Annual Business Meeting
- National Meeting of Influenza Surveillance Coordinators
- BioSense Workshop
- Injury Training
- Public Health Surveillance Workshop
- Epidemiology , Laboratory, and Health Information Systems Capacity for Infectious Disease (ELC) Grantee Meeting
- Analysis of Healthcare-associated Infection Data from the CDC National Healthcare Safety Network (NHSN) Workshop
- National Meeting of Environmental Health Epidemiologists
- National Meeting of Occupational Health Epidemiologists
- RODS-TriSano® OpenSource Integration Workshop

PLENARY SESSIONS

MONDAY PLENARY ▸ Public Health Prevention, Mental Health and Substance Abuse, and Informatics: The View from Our Federal Partners

TUESDAY PLENARY ▸ Three Perspectives on Crisis Epidemiology: Intentional Disasters, Unintentional Disasters, and Traumatic Stress in the Military

WEDNESDAY PLENARY ▸ Epidemiology Then and Now: A Century of Disease Surveillance, Marketing and Alcohol Seeking Behavior, Tools for Today's Epidemiologist

2011

ANNUAL CONFERENCE SUMMARY

PLANNING COMMITTEE

Carina Blackmore
Committee

Brienne Brown
Committee

Beverly Christner
CSTE Staff Lead

Jay Devasundaram
Committee

Lisa Ferland
CSTE Staff

Katarina Hedberg
Cross Cutting1 Chair

Monica Huang
CSTE Staff

Sara Huston
Chronic Disease/MCH/Oral Health Committee Chair

Brian Labus
Committee

James Logue
Committee

Laurene Mascola
Infectious Disease Committee Chair

Amanda Master
CSTE Staff

Bob Rolfs
Surveillance/Informatics Chair

Lauren Rosenberg
CSTE Staff

Tom Safranek
Planning Chair

Erin Simms
CSTE Staff

Martha Stanbury
Environmental/Occupational/ Injury Chair

Ron Tringali
Committee

Marshall Vogt
Committee

Duc Vugia
Cross Cutting 2 Chair

2011

BUSINESS MEETING MINUTES

THURSDAY, JUNE 16, 2011
PITTSBURGH, PENNSYLVANIA

Meeting called to order 8:06 AM EDT

ROLL CALL

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

ABSENT: American Samoa, Arkansas, California, Connecticut, Federated States of Micronesia, Guam, Montana, Northern Mariana Island, Rhode Island, Virgin Islands.

STATE OF CSTE ADDRESS

PRESIDENT: Steve Ostroff
PRESENTATION: PowerPoint

ANNUAL MEETING

- Despite fiscal situation in states:
  - 2nd consecutive year attendance >1,000
  - 2nd consecutive year >600 abstracts submitted
- High quality plenary speakers
- Positive feedback about venue and logistics
- Membership clearly values the annual meeting
- Introducing topical areas of priority
- Challenge to sustain enthusiasm throughout the year
- Should we do something for members who can't come to the meeting?

2011
BUSINESS MEETING MINUTES

THURSDAY, JUNE 16, 2011

CSTE MEMBERSHIP

- Has grown from fewer than 400 in 2002 to more than 1,000 in 2011
- 70% active members
- 25% associate
- 5% student

PEOPLE

- We're an organization with a small staff that does incredible things
- We're an organization of volunteers and we need more people to volunteer
- We need to stay relevant to the membership
- Build programs to support the membership
    - Training, technical support, meetings, policies
- Better communicate to the membership

PRESIDENTIAL PRIORITIES 2010-2011

- Strengthening the State and Local epidemiology workforce
- Supporting state-based surveillance systems
- Leveraging informatics as a tool for state-based epidemiology
- Elevating the role of epidemiology as health care reform is implemented
- Addressing the obesity epidemic
- Addressing public health implications of climate change
- Nurturing global epidemiology partnership

MAJOR ACCOMPLISHMENTS

- 3rd CSTE Workforce Summit
    - Feb 2011 in San Diego (Bob Harrison/Katrina Hedberg)
- National Surveillance Strategy Workshop
    - March 2011 in Denver (Perry Smith/Kris Moore)
- Rapid Assessment of Epidemiology Capacity (2010)
- Developed and distributed the CIFOR Guidelines Toolkit
- Supported 61 CSTE Applied Epidemiology Fellows
- Completed 5 National Assessments

2011

BUSINESS MEETING MINUTES

THURSDAY, JUNE 16, 2011

CDC/CSTE APPLIED EPIDEMIOLOGY FELLOWSHIP PROGRAM

- Needed now more than ever
- Goal should be at least one fellow in every jurisdiction
- Continue to look for opportunities to build
  - Environmental epidemiology
  - Substance abuse
  - Injury
  - Occupational
  - MCH
  - Informatics
- Concern about exclusive support through federal funds

MEMBERSHIP SERVICES

- Over 100 Formal Consultations to CDC, ASTHO, APHL, AHIC, IOM, etc.
- Member and state communications
- CSTE newsletter
- Refined CSTE website
- Improved mechanism for online surveys
- Provided support for all Cooperative Agreement projects
- New state epidemiologists orientation

CSTE MEMBERSHIP STRUCTURE

INFECTIOUS DISEASE STEERING COMMITTEE

- Adult Immunization
- Child Immunization
- Enteric
- Infectious Disease/Food Safety
- HIV
- Healthcare Associated Infections
- Antibiotic Resistance
- Influenza
- STDs

2011

BUSINESS MEETING MINUTES

THURSDAY, JUNE 16, 2011

CSTE MEMBERSHIP STRUCTURE *(Continued)*

CHRONIC DISEASE/MCH/ORAL HEALTH STEERING COMMITTEE

- Cancer
- Cardiovascular
- CD
- Epidemiology Capacity Building
- CD Indicators
- MCH
- Surveillance and Informatics

ENVIRONMENTAL/OCCUPATIONAL/INJURY STEERING COMMITTEE

- Climate Change
- Disaster Epidemiology
- Injury
- Surveillance and Control
- Environmental Epidemiology
- Environmental Health Indicators (SEHIC)
- Occupational Health
- Surveillance

SURVEILLANCE/INFORMATICS STEERING COMMITTEE

- Surveillance Policy
- Surveillance Practice and Implementation
- Indicators
- ELR

CROSS-CUTTING STEERING COMMITTEE

- Disparities
- Workforce
- Border and International Health
- Public Health law

BUSINESS MEETING MINUTES

THURSDAY, JUNE 16, 2011

CSTE MEMBERSHIP STRUCTURE *(Continued)*

CROSS-CUTTING STEERING COMMITTEE

- Alcohol
- Alcohol and Drugs-Surveillance
- Tribal Epidemiology
- Local Epidemiology
- Substance Abuse Epidemiology

INFECTIOUS DISEASE STEERING COMMITTEE

- Influenza Subcommittee
  - Influenza Incidence Surveillance Project (IIP)
  - Hospitalization Surveillance Project (IHSP)
  - Advancing Strategies to Improved Influenza Surveillance
- Food Safety Subcommittee
  - Outbreak Response Guidelines
  - Epidemiology/Laboratory Integrated Reporting Pilot
  - Foodborne Outbreak Training
- HIV/AIDS Surveillance Subcommittee
  - Surveillance Coordinator Orientation Manual
  - Surveillance Coordinator Training Activities
- NASPHV
  - Support for Compendiums

ENVIRONMENTAL/OCCUPATIONAL/INJURY STEERING COMMITTEE UPDATES

- Environmental Surveillance Subcommittee
  - Development of Environmental PH Indicators
  - Environmental Health Workforce and Consultation Programs
  - Development of Surveillance Tools for Disaster Epidemiology
- Occupational Subcommittee
  - Occupational Health Indicators (OHI)
  - Promoting state, regional, national collaboration
- Injury Subcommittee
  - Injury Surveillance Workgroup
  - Injury Prioritization Assessment
  - Workgroup for External Cause Coding Improvement

2011
BUSINESS MEETING MINUTES

THURSDAY, JUNE 16, 2011

CSTE MEMBERSHIP STRUCTURE *(Continued)*

CHRONIC DISEASE/MCH/ORAL HEALTH STEERING COMMITTEE UPDATES

- Heart Disease and Stroke Prevention Data Linkages Demonstration Project
- Distribution of CD State Profiles
- Development of CD Epidemiology Capacity Indicators and Assessment
- Expanding MCH Epidemiology Subcommittee within CSTE

SURVEILLANCE/INFORMATICS COMMITTEE UPDATES

- Public Health Informatics Subcommittee
  - Reviewing/revising the CDC National Biosurveillance Strategy for Human Health
  - Participating in the CDC Public Health Information Network's Communities of Practice
  - Assessing state programs that monitor and assess healthcare resources in emergencies
- Surveillance Coordination Subcommittee
  - State Reportable Conditions Assessment (SRCA)
  - Drafting a Strategic roadmap for the Knowledgebase of State Reportable and Nationally Notifiable Conditions
  - Finalizing the reformatted Nationally Notifiable Conditions
- Surveillance Policy Subcommittee
  - Collaboration with CDC to determine transmission of information to CDC on disease deemed "immediately notifiable"
  - Revising/reviewing the Biosense Strategic Plan

CROSS-CUTTING COMMITTEE UPDATES

- Workforce Development
  - CSTE/CDC Applied Epidemiology Fellowship Program
  - Epidemiology Capacity Assessment
  - National and international Epidemiology Consultations
  - Orientation for New State Epidemiologists

THURSDAY, JUNE 16, 2011

CSTE MEMBERSHIP STRUCTURE *(Continued)*

- Tribal Epidemiology
  - Investigation data sharing policies
  - Analyzing state regulations that authorize or limit the sharing of identifiable public health data
  - Recommend revisions to state-specific laws with regards to data sharing for those 8 states
- Other
  - Substance Abuse Epidemiology Capacity Assessment

ORGANIZATIONAL CHALLENGES GOING FORWARD

- Build capacity and integrate informatics and epidemiology
- Build state & local capacity in areas of chronic disease, mental health, substance abuse, etc.
- Get more of our members involved
  - Every state epi/deputy state epi ought to be on a committee
- Strengthen our relationship with the local level
- Partnerships with other organizations
- Assure adequate resources & diversify resources
  - CDC Cooperative agreement
- Transition planning

ACTION NEEDED: NONE

2011
BUSINESS MEETING MINUTES

THURSDAY, JUNE 16, 2011

REVIEW OF THE VOTING RIGHTS

DISCUSSION: Tom Safranek

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 47 States attending the meeting. A majority vote shall be required to elect board members. If no candidates receive 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. During the Elections, CSTE will use the Electronic Voting System. Each State received a handheld electronic clicker. CSTE /Tim Jones instructed the membership on how the electronic clickers worked. A mock vote was done to ensure that each state's electronic clicker was working.

EXECUTIVE BOARD ELECTIONS AND PRESENTATIONS OF RESULTS

DISCUSSION: Tom Safranek

Tim Jones called for the Elections of open positions on the Executive Board. The appointed tellers were Patricia Quinlisk (IO) and MarySue Shulin.

Tim Jones called for the membership to vote for the **President-Elect** position. The names placed on the ballot were **Katrina Hedberg (OR)** and **Laurene Mascola (CA)**. There was a call for additional nominations from the floor. None were put forward. The members cast their electronic vote and **Laurene Mascola (CA)** was elected to the **President-Elect position**.

Tim Jones called for the membership to vote for the **At-Large position Three Year Term.** The names placed on the ballot were **Megan Davies (NC), Cortland Lohff (MI), Joe McLaughlin (AK) and Corinne Miller (MI).** There was a call for additional nominations from the floor. None were put forward. The members cast their electronic vote and Joe McLaughlin (AK) was elected to the **At-Large position.**

Tim Jones called for the membership to vote for the **Infectious Disease Chair Three Year Term.** The names placed on the ballot were **Bernadette Albanese (NM)** and Alfred DeMaria (MA). There was a call for additional nominations from the floor. None were put forward. The members cast their electronic vote and **Alfred DeMaria (MA)** was elected to the **Infectious Disease Chair.**

THURSDAY, JUNE 16, 2011

Tim Jones called for the membership to vote for the **Secretary-Treasurer position.** The name placed on the ballot was **Tim Jones (TN).** There was call for additional nominations from the floor. **Megan Davies' (NC)** name was put forward. The members cast their electronic vote and **Tim Jones (TN)** was elected to the **Secretary-Treasurer position.**

Tim Jones called for the membership to vote for the **At-Large position One Year Term.** The names placed on the ballot were **Janet Hamilton (FL), Bryant Karras (WA) and Christina Tan (NJ).** There was a call for additional nominations from the floor. None were put forward. The members cast their electronic vote and **Janet Hamilton (FL)** was elected to the **At-Large position.**

ACTION NEEDED: NONE

CSTE BYLAWS

DISCUSSION: Tom Safranek

HANDOUT: Bylaws Document

A motion to approve the proposed CSTE Bylaw Changes to ARTICLE III. Membership was made and seconded. After a short discussion, the CSTE Bylaws were approved.

ACTION NEEDED:

- Post on the CSTE Website

2011
BUSINESS MEETING MINUTES

THURSDAY, JUNE 16, 2011

POSITION STATEMENTS

DISCUSSION: Tim Jones

HANDOUT: Position Statement Documents

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

2011 POSITION STATEMENT CONSENT CALENDAR

COMMITTEE ASSIGNMENT	TITLE	AUTHOR
11-ID-02	Public Health Reporting and National Notification for Hepatitis A	Gary Heseltine
11-ID-03	Public Health Reporting and National Notification for Acute Hepatitis B Infections	Kristin Sweet
11-ID-04	Public Health Reporting and National Notification for Chronic Hepatitis B	Kristin Sweet
11-ID-05	Public Health Reporting and National Notification for Acute Hepatitis C	Gary Heseltine
11-ID-06	Public Health Reporting and National Notification for Hepatitis C Infection, Past or Present	Gary Heseltine
11-ID-07	Establishing a Standard Case Classification Definition for Influenza-Associated Hospitalizations	Matthew Cartter
11-ID-08	Public Health Reporting and National Notification for Salmonellosis	Sherri Davidson
11-ID-10	Creation of a National Notification Campylobacteriosis Case Definition	Janet Hamilton
11-ID-12	Update to Vibriosis Case Definition	John Dunn
11-ID-15	Case Definition for Non-notifiable Infections Caused by Free-living Amebae (Naegleria fowleri, Balamuthia, mandrillaris, and Acanthamoeba spp.)	Carina Blackmore
11-ID-18	Public Health Reporting and National Notification for Mumps	Paul Cieslak
11-ID-19	Public Health Reporting and National Notification for Shigellosis	Sherri Davidson
11-OH-01	CDC and cleaning products health messages	Elise Pechter
11-SI-01	CSTE Endorsement of the CDC-ATSDR Data Release Guidelines & Procedures for Re-release of State-Provided Data	Harold Jaffe

THURSDAY, JUNE 16, 2011

2011 POSITION STATEMENT CONSENT CALENDAR (Continued)

COMMITTEE ASSIGNMENT	TITLE	AUTHOR
11-SI-02	Implementation of US-Mexico Guidelines for Coordination on Epidemiologic Events of Mutual Interest, Communication Pathways for Binational Reporting	Allison Abell Banicki
11-SI-04	Revised Guidelines for Determining Residency for Disease Reporting Purpose	Paul Jarris
11-CC-01	Mutual Notification Framework for CDC and State and Local Health Departments of Communicable Disease of Public Health Concern related to International or Interstate Travelers	Gilberto Chavez

POSITION STATEMENTS THAT WERE DISCUSSED AND ADOPTED AT THE BUSINESS MEETING

COMMITTEE ASSIGNMENT	TITLE	AUTHOR
Interim Position Statement	Prioritizing Electronic Reporting of Healthcare-Associated Infection Data	William Hacker
11-ID-14	Update to Cryptosporidiosis Case Definition	Kristy Bradley
11-SI-03	Proposal for a CSTE Healthcare-Associated Infections (HAI) Standards Committee	Marion Kainer

POSITION STATEMENTS THAT WERE DISCUSSED AND PASSED WITH MODIFICATIONS

11-ID-16	National Surveillance Definition for Melioidosis	Alfred DeMaria

2011
BUSINESS MEETING MINUTES

THURSDAY, JUNE 16, 2011

2011 ANNUAL CONFERENCE ANNOUNCEMENT

The 2012 CSTE Annual Meeting will take place in Omaha, Nebraska, June 3-7.

ADJOURNMENT

The meeting adjourned at 11:30 a.m. as President Steve Ostroff handed the gavel to new CSTE President Tom Safranek.

2011

BALLOT AND RESULTS

2011 ELECTION OF PRESIDENT-ELECT

_____ Katrina Hedberg, MD, MPH
State Epidemiologist
Oregon Department of Human Services

__X__ Laurene Mascola, MD, MPH, FAAP
Chief of the Acute Communicable Disease Control Program
Los Angeles County Department of Public Health

2011 ELECTION OF INFECTIOUS DISEASE CHAIR (3 YEAR TERM)

_____ Bernadette Albanese, MD, MPH
Medical Director and Director of the Disease Prevention and Control Division
El Paso County Public Health in Colorado

___X__ Alfred Demaria, Jr., MD
State Epidemiologist
Massachusetts Department of Public Health

2011 ELECTION OF AT-LARGE POSITION (3 YEAR TERM) CROSS CUTTING II STEERING COMMITTE CHAIR

_____ Megan Davies, MD
State Epidemiologist
North Carolina Department of Health

_____ Cortland Lohff, MD, MPH
Medical Director
Chicago Department of Public Health

__X___ Joe McLaughlin, MD, MPH, TM
State Epidemiologist
Alaska Department of Health and Social Services

_____ Corinne Miller, PhD
State Epidemiologist
Michigan Department of Community Health

2011

BALLOT AND RESULTS

2011 ELECTION OF SECRETARY-TREASURER (3 YEAR TERM)

__X___ Tim Jones, MD
State Epidemiologist
Tennessee Department of Health

_____ Megan Davies, MD
State Epidemiologist
North Carolina Department of Health

2011 ELECTION OF THE AT LARGE POSITION (1 YEAR TERM) SURVEILLANCE INFORMATICS STEERING COMMITTEE CHAIR

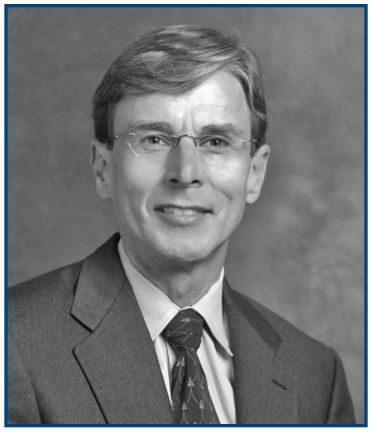
__X___ Janet Hamilton, MPH
Surveillance & Reporting Section Manager
Florida Department of Health

_____ Bryant Karras
Senior Epidemiologist/PH Informatics Officer
Washington Department of Health

_____ Christina Tan, MD
State Epidemiologist
New Jersey Department of Health and Senior Services

2011

JONATHAN MANN MEMORIAL LECTURER



DAVID W. FLEMING, M.D

Director and Health Officer
Public Health - Seattle & King County

David W. Fleming, M.D., is Director and Health Officer for Public Health - Seattle & King County, a large metropolitan health department with 1900 employees, 39 sites, and a budget of $296 million, serving a resident population of 1.8 million people. Programs and services range from core prevention activities to environmental health, community oriented primary care, emergency medical services, correctional health services, Public Health preparedness, and community-based public health assessment and practices.

Prior to assuming this role, Dr. Fleming directed the Bill & Melinda Gates Foundation's Global Health Strategies Program. In this capacity, Dr. Fleming oversaw the Foundation's portfolios in vaccine-preventable diseases, nutrition, newborn and child health, leadership, emergency relief, and cross-cutting strategies to improve access to health tools in developing countries.

Dr. Fleming has also served as the Deputy Director of the Centers for Disease Control and Prevention and as the State Epidemiologist of Oregon. He has published on a wide range of public health issues, and has served on a number of boards and commissions and committees.

Dr. Fleming received his medical degree from the State University of New York Upstate Medical Center in Syracuse. He is board certified in internal medicine and preventive medicine and serves on the faculty of the departments of public health at both the University of Washington and Oregon Health Sciences University.

2011

PUMPHANDLE AWARD WINNER

HENRY (ANDY) ANDERSON, 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.

After decades in public health and epidemiology, the 2011 recipient of the Pumphandle Award, Dr. Henry "Andy" Anderson, called the award "a lifetime achievement."

"It really is an important award, being recognized by peers in public health," said Dr. Anderson. "I'm really honored to be amongst the previous recipients and the work they have done."

During his public health and epidemiology "lifetime," Dr. Anderson has focused on environmental and occupational health, particularly research and surveillance. "I've tried to encourage other states and agencies to build capacity in environmental and occupational health. It is so wide ranging, and goes across chronic and infectious diseases issues as well," he said. "For example, now with the impacts of weather – flooding, tornadoes, heat waves, etc. – we have to be prepared to address everything from injury to infections to water contamination and more."

In addition to increasing capacity, Dr. Anderson works to maintain and improve relationships with outside agencies. As the responsibilities covered by agencies like OSHA and NIOSH have moved out of the state public health departments and to the federal level, those relationships have become increasingly important. "It's critical for us to reach out to these agencies. We often end up being the state lead on issues during a crisis situation, so we have to liaise with them before that crisis occurs," he said.

Dr. Anderson cites CSTE as making this and other efforts in public health easier. "CSTE's willingness to support the membership and be in a leadership position has been a hallmark of the organization,' he said. "It has grown in stature and recognition over the years, and its work with states and local health departments has made it a true leader in public health."

Dr. Anderson currently serves as the Wisconsin State Environmental and Occupational Disease Epidemiologist, and as the State Health Officer. He also holds adjunct professorships at the University of Wisconsin, Madison, Department of Population Health Sciences and the University of Wisconsin Nelson Institute for Environmental Studies, Center for Human Studies.

CSTE congratulates Dr. Henry Anderson on his recognition as the 2011 Pumphandle Award winner.

COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS

2011 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	✓	

2011
POSITION STATEMENTS

Copies can be downloaded from the CSTE website (www.cste.org)

TITLE	AUTHOR	COMMITTEE ASSIGNMENT
INFECTIOUS DISEASE STEERING COMMITTEE		
Public Health Reporting and National Notification for Hepatitis A	Heseltine	11-ID-02
Public Health Reporting and National Notification for Acute Hepatitis B Infections	Sweet	11-ID-03
Public Health Reporting and National Notification for Chronic Hepatitis B	Sweet	11-ID-04
Public Health Reporting and National Notification for Acute Hepatitis C	Heseltine	11-ID-05
Public Health Reporting and National Notification for Hepatitis C Infection, Past or Present	Heseltine	11-ID-06
Establishing a Standard Case Classification Definition for Influenza-Associated Hospitalizations	Cartter	11-ID-07
Public Health Reporting and National Notification for Salmonellosis	Davidson	11-ID-08
Creation of National	Hamilton	11-ID-10
Update to Vibriosis Case Definition	Dunn	11-ID-12
Update to Cryptosporidiosis Case Definition	Bradley	11-ID-14
Case Definitions for Non-notifiable Infections Caused by Free-living Amebae (Naegleria fowleri, Balamuthia mandrillaris, and Acanthamoeba spp.)	Blackmore	11-ID-15
National Surveillance Definition for Melioidosis	Gibson	11-ID-16
Public Health Reporting and National Notification for Mumps	Cieslak	11-ID-18
Public Health Reporting and National Notification for Shigellosis	Davidson	11-ID-19

2011 POSITION STATEMENTS

Copies can be downloaded from the CSTE website (www.cste.org)

SURVEILLANCE STEERING COMMITTEE		
CSTE Endorsement of the CDC-ATSDR Data Release Guidelines & Procedures for Re-release of State-Provided Data	Macdonald	11-SI-01
Implementation of the US-Mexico Guidelines for Coordination on Epidemiologic Events of Mutual Interest,	Abell	11-SI-02
Proposal for a CSTE Healthcare-Associated Infections (HAI) Standards Committee	Kainer	11-SI-03
Revised Guidelines for Determining Residency for Disease Reporting	Hopkins	11-SI-04
Prioritizing Electronic Reporting of Healthcare-Associated Infection Data	Birnbaum	11-SI-05
CROSS CUTTING STEERING COMMITTEE		
Mutual Notification Framework for CDC and State and Local Health Departments of Communicable Diseases of Public Health Concern related to International or Interstate Travelers	Chavez	11-CC-01
OCCUPATIONAL HEALTH STEERING COMMITTEE		
CDC and cleaning products health messages	Pechter	11-OH-01

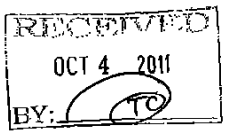
2011
POSITION STATEMENT AGENCY RESPONSES

11-OH-01

COMMITTEE: Occupational Health

TITLE: CDC and cleaning products health messages

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service



National Institute for
Occupational Safety and Health
Centers for Disease Control
and Prevention (CDC)
395 E Street, SW
Washington, DC 20201

September 21, 2011

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

Dear Mr. McConnon:

Thank you for sharing the Council of State and Territorial Epidemiologists' (CSTE) Position Statement 11-OH-01, "CDC and cleaning products health messages." You note that the effectiveness of cleaning and disinfection intended to prevent transmission of infectious diseases is not well documented, and that overuse or prolonged exposure to cleaning products can have harmful effects. Thus, the "position statement calls for the CDC to convene a process to develop evidence-based recommendations regarding the use of cleaning agents and to promote education about environmentally preferable products offering protection to workers and bystanders." The National Institute for Occupational Safety and Health (NIOSH) stands ready to participate when the Centers for Disease Control and Prevention (CDC) convenes a process to develop evidence-based recommendations.

NIOSH is the part of CDC that conducts research on occupational safety and health and transfers findings into practice for the betterment of workers. Although some aspects of the statement, such as disinfection in the home, are outside of our mission, NIOSH has a strong interest in occupational aspects of using cleaners and disinfectants. NIOSH has vigorously supported efforts to understand exposures resulting from the use of cleaning and disinfecting products in workplace settings, and how such exposures might impact the health of workers. Current support includes the following:

- *State-based surveillance for work-related asthma.* NIOSH has coordinated state-based surveillance for work-related asthma (WRA) for over 20 years. This surveillance has led to reports and articles on WRA and exposure to cleaning and disinfection agents, such as by Rosenman et al. 2003 (reference 47 in the CSTE Position Statement 11-OH-01). Surveillance has played an important role in identifying these agents as asthmagens and will likely identify additional WRA cases related to cleaning and disinfecting products.
- *Internal research on asthma and related symptoms among healthcare workers.* In late 2010, NIOSH initiated a four-year project entitled "Research to Inform the Prevention of Asthma in Health Care." The primary objective of the project is to identify

11-OH-01 (Continued)

COMMITTEE: OCCUPATIONAL HEALTH

TITLE: CDC AND CLEANING PRODUCTS HEALTH MESSAGES

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Page 2 - Patrick J. McConnon, MPH

modifiable occupational risk factors for asthma in healthcare that will inform strategies for prevention. NIOSH researchers measured airborne exposures in several medical centers, with an emphasis on chemicals from cleaning and disinfecting products. Workers in healthcare, including housekeepers, will be asked to complete a survey, enabling estimations of the association of asthma and related symptoms with airborne exposures assessed using a job- and task-exposure matrix.

- *Educational materials for protecting workers who use cleaning products.* NIOSH and Occupational Safety and Health Administration (OSHA) staff are jointly developing an educational poster for workers and a fact sheet for employers aimed at reducing risks for skin and respiratory disorders associated with building cleaning and maintenance work. The materials will provide information on potential health problems, safe work practices, training requirements, appropriate cleaner choice, and certifying organizations of environmentally preferable products.
- *NIOSH Office of Extramural Programs* (www.cdc.gov/niosh/oep/default.html). NIOSH funded investigators at the University of Connecticut for Project 5R21OH009831-02, Green Cleaning: Exposure Characterization and Adoption Process Among Custodians. This project investigates the use and impact of environmentally-preferable cleaning products (EPPs) and disinfectants among custodians to assess their health effects, and to implement effective strategies to prevent exposures and reduce potential health risks. The project end date is August 31, 2013. You can find more information at: http://projectreporter.nih.gov/project_info_description.cfm?aid=7934601&icde=0.

Thus, NIOSH has played an important role in identifying cleaning and disinfecting agents' abilities to cause and/or exacerbate WRA and is building on that evidence base to guide prevention recommendations. Furthermore, NIOSH is developing educational materials to transfer what we already know into practice. We will gladly contribute these materials to a CDC process to develop evidence-based recommendations with our infection control and environmental health colleagues.

Thank you for your involvement in this very important area. We greatly appreciate your efforts.

Sincerely,

John Howard, M.D.
Director

2011
POSITION STATEMENT AGENCY RESPONSES

11-SI-04

COMMITTEE: SURVEILLANCE

TITLE: REVISED GUIDELINES FOR DETERMINING RESIDENCY FOR DISEASE REPORTING

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control and Prevention

February 15, 2012

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

Dear Mr. McConnon:

Thank you for your letter dated July 11, 2011 officially informing CDC that the Council of State and Territorial Epidemiologists (CSTE) approved position statement 11-SI-04 titled *Revised Guidelines for Determining Residency for Disease Notification* at CSTE's June 2011 annual meeting. I have shared your letter with the National Notifiable Diseases Surveillance System (NNDSS) staff responsible for addressing implementation issues related to this position statement, in collaboration with other CDC programs and the NNDSS reporting jurisdictions. NNDSS staff implementation plan responses to the desired actions in the position statement are provided below.

The primary change in the *Revised Guidelines for Determining Residency* is that although US cases of nationally notifiable diseases that occur in residents of foreign countries should have case notifications sent to CDC, these case notifications should not be included in state-specific counts or state-specific incidence rates. However, based on our interpretation, the position statement does not preclude CDC from publishing national incidence counts or rates of nationally notifiable diseases among non-U.S. residents, including the jurisdiction source of notification. In addition, the guidelines also clarify that for immediately nationally notifiable diseases, the jurisdiction leading the response to the case should make the immediate notification to CDC, even if the case is permanently notified by a different state or is in a non-U.S. resident. The specific statement of desired actions and corresponding NNDSS implementation plans are listed below:

CSTE Statement of Desired Action	Response
1. CSTE should adopt these updated guidelines for determining residency for disease reporting.	CDC and CSTE are currently establishing a working group to collaboratively develop implementation plans for the *Revised Guidelines*, to address issues and concerns identified by reporting jurisdictions, CDC subject matter experts, and the NNDSS Team.
2. CDC programs participating in NNDSS will follow the updated guidelines for determining residence for notification of cases of nationally	CDC's NNDSS team has informed CDC programs responsible for prevention and control of nationally notifiable diseases about the *Revised Guidelines*. The *Revised Guidelines*

11-SI-04 (Continued)

COMMITTEE: SURVEILLANCE

TITLE: REVISED GUIDELINES FOR DETERMINING RESIDENCY FOR DISEASE REPORTING

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

Centers for Disease Control and Prevention

notifiable diseases.	have been posted to the NNDSS web site. In addition, the NNDSS Team will inform the Emergency Operations Center of the clarification within the Guidelines related to voice notifications of immediately nationally notifiable diseases.
3. CDC should, as soon as practical, add a Foreign Residence variable for all case notification messages from states to CDC, as defined in Appendix II.	The new Foreign Residence data element (DEM245) has been added to the Generic tab of the Generic v2 Message Mapping Guide. The variables included in the generic tab of the Generic guide will be sent to CDC for all HL7case notification messages in the future, as transition occurs from NETSS to HL7. A priority of the NNDSS Team is to work with reporting jurisdictions to transition to HL7 case notification messages. The Generic variables are foundational data elements which will be included in revisions of existing and or new disease-specific Message Mapping Guides.
4. States and other notifying jurisdictions to CDC's NNDSS should collect information about U.S. residence status and should prepare to include this information in notifications to CDC when CDC updates the content of the generic and disease-specific notification messages to include the new Foreign Residence variable.	The Foreign Residence variable (DEM245) has been designated required in HL7 case notifications to CDC.
5. The effective date of these guidelines will be January 1 of the year following that in which the Foreign Residence variable has been made available for jurisdictions electronic case notifications to CDC.	CDC and CSTE are collectively developing an implementation plan for the *Revised Guidelines*. All jurisdictions should begin to collect data about Foreign Residence, so it can be submitted to CDC through NNDSS case notifications. The NNDSS Team, in collaboration with CDC subject matter experts and CSTE, will develop a plan for table revisions to accommodate the new variable and implementation plan.

11-SI-04 (Continued)

COMMITTEE: Surveillance

TITLE: Revised Guidelines for Determining Residency for Disease Reporting

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control and Prevention

CDC and CSTE share a long history of collaboration on important public health issues. We look forward to working with you on the implementation of this initiative and other activities that support public health surveillance.

Sincerely yours,

Stephen B. Thacker, MD, MSc, USPHS
Director
Office of Science, Epidemiology and Laboratory Services
Centers for Disease Control and Prevention

2011

POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: Infectious Diseases / Surveillance / Cross Cutting

SUBMITTING AUTHOR: Rima F. Khabbaz, M.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30329

November 15, 2011

Patrick J. McConnon, M.P.H.
Executive Director
Council of State and Territorial Epidemiologists
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341-4015

Dear Mr. McConnon:

I am responding to your letters to Dr. Thomas Frieden regarding the Council of State and Territorial Epidemiologists (CSTE) position statements that provide recommendations around surveillance and recommended changes in current case definitions of several conditions. Enclosed is the Centers for Disease Control and Prevention's (CDC) response to the CSTE Position Statements listed below. These statements were reviewed by the National Center for Emerging and Zoonotic Infectious Diseases, the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, and the National Center for Immunization and Respiratory Diseases and by the Center for Global Health (11-ID-14, 11-ID-15, 11-SI-02, and 11-CC-01).

Position statements

11-ID-02 "Public Health Reporting and National Notification for Hepatitis A"

11-ID-03 "Public Health Reporting and National Notification for Acute Hepatitis B Infections"

11-ID-04 "Public Health Reporting and National Notification for Chronic Hepatitis B"

11-ID-05 "Public Health Reporting and National Notification for Acute Hepatitis C"

11-ID-06 "Public Health Reporting and National Notification for Hepatitis C Infection, Past or Present"

11-ID-07 "Establishing a Standard Case Classification Definition for Influenza-Associated Hospitalizations"

11-ID-08 "Public Health Reporting and National Notification for Salmonellosis"

11-ID-10 "Creation of a National Campylobacteriosis Case Definition"

11-ID-12 "Update to Vibriosis Case Definition"

11-ID-14 "Update to Cryptosporidiosis Case Definition"

11-ID-15 "Case Definitions for Non-notifiable Infections Caused by Free-living Amebae (*Naegleria fowleri*, *Balamuthia mandrillaris*, and *Acanthamoeba* spp.)"

11-ID-16 "Add Melioidosis to the List of Nationally Notifiable Conditions"

2011
POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: Infectious Diseases / Surveillance / Cross Cutting

SUBMITTING AUTHOR: Rima F. Khabbaz, M.D.

11-ID-18 "Public Health Reporting and National Notification for Mumps"

11-ID-19 "Public Health Reporting and National Notification for Shigellosis"

11-SI-02 "Implementation of the US–Mexico Guidelines for Coordination on Epidemiologic Events of Mutual Interest, Communication Pathways for Binational Notifications, and Creating a List of Binationally Notifiable Infectious Diseases"

11-SI-03 "Proposal for a CSTE Healthcare-Associated Infections (HAI) Standards Committee"

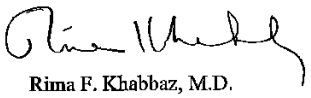
11-SI-05 "Prioritizing Electronic Reporting of Healthcare-Associated Infection Data"

11-CC-01 "Communicable Diseases of Public Health Concern among International or Interstate Travelers on Commercial Conveyances: A Framework for Mutual Notification between CDC and State and Territorial Health Departments"

In addition, regarding the letter sent to me and Dr. John Howard of the National Institute for Occupational Safety and Health (NIOSH) concerning CSTE Position Statement 11-OH-01, "CDC and Cleaning Products Health Messages," the relevant infectious disease programs and I have reviewed the statement and we support the response sent to you earlier from Dr. Howard.

I appreciate CSTE's ongoing commitment to these important public health issues as well as the opportunity for CDC's infectious disease programs to provide input to the position statements. We look forward to continued collaboration with CSTE regarding these and other public health issues of mutual concern.

Sincerely,



Rima F. Khabbaz, M.D.
Deputy Director for Infectious Diseases

Enclosure

cc:
NCEZID
NCHHSTP
NCIRD
CGH
NIOSH

2011

POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: INFECTIOUS DISEASES / SURVEILLANCE / CROSS CUTTING

SUBMITTING AUTHOR: RIMA F. KHABBAZ, M.D.

The Centers for Disease Control and Prevention's Comments
Regarding the
2011 Council of State and Territorial Epidemiologists' (CSTE)
Position Statements

CSTE Position Statement 11-ID-02
Title: Public Health Reporting and National Notification for Hepatitis A

Statement of the desired action(s) to be taken:
CSTE requests that CDC adopt this standardized reporting definition for Hepatitis A to facilitate more timely, complete, and standardized local and national reporting of this condition.

CDC Comments:
CDC concurs with the position statement.

CSTE Position Statement 11-ID-03
Title: Public Health Reporting and National Notification for Acute Hepatitis B Infections

Statement of the desired action(s) to be taken:
CSTE requests that CDC adopt this revised reporting definition for acute HBV.

CDC Comments:
CDC concurs with the position statement.

CSTE Position Statement 11-ID-04
Title: Public Health Reporting and National Notification for Chronic Hepatitis B

Statement of the desired action(s) to be taken:
CSTE requests that CDC adopt this standardized reporting definition for chronic hepatitis B.

CDC Comments:
CDC concurs with the position statement.

CSTE Position Statement 11-ID-05
Title: Public Health Reporting and National Notification for Acute Hepatitis C

Statement of the desired action(s) to be taken:
CSTE requests that CDC adopt this standardized reporting definition for acute hepatitis C to facilitate more timely, complete, and standardized local and national reporting of this condition.

1

2011
POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: Infectious Diseases / Surveillance / Cross Cutting

SUBMITTING AUTHOR: Rima F. Khabbaz, M.D.

CDC Comments:
CDC concurs with the position statement.

CSTE Position Statement 11-ID-06
Title: Public Health Reporting and National Notification for Hepatitis C Infection, Past or Present

Statement of the desired action(s) to be taken:
CSTE requests that CDC adopt this standardized reporting definition for hepatitis C to facilitate more timely, complete, and standardized local and national reporting of this condition.

CDC Comments:
CDC concurs with the position statement.

CSTE Position Statement 11-ID-07
Title: Establishing a Standard Case Classification Definition for Influenza-Associated Hospitalizations

Statement of the desired action(s) to be taken:
Establish standard reporting and case classification methods for influenza-associated hospitalization and recommend that any State or Territory conducting surveillance for this condition use these standard methods.

CDC Comments:
CDC is very supportive of establishing a standardized case definition. Some States and Territories are already conducting surveillance for influenza-associated hospitalizations, and the adoption of a standardized surveillance case definition is a good idea. However, it is important to consider that despite increased availability and use of influenza laboratory tests, testing practices vary substantially.

Reported influenza-associated hospitalizations are likely to be an underestimation of the actual number of true cases. Besides underreporting issues, influenza-related hospitalizations can also be missed either because testing is not performed, or because cases may be attributed to other causes of pneumonia or other common influenza-related complications.

Specific comments are as follows:

1- Defined goals. Because of the issues described above that imply uncertainty regarding case ascertainment and reporting completeness, population-based estimates of disease incidence and accurate description of geographical distribution is important. Every effort should be made to identify and describe the population under surveillance.

2

POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: Infectious Diseases / Surveillance / Cross Cutting

SUBMITTING AUTHOR: Rima F. Khabbaz, M.D.

2- It is important to define hospitalization. In order to be consistent with other state and local jurisdictions conducting surveillance for influenza-associated hospitalization, the recommended definition for hospitalization is:
An admission to an inpatient ward of the hospital. Patients who are admitted to and discharged from the hospital on the same day would be considered hospitalized. (Overnight stay is not required to meet definition.) Emergency room and outpatient visits would not constitute a "hospitalization."

3- Disease-specific data elements to be collected.

C. Disease-specific data elements
Date of hospitalization
Influenza test type
Influenza test result
Total doses influenza vaccine
Date of last influenza vaccination

Because the definition of influenza-associated hospitalization involves time between hospital admission and positive laboratory test results for influenza, it is imperative that date of positive test result be included among data elements. Other data elements to be considered would include age (date of birth), sex, race/ethnicity and hospital where patient was hospitalized. The latter would be important to understand reporting patterns in the surveillance area and assess specific distribution by local area or state level (per described goals).

The inclusion of "total doses of influenza vaccine" and "date of last influenza vaccination" as part of data elements seems unnecessary and reasons for that unclear. In our experience, number of doses and dates of vaccine receipt are difficult to collect accurately. They are often missing from hospital records/medical charts. The only way to accurately capture vaccine dose-related data elements would be to contact regular/primary providers of admitted patients, or the patients themselves. This would add considerably to the workload of state and local health departments and may not add to any of the surveillance goals listed in this position statement.

4- Period of surveillance. RIDTs produce very quick results, but the results may not be accurate during times when influenza virus is not commonly circulating—generally at the beginning and end of the influenza season and during the summer. Therefore, besides establishing surveillance as ongoing, reporting of influenza-associated hospitalizations should be recommended only during the influenza season, i.e., approximately October through May.

5- Laboratory Evidence: Delete serologic test positive for influenza or Add Acute and convalescent serologic specimens 2-3 weeks apart indicating a 4-fold increase in convalescent antibody titer.

3

2011
POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: Infectious Diseases / Surveillance / Cross Cutting

SUBMITTING AUTHOR: Rima F. Khabbaz, M.D.

CSTE Position Statement 11-ID-08
Title: Public Health Reporting and National Notification for Salmonellosis

Statement of the desired action(s) to be taken:
CSTE requests that CDC adopt this new case definition category for Salmonellosis in order to accommodate cases diagnosed by non-culture based methods. By adding a "Suspect" category, Public Health will be able to track and assess *Salmonella* cases diagnosed by non-culture based methods.

CDC Comments:
CDC concurs with the position statement.

The same error exists in the *Salmonella* statement (page 5) that is noted in the *Shigella* statement. It should read "When available, serotype characterization should be reported."

CSTE Position Statement 11-ID-10
Title: Creation of a National Campylobacteriosis Case Definition

Statement of the desired action(s) to be taken:
Establish standard reporting and case classification for campylobacteriosis and recommend that any State or Territory conducting surveillance for this condition use these standards.

CDC Comments:
CDC concurs with the position statement.

CSTE Position Statement 11-ID-12
Title: Update to Vibriosis Case Definition

Statement of the desired action(s) to be taken:
The national surveillance case definition of vibriosis should be revised. We propose to expand the case definition to include isolation of a species from the family *Vibrionaceae* from a clinical specimen.

CDC Comments:
CDC concurs with the position statement.

CSTE Position Statement 11-ID-14
Title: Update to Cryptosporidiosis Case Definition

Statement of the desired action(s) to be taken:
The national surveillance case definition for cryptosporidiosis should be revised. We propose to: 1) clarify the laboratory criteria language to standardize confirmed or

4

POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: Infectious Diseases / Surveillance / Cross Cutting

SUBMITTING AUTHOR: Rima F. Khabbaz, M.D.

probable case status based on the type of diagnostic test used; 2) assign a probable case status to persons meeting the clinical criteria and epidemiologically linked to a confirmed case (e.g., case-patient in the same household or other group setting, or with an identical exposure as the confirmed case); and 3) for epidemiologically linked cases, require clinical criteria of diarrhea, plus one or more symptoms of diarrhea of ≥72 hours duration, abdominal cramping, vomiting or anorexia.

CDC Comments:
Introduction—In 2011, a CSTE position statement was introduced to alter the cryptosporidiosis case definition to classify positive results from immunochromatographic card tests ("rapid test") as "probable." These changes were made based on a recent report of discrepant, false-positive results being associated with commercially available immunochromatographic card tests for combined diagnosis of *Cryptosporidium* and *Giardia (1)*.

CDC response—CDC has concerns about the revision of the cryptosporidiosis case definition that occurred. The new case definition now includes:

Laboratory criteria for diagnosis

Confirmed: Evidence of *Cryptosporidium* organisms or DNA in stool, intestinal fluid, tissue samples, biopsy specimens, or other biological sample by certain laboratory methods with a high positive predictive value (PPV), e.g.,

- direct fluorescent antibody [DFA] test,
- polymerase chain reaction [PCR],
- enzyme immunoassay [EIA], or
- light microscopy of stained specimen.

Probable: The detection of *Cryptosporidium* antigen by a screening test method, such as immunochromatographic card/rapid card test; or a laboratory test of unknown method.

Case classification

Confirmed: A case that is diagnosed with *Cryptosporidium* spp. infection based on laboratory testing using a method listed in the confirmed criteria.

Probable: A case with supportive laboratory test results for *Cryptosporidium* ~~*Cryptosporidia*~~ [tracked change is a suggested edit] spp. infection using a method listed in the probable laboratory criteria. When the diagnostic test method on a laboratory test result for cryptosporidiosis cannot be determined, the case can only be classified as probable.

OR

A case that meets the clinical criteria and is epidemiologically linked to a confirmed case.

5

2011
POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: Infectious Diseases / Surveillance / Cross Cutting

SUBMITTING AUTHOR: Rima F. Khabbaz, M.D.

Comment: Persons who have a diarrheal illness and are epidemiologically linked to a probable case who was only diagnosed with cryptosporidiosis by an immunocard/rapid test or unknown test method cannot be classified as probable cases. These epi-links can be considered suspect cases only.

CDC believes that these changes do not address the issues related to the immunochromatographic card tests and they now put a substantial burden on state and territorial surveillance staff to try to determine what type of test was performed before classifying a case. While CDC fully agrees that the issue of antigen testing for cryptosporidiosis diagnosis should be examined fully (CDC is funding APHL to investigate this issue more fully in the federal fiscal year 2012), CDC does not believe that addressing this issue through a CSTE position statement or case definition change is an effective way to proceed.

Our concerns about the implementation of this case definition change are as follows:

1) The definition excludes some of the most effective and frequently used diagnostic test methods. It also inaccurately categorizes rapid tests as having low PPV. Multiple studies have found that these tests have similar or higher PPV as the tests considered confirmatory. Excluding "immunodiagnostic methods" from the laboratory diagnosis criteria for "Confirmed" cases will not only exclude the intended immunochromatographic card testing from the "Confirmed" case definition but also might be interpreted to exclude all commercially available ELISA tests as well as the gold standard for *Cryptosporidium* and *Giardia* testing, direct fluorescence antibody testing.
2) Case definition assignment will be difficult. Most reporting labs do not report the method of laboratory diagnosis, which may lead states or territories to classify most cases as "unknown."
3) Reporting "Probable," epidemiologically linked cases will be reduced. By definition, they need to be linked to a case confirmed by non-antigen-based testing, which will limit the number of such cases assigned. This will reduce our understanding of the burden of cryptosporidiosis in the United States. The original reason for adding a "Probable" case definition resulted from state requests to be able to do so.
4) This might set a precedent for the classification of other parasitic and bacterial notifiable diseases that also use immunodiagnostic testing. Developing criteria for including this class of test rather than broadly modifying case definitions might be a more effective way of excluding inadequate test methods.
5) This could also affect the immunodiagnostic test market, possibly negatively impacting the ability of clinicians to diagnose diseases.

CDC recommends that CSTE not adopt this wording in the lab criteria or case definition until a more detailed discussion can be undertaken on the ramifications of such a change. In the interim, CSTE could:
1) Retain the current case definition unchanged OR
2) Adopt the wording in the position statement proposed at the 2010 CSTE conference, which sought to remove language referring to specific laboratory diagnostic methods

6

POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: INFECTIOUS DISEASES / SURVEILLANCE / CROSS CUTTING

SUBMITTING AUTHOR: RIMA F. KHABBAZ, M.D.

from the laboratory criteria and broaden the language to include the possibility of additional gastrointestinal symptoms OR

3) Adopt a new case definition that specifies immunodiagnostic tests for confirmed (e.g., DFA and EIA) and probable (e.g., immunochromatographic card tests).

2010 original proposed case definition:

Laboratory criteria for diagnosis

Laboratory-confirmed cryptosporidiosis shall be defined as the detection of *Cryptosporidium* organisms, antigens, or DNA in stool, intestinal fluid, tissue samples, biopsy specimens, or other biological sample.

Case classification

Confirmed: a case that meets the clinical description and the criteria for laboratory-confirmation as described above. When available, molecular characterization (e.g., species, genotype, or subtype designation), should be reported.

Probable: a case that meets the clinical description and has probable criteria for laboratory diagnosis or that is epidemiologically linked to a confirmed case.

Reference *(1)*:
Robinson TJ, Cebelinski EA, Taylor C, Smith KE. Evaluation of the positive predictive value of rapid assays used by clinical laboratories in Minnesota for the diagnosis of cryptosporidiosis. Clin Infect Dis. 2010 Apr 15;50(8):e53-5.

CSTE Position Statement 11-ID-15

Title: Case Definitions for Non-notifiable Infections Caused by Free-living Amebae (*Naegleria fowleri*, *Balamuthia mandrillaris*, and *Acanthamoeba* spp.)

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

1. Establish standard reporting and case classification for non-notifiable diseases caused by *N. fowleri*, *B. mandrillaris*, and *Acanthamoeba* spp. (including keratitis) and recommend that any State or Territory conducting surveillance for these conditions use standard reporting and case classification.
2. CSTE recommends that States and Territories conducting surveillance according to these methods consider reporting case information to CDC.
3. CSTE recommends that CDC publish data on disease caused by *N. fowleri*, *B. mandrillaris*, and *Acanthamoeba* spp. (including keratitis) as appropriate.

In addition, CSTE calls upon CDC to 1) work with the American Medical Association and other partners to expand physician education regarding the diagnosis and treatment of PAM, GAE, *Acanthamoeba* keratitis, and other free-living amebic infections, and 2) increase public education about PAM, GAE, *Acanthamoeba* keratitis, and other free-living amebic syndromes to promote prevention and early recognition.

7

2011
POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: Infectious Diseases / Surveillance / Cross Cutting

SUBMITTING AUTHOR: Rima F. Khabbaz, M.D.

CDC Comments:
Comments on Section VI. A-3—The following suggested edits are based on comments 1 and 2 below:

"Any person with ocular or neurologic manifestations consistent with a free-living amebae infection occurring after having receiveding ~~an organ or~~ a transplanted organ or tissue from a person with ocular or neurologic manifestations consistent with ~~confirmed or suspected to~~ havinge a free-living amebae infection where either the donor or recipient have a confirmed free-living amebae infection."

1) Does this intend for CDC to gather all cases to include transplant recipient with neurologic manifestations consistent with PAM, where the donor is only suspected of having infection? Suggest: that either the donor or recipient has confirmed infection before it is reported. Suggest adding: criteria to be more than one recipient from a common donor, but this makes it more complicated.
2) The trigger is receipt of an organ or "transplanted tissue." Suggest: "transplanted organ or tissue."
3) Concerning "transplanted tissue," is the intent to include all tissues or cells? For instance, including bone marrow? Suggest including a definition for what specific organs and tissues are included.

CSTE Position Statement 11-ID-16
Title: Add Melioidosis to the List of Nationally Notifiable Conditions

Statement of the desired action(s) to be taken:
CSTE requests that CDC adopt this reporting and case definition for melioidosis to place this disease under national surveillance and to facilitate timely, complete, and standardized local and national reporting, by:

- Establishing standard reporting and notification methods for melioidosis
- Recommending that States and Territories conduct surveillance according to these methods
- Melioidosis should be added to the *Nationally Notifiable Conditions* List as immediately urgent notifiable if suspected to be intentional
  - The condition has special importance for international health regulations as defined in IHR 2005 (CSTE position statement 08-EC-02)
- CSTE recommends that all States and Territories make this disease or condition reportable in their jurisdiction.

CDC Comments:
CDC concurs with the position statement.

CSTE Position Statement 11-ID-18
Title: Public Health Reporting and National Notification for Mumps

8

POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: Infectious Diseases / Surveillance / Cross Cutting

SUBMITTING AUTHOR: Rima F. Khabbaz, M.D.

Statement of the desired action(s) to be taken:
The modified case reporting criteria in Part VI-A and modified case classifications in Part VII will be implemented.

CDC Comments:
CDC concurs with and fully supports CSTE's recommended revised case definition for mumps case classification. CDC worked with state health officials and CSTE on this revision. The language of the previous definition often resulted in inconsistent interpretations, especially for probable cases. The new language more clearly outlines the characteristics of a probable case and allows state health departments to define the group or community that should be considered epidemiologically linked. Finally, the updated language recognizes the improvements that have been made in mumps laboratory diagnostics since 2008. This updated case definition specifies that in addition to certain clinical symptoms, a case must have positive laboratory results from either RT-PCR or cultures in order to be classified as confirmed.

CSTE Position Statement 11-ID-19
Title: Public Health Reporting and National Notification for Shigellosis

Statement of the desired action(s) to be taken:
CSTE requests that CDC adopt this new case definition category for Shigellosis in order to accommodate cases diagnosed by non-culture based methods. By adding a "Suspect" category, Public Health will be able to track and assess *Shigella* cases diagnosed by non-culture based methods.

CDC Comments:
CDC concurs with the position statement.

In our review, we noticed an error on page 5 (also see CDC comments on 11-ID-08). It says "When available, O antigen serotype characterization should be reported." This statement could apply to some other enteric pathogens but doesn't apply to *Shigella*. CDC's Division of Foodborne, Waterborne, and Environmental Diseases will let our CSTE contacts know.

CSTE Position Statement 11-SI-02
Title: Implementation of the US–Mexico Guidelines for Coordination on Epidemiologic Events of Mutual Interest, Communication Pathways for Binational Notifications, and Creating a List of Binationally Notifiable Infectious Diseases

Statement of the desired action(s) to be taken:
1. CSTE endorses the ongoing development of the US Mexico Binational Communications Pathways Protocol for presentation to CSTE for discussion and approval at a later date.

9

2011
POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: INFECTIOUS DISEASES / SURVEILLANCE / CROSS CUTTING

SUBMITTING AUTHOR: RIMA F. KHABBAZ, M.D.

2. CSTE requests that CDC continue to work with CSTE and the U.S. border states to implement the "US Mexico Guidelines for Cooperation on Epidemiologic Events of Mutual Interest" by developing a list of binationally notifiable conditions and piloting binational notification using the binational communication pathway protocol.

CDC Comments:
CDC concurs with the position statement.

This effort will improve IHR compliance and information sharing at the federal and state level, and can be a model for North American and international cooperation in disease prevention and control for nations sharing borders.

CSTE Position Statement 11-SI-03
Title: Proposal for a CSTE Healthcare-Associated Infections (HAI) Standards Committee

Statement of the desired action(s) to be taken:
CSTE and CDC should endorse the attached approach and procedures for a CSTE Healthcare-Associated Infections Standards Committee and follow the process.

CDC Comments:
CDC concurs with the position statement.

CSTE Position Statement 11-SI-05
Title: Prioritizing Electronic Reporting of Healthcare-Associated Infection Data

Statement of the desired action(s) to be taken:
Office of the National Coordinator for Health Information Technology (ONC) should move healthcare associated infection surveillance (reporting through NHSN) from a Stage 3 optional consideration to a Stage 2 Improving Quality, Safety and Efficiency Reporting core requirement in its criteria for meaningful use. This would move the financial incentive from 2015-2016 to 2013-2014.

Specifically the following healthcare associated measures should be included as criteria for Meaningful Use:

Core requirement under Stage 2:
1. NHSN: Central line associated blood stream infections (CLABSI)
2. NHSN: Catheter associated urinary tract infections (CAUTI)
3. NHSN: Laboratory identified events: multi-drug resistant organism/*Clostridium difficile* (MDRO/CDAD) module
4. NHSN: Central Line Insertion Practices (CLIP)
5. NHSN: Surgical Site Infections (SSI)

10

POSITION STATEMENT AGENCY RESPONSES

11-ID-02 ,11-ID-03, 11-ID-04, 11-ID-05, 11-ID-06, 11-ID-07, 11-ID-08
11-ID-10, 11-ID-12, 11-ID-14, 11-ID-15, 11-ID-16, 11-ID-18, 11-ID-19,
11-SI-02, 11-SI-03, 11-SI-05, AND 11-CC-01

COMMITTEE: Infectious Diseases / Surveillance / Cross Cutting

SUBMITTING AUTHOR: Rima F. Khabbaz, M.D.

CDC Comments:
CDC concurs with the position statement.

CSTE Position Statement 11-CC-01
Title: Communicable Diseases of Public Health Concern among International or Interstate Travelers on Commercial Conveyances: A Framework for Mutual Notification between CDC and State and Territorial Health Departments

Statement of the desired action(s) to be taken:
1. CSTE and CDC will agree on adopting the proposed framework for bidirectional notification between CDC and state and territorial health departments for communicable diseases on commercial conveyances, ensuring that DGMQ is notified.
2. CSTE and CDC will agree on collecting travel histories for people with suspected cases of the communicable diseases listed in the framework including dates, places and modes of travel.
3. CSTE and CDC/DGMQ will agree to evaluate the proposed notification framework to estimate the public health impact in terms of reducing communicable disease risks to travelers and communities, and the impact to health departments in terms of time and resources required.

CDC Comments:
CDC concurs with the position statement.

11

2011
POSITION STATEMENT AGENCY RESPONSES

11-SI-01

COMMITTEE: Surveillance

TITLE: CSTE Endoresement of the CDC-ATSDR Data Release Guidelines and Procedures for Re-Release of State-Provided Data

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

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

APR 2 6 2012

April 20, 2012

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

Dear Pat,

Thank you for your letter dated April 2, 2012 regarding the Council of State and Territorial Epidemiologists' (CSTE) position statement entitled "CSTE Endorsement of the CDC-ATSDR Data Release Guidelines and Procedures for Re-Release of State-Provided Data."

The Office of Surveillance, Epidemiology and Laboratory Services (OSELS), the Office of the Associate Director for Science (OADS), the Excellence in Science Committee (EISC) and numerous programs across CDC play a major role in this issue. As such, it will take some time to coordinate and determine how best to implement and monitor these recommendations. Please be assured that we are diligently looking into this and will provide a response once our review is completed.

CDC and CSTE share a long history of collaboration on important public health issues. We look forward to working with you on this and other important initiatives.

Respectfully yours,

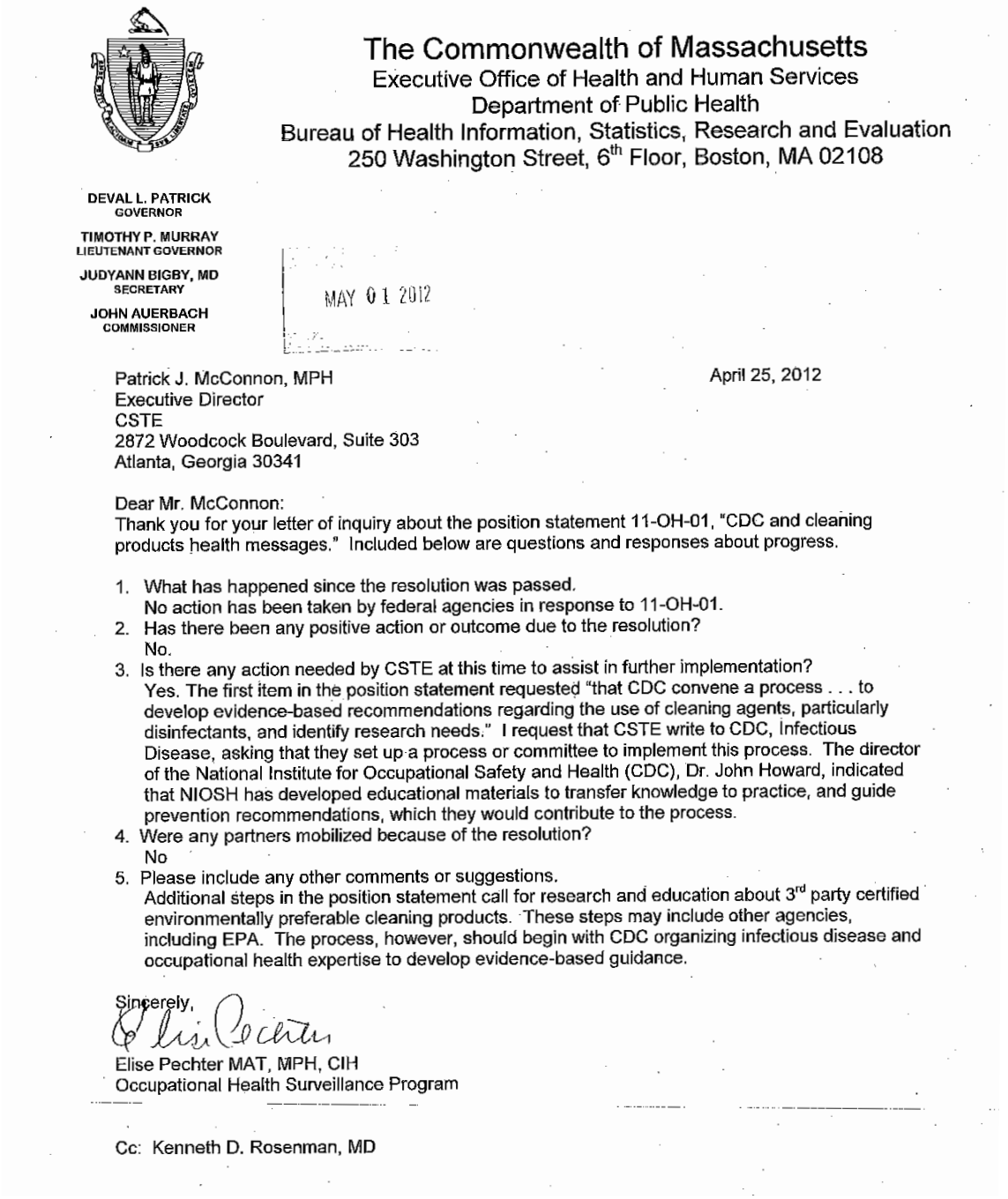
Stephen B. Thacker, M.D., M.Sc.
RADM (Ret.), USPHS
Deputy Director for Surveillance, Epidemiology and Laboratory Services
Centers for Disease Control and Prevention
MS/E94
Atlanta, GA 30333
404-498-6001 (phone)
404-498-6565 (fax)
sbt1@cdc.gov

POSITION STATEMENT AUTHOR PROGRESS REPORTS

11-OH-01

COMMITTEE: Occupational Health

SUBMITTING AUTHOR: Elise Pechter



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Information, Statistics, Research and Evaluation
250 Washington Street, 6th Floor, Boston, MA 02108

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

JUDYANN BIGBY, MD
SECRETARY

JOHN AUERBACH
COMMISSIONER

MAY 01 2012

Patrick J. McConnon, MPH
Executive Director
CSTE
2872 Woodcock Boulevard, Suite 303
Atlanta, Georgia 30341

April 25, 2012

Dear Mr. McConnon:
Thank you for your letter of inquiry about the position statement 11-OH-01, "CDC and cleaning products health messages." Included below are questions and responses about progress.

1. What has happened since the resolution was passed.
   No action has been taken by federal agencies in response to 11-OH-01.
2. Has there been any positive action or outcome due to the resolution?
   No.
3. Is there any action needed by CSTE at this time to assist in further implementation?
   Yes. The first item in the position statement requested "that CDC convene a process . . . to develop evidence-based recommendations regarding the use of cleaning agents, particularly disinfectants, and identify research needs." I request that CSTE write to CDC, Infectious Disease, asking that they set up a process or committee to implement this process. The director of the National Institute for Occupational Safety and Health (CDC), Dr. John Howard, indicated that NIOSH has developed educational materials to transfer knowledge to practice, and guide prevention recommendations, which they would contribute to the process.
4. Were any partners mobilized because of the resolution?
   No
5. Please include any other comments or suggestions.
   Additional steps in the position statement call for research and education about 3rd party certified environmentally preferable cleaning products. These steps may include other agencies, including EPA. The process, however, should begin with CDC organizing infectious disease and occupational health expertise to develop evidence-based guidance.

Sincerely,

Elise Pechter MAT, MPH, CIH
Occupational Health Surveillance Program

Cc: Kenneth D. Rosenman, MD

2011
POSITION STATEMENT AUTHOR PROGRESS REPORTS

11-ID-14

COMMITTEE: Infectious Diseases

TITLE: Update to Cryptosporidiosis Case Definition

SUBMITTING AUTHOR: Kristy Bradley

Oklahoma State Department of Health
Creating a State of Health

May 8, 2012

RECEIVED
MAY 14 2012
BY: TC

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

Re: Position Statement Progress Report
11-ID-14: Update to Cryptosporidiosis Case Definition

Dear Mr. McConnon,

Since the passage of CSTE position statement 11-ID-14 that updated the surveillance case definition for cryptosporidiosis, I have fielded a handful of questions from epidemiologists or surveillance staff in state health departments who were updating their surveillance manuals and wanted to be sure they were correctly applying the revised case definition. Despite the concerns expressed by the CDC in the correspondence from Dr. Rima Khabbaz dated November 15, 2011, I have not received any negative feedback from state or local health departments indicating difficulties in ascertaining the test method used for appropriate case classification. In that same correspondence, it was stated that CDC shared concerns about the increasing laboratory use of rapid antigen tests to diagnose cryptosporidiosis and that CDC was funding APHL to study the issue more fully. This is welcome news and I look forward to the APHL study findings. It is possible that this position statement was an impetus to CDC in providing funding for the study.

The issues surrounding immunodiagnostic test methods that led to this position statement last year are not unique to cryptosporidiosis. Shortly after the 2011 annual CSTE Conference, Dr. Al DeMaria convened a Non-culture Testing Methods Workgroup to further explore the implications on public health surveillance and develop potential strategies for CSTE.

Please contact me if you have any questions related to this report.

Sincerely,

Kristy Bradley

Kristy Bradley, DVM, MPH
State Epidemiologist

Terry L Cline, PhD
Commissioner of Health
Secretary of Health and Human Services

Board of Health
Jenny Alexopoulos, DO, President
Alfred Baldwin Jr.
Martha A Burger
R Murali Krishna, MD, Vice President
Glenn Davis, DDS
Terry R Gerard, DO
Cris Hart-Wolfe, Secretary-Treasurer
Barry L Smith, JD
Ronald Woodson, MD

1000 NE 10TH Street
Oklahoma City, OK 73117-1299
www.health.ok.gov
An Equal Opportunity Employer

POSITION STATEMENT AUTHOR PROGRESS REPORTS

11-ID-02, 11-ID-03, 11-ID-04, 11-ID-05 AND 11-ID-06

COMMITTEE: Infectious Disease

SUBMITTING AUTHOR: Alfred DeMaria, Jr.

SUMMARY:

Subsequent to the passage of position statements 10-ID-07 through 10-ID11 (public health reporting and national notification for hepatitis A, acute hepatitis C, chronic hepatitis C, chronic hepatitis B and acute hepatitis B infections), the CDC Division of Viral Hepatitis asked CSTE to reconsider the respective case definitions in light of their concerns about specific elements. A working group of CSTE members and CDC/DVH was convened and all of the case definitions were reviewed to address CDC concerns and other concerns that had arisen. The product of the work group was position statements 11-ID-02 through 11-ID-06 (public health reporting and national notification for hepatitis A, acute hepatitis B infections, chronic hepatitis B, acute hepatitis C, hepatitis C infection, past or present). These consensus position statements were passed at the 2011 annual meeting and sent to CDC. CDC has pursued the process of case report form development and message mapping for case notification to CDC through the National Notifiable Diseases Surveillance System (NNDSS). In addition, an overall review of viral hepatitis surveillance was initiated by CDC/DVH.

2011

POSITION STATEMENT AUTHOR PROGRESS REPORTS

11-ID-07

COMMITTEE: Infectious Diseases

TITLE: Establishing a Standard Case Classification Definition for Influenza-Associated Hospitalizations

SUBMITTING AUTHOR: Matthew L. Cartter

SUMMARY:

The following progress report is in response to your letter of April 11, 2012:

1. The November 15, 2011 response from the CDC contains numerous suggestions for revisions to the position statement: http://www.cste.org/ps2011/resp/HHSAgencyResp.pdf
2. To determine the number of states and territories using the standard case classification survey for influenza-related hospitalizations would require CSTE or CDC to conduct a survey of state and territorial epidemiologists.
3. CSTE should survey state and territorial epidemiologists to determine the extent to which this new case definition is being used.
4. CSTE should revise the position statement based on the comments from CDC and from state and territorial epidemiologists.

11-ID-12

COMMITTEE: Infectious Diseases

TITLE: Communicable anc Environmental Disease Services

SUBMITTING AUTHOR: John Dunn

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
COMMUNICABLE AND ENVIRONMENTAL DISEASE SERVICES
CORDELL HULL BUILDING
425 5th AVENUE NORTH
NASHVILLE, TENNESSEE 37247

May 2, 2012

Dear CSTE,

Below please find the requested updates to position statement 11-ID-12.

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

   Since the resolution has passed, the Cholera and Other *Vibrio* Illness Surveillance Form has been updated to reflect the taxonomic changes.

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

   There has been increased dialogue between CDC and state partners regarding the updated case definition and reporting requirements. Reporting of the updated taxonomic groups has occurred.

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

   No action is needed at this time.

4. Were any partners mobilized because of the resolution?

   We are working with APHL and ASM to disseminate the update case definition and reporting requirement to the appropriate audience.

Regards,

John Dunn
Deputy State Epidemiologist

2011

POSITION STATEMENT AUTHOR PROGRESS REPORTS

11-SI-03

COMMITTEE: Surveillance

TITLE: Proposal for a CSTE Healthcare-Associated Infections (HAI) Standards Committee

SUBMITTING AUTHOR: Marion Kainer

SUMMARY:

STATEMENT OF THE DESIRED ACTION(S) TO BE TAKEN:

- CSTE and CDC should endorse the attached approach and procedures for a CSTE Healthcare-Associated Infections Standards Committee and follow the process.

CDC RESPONSE:

- CDC concurs with the position statement.

PROGRESS:

- The HAI standards committee has been constituted and has been meeting via teleconference on a monthly basis. Dr. Marion Kainer is the chair; Dr. Kathryn Arnold is co-chair.

WORK PRODUCTS:

1. The committee has developed a new template for healthcare associated infection (HAI) position statements. This template has been approved by the CSTE executive board.

2. The committee has submitted a position statement on central line associated blood stream infection (CLABSI) for consideration by membership at the 2012 annual meeting.

ADDITIONAL ACTION REQUIRED?

- No additional action or follow-up is required by CSTE at this time.

POSITION STATEMENT AUTHOR PROGRESS REPORTS

11-SI-05

COMMITTEE: Surveillance

TITLE: Prioritizing Electronic Reporting of Healthcare-Associated Infection Data

SUBMITTING AUTHOR: David Birnbaum
Marion Kainer

SUMMARY:

Following passage of this position statement at CSTE's 2011 annual conference and its incorporation into a CSTE response to an open public comment period of the Office of the National Coordinator for Health Information Technology (ONC):

- Correspondence was received from CDC stating "CDC concurs with the position statement";
- No indication of consideration or adoption could be found in subsequent meeting minutes or recommendations from the pertinent ONC committee.
- The ONC and CMS Notice of Public Rule Making on proposed Meaningful Use Stage 2 requirements posted in March 2012 do not include any of the changes we recommended in 11-SI-05.

A small group, party to the original position statement and concerned about lack of ONC response, started meeting in the fall of 2011 through conference calls to discuss further action needed. It explored and rejected other routes to put this item back on the ONC agenda as a standard. It confirmed that the best approach for CDC's National Healthcare Safety Network (NHSN) system and state health department HAI programs would be inclusion in Meaningful Use core requirements, and use of the next NPRM call for public input would be the best strategy. We also participated in an ONC Standards & Interoperability Framework Public Health Reporting Initiative project (submitting an "HAI Reporting" user story, helping deconstruct all user stories into their key elements and then constructing a single use-case model onto which all user stories can fit), a project aimed at producing a model for Stage 3 of Meaningful Use. Since Stage 3 is not scheduled for implementation for another 3-4 years, most other user stories relate to systems that are not yet in existence, and the HAI reporting need addresses requirements imposed on hospitals and an existing electronic reporting system this year, we have maintained that we want HAI reporting considered for Stage 2.

2011
POSITION STATEMENT AUTHOR PROGRESS REPORTS

11-SI-05 (Continued)

COMMITTEE: Surveillance

TITLE: Prioritizing Electronic Reporting of Healthcare-Associated Infection Data

SUBMITTING AUTHOR: David Birnbaum
Marion Kainer

Our small group came to realize that ONC's conceptual model focused on aggregated quality metrics being delivered to CMS not necessarily through NHSN; the "Common Formats" voluntary anonymous reporting scheme of other federal agencies had had stronger representation than NHSN within the S&I Framework project until our involvement; and number of letters received carries more weight than society letters written on behalf of multiple members. We therefore created a letter template in collaboration with the CSTE HAI Subcommittee for use by all state HAI programs, which also was shared with the other professional associations that had supported CSTE when it submitted 11-SI-05 as part of its response to ONC's 2011 public comment period. Use of our template to create letters for the current public comment period (which closes in May) was promoted in March and April e-mail to the HAI Subcommittee distribution list by CSTE.

We also have been in communication with the Joint Public Health Informatics Taskforce. The position in our 2012 draft letter is being supported by JPHIT in their response letter to ONC and CMS.

CSTE staff has continued to be of immense help in this effort, by facilitating the organization of our small group's conference calls, monitoring NPRM response instructions and deadlines, and distributing our updates to all members concerned.

CSTE may wish to consider expressing its concern to a more senior level within the Department of Health and Human Services that CSTE's 2011 recommendations were not even acknowledged by the Health Information Technology National Coordinator. Drs. Farzad Mostashari and Donald Wright were listed under the Agencies for Response in 11-SI-05.

[1] The Association for Professionals in Infection Control and Epidemiology, Inc. (APIC), and the Society for Healthcare Epidemiology of America (SHEA)

POSITION STATEMENT AUTHOR PROGRESS REPORTS

11-SI-04

COMMITTEE: Surveillance

TITLE: Revised Guidelines for Determining Residency for Disease Notification Purposes
Adopted at our 2011 annual meeting in Pittsburgh PA

SUBMITTING AUTHOR: Richard S. Hopkins

SUMMARY:

Implementation work for this position statement has been moving ahead largely under the direction of Dr. Ruth Ann Jajosky, who is with the Office of Surveillance, Epidemiology and Laboratory Services at CDC. She leads CDC's Nationally Notifiable Diseases Team. There have been at least four conference calls among Dr. Jajosky, several members of her team, and appropriate CSTE Steering Committee and Subcommittee chairs and members -- Lesliann Helmus, Janet Hamilton, Steve Macdonald and others -- as well as CDC contractors and staff. Adding the requested variable to the NETSS record and to the PHIN generic message mapping guide for national notification of NNDSS case reports turns out to be more complex than I had anticipated, and (it turns out) will also need OMB review. Dr. Jajosky estimates that full implementation may not be complete until 1/1/2015.

We have also discussed the implementation of this position statement on the bimonthly CSTE/CDC coordination conference calls with Dr. Jim Buehler and members of his staff. Dr. Buehler is very supportive and is concerned about the long time-line for implementation. It is possible that the implementation schedule may be compressed to some degree as a result of his intervention.

We received a letter in response to the position statement from Dr. Stephen Thacker, director of OSELS, outlining an appropriate CDC response, dated February 15, 2012.

In conversations among CSTE leaders in surveillance and informatics, it was decided that the variable called for in the position statement, instead of being operationalized as "Foreign resident, yes/no", would be implemented as "What is your country of usual residence?". Input from the Division of Quarantine and Global Migration as well as from several interested members was important in reaching this decision. In a related move, CSTE members involved in this discussion agreed to move forward to modify the existing "Imported" variable so that it focuses on the jurisdiction in which disease was acquired or the key exposure occurred. The answer then, like the answer to the question about "country of usual residence", will be a country name or, in the case of Canada and Mexico, the name of a province or state.

2011

POSITION STATEMENT AUTHOR PROGRESS REPORTS

11-SI-04 (Continued)

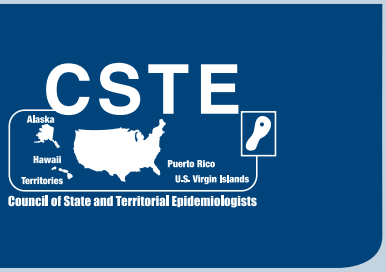
COMMITTEE: Surveillance

TITLE: Revised Guidelines for Determining Residency for Disease Notification Purposes
Adopted at our 2011 annual meeting in Pittsburgh PA

SUBMITTING AUTHOR: Richard S. Hopkins

The CDC Division of Quarantine and Global Migration (DGMQ) is interested in adding additional variables to the NETSS record and the PHIN Message Map for the generic NNDSS notification, in support of both their binational surveillance and investigation projects with Canada and Mexico, and their broader mission for public health cooperation with other countries. They would like to add a variable for country of birth, and another for whether this case is a "binational case" of a notifiable condition, that would require any of several kinds of follow-up with Mexican or Canadian public health authorities. While the need for these variables is suggested by position statement 11-SI-02 "Implementation of the US-Mexico Guidelines for Coordination on Epidemiologic Events of Mutual Interest, Communication Pathways for Binational Notifications, and Creating a List of Binationally Notifiable Infectious Diseases", they are not needed for implementation of position statement 11-SI-04. As it would be convenient for these changes in the notification message all to be processed by CDC as a group, the discussions of these two sets of changes are proceeding together, but they differ in how and whether they flow from position statements already adopted. We have been encouraging DGMQ and their state partners to come to the 2012 annual meeting with a new position statement formalizing the next steps needed for implementation of 11-SI-02.

No further action is needed by CSTE at the annual meeting, but continued staff support for this rather long implementation process will be appreciated.



COUNCIL OF STATE AND TERRITORIAL EPIDEMIOLOGISTS

National Office

2872 Woodcock Boulevard

Suite 303

Atlanta, Georgia 30341

t 770.458.3811

f 770.458.8516

www.cste.org