



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

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

I am responding to your letter to Dr. Julie Louise Gerberding regarding the Council of State and Territorial Epidemiologists (CSTE) position statements that provide recommendations around surveillance and recommended changes in current case definitions of several conditions. Enclosed is the Centers for Disease Control and Prevention's (CDC) response to the following CSTE Position Statements:

07-ID-02, Revision of the Surveillance Case Definition for Mumps
07-ID-03, Revision of the National Surveillance Case Definition for Ehrlichiosis
(Ehrlichiosis/Anaplasmosis)
07-ID-04, Revision of the Surveillance Case Definition for Q fever
07-ID-05, Revision of Surveillance Case Definition for Rocky Mountain spotted fever
07-ID-08, Use of HIV/AIDS surveillance data in future Ryan White HIV/AIDS Treatment
Modernization Act funding formula
07-ID-09, Heterosexual HIV Transmission Classification
07-ID-10, Revision of CSTE 06-ID-01: Surveillance Case Definition for HIV Infection among
Children age < 18 months
07-ID-11, Revised National Surveillance Case Definition for Lyme disease
07-ID-12, Establishing Neonatal Herpes Surveillance
07-ID-13, Revision of the Surveillance Case Definition for Coccidioidomycosis
07-ID-14, Influenza-Associated Pediatric Mortality

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

Sincerely,

Mitchell L. Cohen, M.D.
Director, Coordinating Center for
Infectious Diseases

Enclosure

**The Centers for Disease Control and Prevention's Comments
Regarding the
2007 Council of State and Territorial Epidemiologists'
Position Statements**

CSTE Position Statement 07-ID-01

Title: National Reporting for Novel Influenza A Virus Infections"

CDC Comments:

None.

CSTE Position Statement 07-ID-02

Title: "Revision of the Surveillance Case Definition for Mumps"

CSTE recommends modified mumps case definition, case classifications and case classifications of import status for mumps.

CDC Comments:

CDC supports the CSTE recommendations and suggests the following:

- Clarification of the suspected case status by changing the word "testing" to "confirmation." The suspected case would then read "A case with clinically compatible illness or meets the clinical case definition without laboratory confirmation, or a case with laboratory tests suggestive of mumps without clinical information." This change would provide a clear classification for a single clinically compatible case with laboratory testing but without a positive test result.
- Addition of two sentences in the comment section to (1) clarify the meaning of "without laboratory confirmation" in the suspect case classification and to (2) clarify the intent of the term "confirmed case" in the confirmed case classification. Suggested wording for these additions: (1) In the suspect case classification, a case "without laboratory confirmation" would include those not tested as well as those tested but with negative results. (2) To be considered a confirmed case based on epidemiologic linkage, there must be a laboratory confirmed case in the chain of transmission."

CSTE Position Statement 07-ID-03

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

CSTE recommends revision of the national surveillance case definition for Ehrlichiosis.

CDC Comments:

CDC concurs with and fully supports the CSTE recommendation and would suggest a minor revision to the definition of a suspect case. CDC believes that a “Suspect” case should be defined as “A clinically compatible case but with no supportive laboratory results.” As written, a suspect case is defined as having laboratory evidence without clinical information. Laboratory testing on asymptomatic (or non-clinically compatible) individuals is not warranted.

CSTE Position Statement 07-ID-04

Title: “Revision of the Surveillance Case Definition for Q fever”

CSTE recommends revision of the national surveillance case definition for Q Fever.

CDC Comments:

CDC concurs with and fully supports the CSTE recommendation and would suggest adding a definition of a suspect case. As written, the document does not include case definitions for acute or chronic Q fever. For consistency with the other rickettsial case definitions, it would be beneficial to extend the acute case definition for Q fever to include a "suspect case" category. The suggestion by CDC is to add a definition for a suspect case, “A clinically compatible case but with no supportive laboratory results.”

CSTE Position Statement 07-ID-05

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

CSTE recommends revision of the national surveillance case definition for Rocky Mountain Spotted Fever.

CDC Comments:

CDC concurs with and fully supports the CSTE recommendation and would suggest a minor revision to the definition of a suspect case. CDC believes that a “Suspect” case should be defined as “A clinically compatible case but with no supportive laboratory results.” As written, a suspect case is defined as having laboratory evidence without clinical information. Laboratory testing on asymptomatic (or non-clinically compatible) individuals is not warranted.

CSTE Position Statement 07-ID-08

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

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

CDC Comments:

1. CDC, in collaboration with CSTE, determine the most scientifically valid method for combining data from states that are in various stages of implementing name-based HIV reporting for the purposes of the formulas used to fund care programs.

CDC supports the CSTE recommendation that “CDC, in collaboration with CSTE, determine the most scientifically valid method for combining data from states that are in various stages of implementing name-based HIV reporting for the purposes of the formulas used to fund care programs.” During 2007, CDC has worked closely with the Health Resources and Services Administration (HRSA) and HIV/AIDS surveillance coordinators to develop technical guidance for submission of code-based HIV data to HRSA for use in funding formulas. This guidance provides standard criteria for data submissions that enable code-based states to submit data comparable to that of name-based reporting areas, which CDC then submits to HRSA for formula allocations. As the remaining states transition to name-based HIV reporting, CDC will continue to work with HRSA and surveillance coordinators on these issues and provide necessary input as revisions to the formulas are considered.

2. Any future eligibility and funding formulas should include name-based reported cases living with HIV infection (including AIDS), confirmed by CDC, as the basis of the formula(s).

CDC concurs with and supports the CSTE recommendation that future eligibility and funding formulas include name-based reported cases living with HIV infection (including AIDS), as confirmed by CDC.

3. CSTE recommends that CDC should provide technical support to ensure and require that by September 30, 2009 all project areas (states, cities and territories) : a) de-duplicate their HIV/AIDS cases both inside their state as well as with jurisdictions outside of their state within six months of receiving their list of potential interstate duplicates from CDC and, b) perform a match with their state death registry at least annually. Following the death match, CDC should verify that the area uses the results of the match to update vital status of reported cases in the HIV/AIDS registry. They should assure that states have the necessary funding to perform these fundamental activities and should be able to assure and verify that these activities are taking place.

CDC supports the CSTE recommendation that CDC provide technical support to ensure areas de-duplicate their HIV/AIDS cases and perform state death registry matches annually. Both de-duplication and death ascertainment activities are part of routine core HIV/AIDS surveillance activities funded under CDC HIV/AIDS Surveillance cooperative agreements. These ongoing activities are currently part of the process standards for evaluation activities outlined in the Technical Guidance for HIV/AIDS Surveillance. In addition, CDC is currently developing standard protocols and procedures for these activities, which it will work with state and local health departments to implement over the next 2 years. As part of these protocols, CDC will work with areas to develop standard report cards to assist with assessing area progress in implementing these activities. Finally, CDC plans to continue technical support for these activities; however, the provision of additional funding, beyond that which is currently available, cannot be guaranteed and will be provided if resources allow.

CSTE Position Statement 07-ID-09

Title: "Heterosexual HIV Transmission Classification"

CDC Comments:

CSTE recommends that:

1. CDC add the category "Presumed Heterosexual" contact (PHC) to the categories used to describe females with HIV infection (including AIDS).

CDC is concerned that recommendation #1, as defined in the CSTE position statement, does not make it clear that a "no" or "unknown" on risk factors other than injection drug use must be documented. Without such a stipulation, it is unclear how to ensure future reported cases are not less valid than those that are currently reported. As surveillance staff may be tempted to report PHC when they are unable to find any risk factor information for an HIV-infected female, PHC could easily become a default category if measures to guard against such practices are not in place.

2. Additional information be collected on female presumed heterosexual cases in areas for which this is feasible in order to better qualify and understand heterosexual HIV transmission. However, this information is not required for classification as presumed heterosexual transmission.

CDC is concerned that state and city surveillance programs will be distracted with collecting additional information, the utility of which is as yet undetermined. Specifically, how will surveillance areas be able to collect more information on behavioral risk factors when they cannot collect what is currently being asked of them? It is problematic to introduce more work when it is unclear who will collect the data sought; how it will be used; and whether such information will even be useful in light of the first recommendation.

3. CDC and CSTE convene one or more workgroups to:

- a. Select and standardize the data elements listed in recommendation #2 above;**
- b. Begin the process of changing the current hierarchical system to one that is nonhierarchical and allows for multiple categories of risk factor classification.**

Recommendation #3a suggests a workgroup be formed to standardize the data elements for Recommendation #2. Rather than work on issues for supplemental variables that may have limited value to surveillance, CDC thinks that this workgroup should address the definition, as well as implementation and evaluation plans for introducing the new category. Addressing these concerns and issues will help clarify a way to proceed on this topic.

With respect to recommendation #3b, CDC is working on implementation of the exposure category variable to present multiple risk factor categories in a nonhierarchical way. In fact, this variable is already available in eHARS. However, timing of its full implementation will depend on the availability of internal resources.

c. Evaluate the impact of adding this presumed heterosexual category for females;

CDC supports convening a workgroup to develop a definition for a female presumed heterosexual contact category and draft evaluation and implementation plans for the new category. The implementation plan should consider necessary systems changes, training, dissemination, and hardware or software needs at all levels of implementation, as well as other items identified by the workgroup. CDC will convene a workgroup before the end of 2007 to address these three documents (definition, evaluation plan, and implementation plan); execution of the agreed upon plans will follow that meeting.

d. Explore the issues related to, and the feasibility of, creating a presumed heterosexual category for males.

The adoption of a male presumed heterosexual contact category is likely to be far more problematic than it is for females. Therefore, CDC does not think it is appropriate to explore issues related to creation of a male presumed heterosexual contact category until the issues with a female presumed heterosexual contact category have been addressed.

CSTE Position Statement 07-ID-10

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

CSTE recommends that CDC adopt the revised definition for the presumptive uninfected category for HIV infection among children age <18 months.

CDC concurs with, and fully supports, the CSTE recommendation that CDC adopt the revised presumptive uninfected category for HIV infection among children age <18

months. Accordingly, the revised case definition will be incorporated into *HIV Infection Among Children Aged <18 Months* and disseminated through official CDC publications (e.g., the *Morbidity and Mortality Weekly Report, Recommendations and Reports*).

To further ensure that all HIV/AIDS surveillance coordinators are aware of this revised definition for categorizing children age <18 months as presumptive uninfected, CDC will immediately implement the revised definition and will update data management software accordingly. The revised definition will then be used in the data analyses of all subsequent papers and presentations.

CSTE Position Statement 07-ID-11

Title: “Revised National Surveillance Case Definition for Lyme disease”

CSTE recommends that CDC revise the national surveillance case definition for Lyme disease.

CDC Comments:

CDC concurs with and fully supports CSTE's recommended revised surveillance case definition. The revised definition provides local and state health departments the flexibility to classify Lyme disease reports as confirmed, probable, or suspect and therefore more effectively capture the public health impact of Lyme disease. CDC expects that this will appreciably increase the number of cases tallied. Therefore, the result of this revision will be to increase the accuracy of reporting while decreasing the burden on state and local health departments.

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

CSTE Position Statement 07-ID-12

Title: Establishing Neonatal Herpes Surveillance

CSTE recommends that CDC should convene an expert panel to include those states that currently have neonatal herpes as a reportable condition as well as those states that would like to consider making this a reportable condition, to develop a standard case definition for neonatal herpes surveillance that could be considered for use by those states.

CDC Comments:

CDC appreciates the opportunity to comment on CSTE's position statement on neonatal herpes surveillance. After having worked closely with CSTE on the meeting of the expert panel in March 2007 and attending the CSTE annual meeting in June 2007, at which this issue was discussed, we support a slightly different strategy to further this discussion. The expert panel in March did an excellent job of discussing the relevant

issues and making its recommendations. Instead of convening the expert panel again or convening a second expert panel, CDC supports a process by which CDC and CSTE would approach a number of states that currently have neonatal herpes under surveillance or have an interest in putting it under surveillance to assess these states' interest in adopting the case definition that was developed by the March 2007 Expert Panel. CDC and CSTE would use the March 2007 Expert Panel as advisors for clarification and consultation, as needed, but would do so via phone, conference calls, and e-mail exchanges. Implementing this strategy would assist those states in which neonatal herpes is reportable to improve their surveillance and the quality of their data. Improved data could be a basis for CSTE decision-making on future actions or position statement development.

CSTE Position Statement 07-ID-13

Title: Revision of the Surveillance Case Definition for Coccidioidomycosis

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

CDC Comments: CDC is in the process of developing an implementation plan for the revision to the coccidioidomycosis surveillance case definition and any other related changes. The new case definition will be implemented by January 2008.

CSTE Position Statement 07-ID-14

Title: 07-ID-14, Influenza-Associated Pediatric Mortality

CSTE recommends that influenza-associated pediatric death should be maintained on the national reportable disease list and placed under surveillance through the National Notifiable Diseases Surveillance System (NNDSS).

CDC Comments:

CDC supports the continued inclusion of influenza-associated pediatric mortality in the NNDSS and we will work toward integrating the variables needed for this condition into the National Electronic Disease Surveillance System.