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Council of State and Territorial Epidemiologists

YEAR 2000 OBJECTIVES AVAILABLE

For those of you who haven't yet received a copy of the draft of the year 2000 objectives, copies can be obtained by writing the following address:

Deputy Assistant Secretary for Health
(Disease Prevention and Health Promotion)
Department of Health and Human Services
330 C Street, SW., Room 2132
Washington, DC 20201

This is an opportunity for all of us to respond to the nation's year 2000 objectives in draft form. Comments on these objectives must be received by November 15, 1989. I have asked each of the CSTE consultants to review the sections which deal with their consulting area (at a minimum) and make comments where appropriate to the Public Health Service. All of us should attempt to review these and respond as needed.

FROM THE CSTE CONSULTANTS:

SURVEILLANCE COORDINATING GROUP (Rick Vogt, Vermont)

"The last meeting of the surveillance coordinating group reviewed the goals for the year 2000 objectives for surveillance. There is a large amount of data which will need to be coordinated at the level of CDC, with dissemination of the data to the state and local level. Several of the year 2000 objectives are state-level objectives that are clearly going to need to be addressed in concert with CDC, making it even more imperative that the surveillance coordinating group play a major role in facilitating activities between the CDC and the states and local health departments. The surveillance coordinating group is at the threshold of trying to determine surveillance needs. This discussion will be a continuing one over the next several months."

Rick also reports that the graphics for the MMWR will be changing soon, to include some of the modifications which were presented to CSTE last May. One will involve a graphic which depicts trends in cases as a ratio of previous cases. We can expect the change soon.

Rick also wanted to let us know that the SCG is discussing with laboratory directors the possible implementation of lead poisoning through state labs and state epidemiologists. Epidemiologists who may be in charge of lead surveillance in their states may want to think about receiving laboratory data from their own state lab and from other labs in the state, channeling it through the NETS System and transmitting it to CDC. This will probably be a topic of discussion at the next April CSTE meeting and those of you who are interested in lead surveillance may want to talk to Rick Vogt about how this is progressing.

ASTHO TOBACCO CONTROL PLAN TO BE AVAILABLE SOON

Very shortly, the first publication of the monograph "Guide to Public Health Practice: State Health Agency Tobacco Prevention and Control Plans" will be sent to key individuals throughout the country. The document is prepared by ASTHO in conjunction with NCI. Doug Lloyd, M.D., the co-senior editor of the document, wants to be sure that epidemiologists and other CSTE members be made aware of its impending availability, since we may play a key role in the development of statewide comprehensive tobacco control plans. The guide should be arriving in health departments in early November (a first mailing will be going to state health officers, governors, and a few other key people). Approximately three months later, about 10,000 more copies will be made available. More information can be obtained from Doug Lloyd (Farmington, CT) or the ASTHO committee on smoking or health.

ON TOBACCO OR HEALTH (Pat Remington, Wisconsin)

Pat has been the CSTE representative on the ASTHO Committee on Tobacco for Health. The committee is working in three areas: (1) Publication of the guide mentioned above. (2) Development of a network of tobacco control persons. ASTHO, NCI, and CDC are working to conduct a conference with these persons in the spring of 1990. (3) Development of a position statement on tobacco use and death certification. Currently, four states have added tobacco use to the death certificate and other states have legislation pending. ASTHO has requested that CSTE develop a position statement on the desirability of adding this information. The Association of Vital Registrars has already issued a position statement. Anyone who has issues which they wish Pat to raise at the committee should contact him.

FROM THE ACIP (Greg Istre, Oklahoma)

"We can expect to see the new ACIP Measles Statement appearing in print sometime in November. The key points of the statements are as follows:

1. A routine two-dose measles immunization schedule will be recommended; the statement will allow some flexibility in allowing states to choose to give the second dose either at school entry (kindergarten) or at middle school (in line with the Red Book Statement). In addition, the statement will recommend two-doses for college entry, since there have been numerous outbreaks on college campuses in the last few years.

2. Outbreak recommendations will now include making sure that exposed children in schools have received two-doses of measles vaccine to be considered immune.

3. The statement will be permissive on the issue of restriction of events during measles outbreaks (it will say that restrictions of some events may be warranted), but will not recommend these measures for routine outbreak control.

Obviously, the two-dose series will be difficult or impossible to implement without more funding. CDC plans to develop a statement with a list of priorities for measles control, until adequate funding can be obtained for the institution of all the components of the recommendation."

testing oversight.
- define endemic area on a county basis by presence of tick vectors or two or more confirmed indigenous cases.
- include only one definition on a national basis. An asterisk will be used to indicate that non-endemic areas need to have confirmatory information that they do indeed have a case (e.g., similar to that which would be required to confirm a dengue diagnosis in an area where that disease would not be expected).

Extensive discussions were held on the problems with the current laboratory tests and their lack of sensitivity a specificity for Lyme disease. There has also been major variability by lab. I presented data on our Lyme disea surveillance and on our labs proficiency testing program. Everyone felt that this data was encouraging and that t type of program should be extended on a national basis.

Thirty-three states and the District of Columbia have made Lyme disease reportable. The Council of State and Territo Epidemiologists will consider making it a national notifiable disease this coming year.

BE READY FOR NEW ACIP MEASLES STATEMENT (Greg Istre - Oklahoma)

The December 8, 1989 MMWR will have the updated ACIP recommendations for measles. The following informati was taken directly from a summary from the Division of Immunization at CDC and should be available over Dialcom you need more of the rationale:

"The major recommendations are as follows:

1. A routine two dose schedule using combined measles-mumps-rubella vaccine. The first dose will generally be given at 15 months of age. The second dose will generally be given at school entry but flexibility is provided.

2. More aggressive outbreak control in school-based outbreaks. Revaccination is recommended for all persons in affected schools who have not received two doses of live measles vaccine on or after the first birthday and who do not have other evidence of measles immunity (i.e., prior physician diagnosed measles disease or laboratory evidence of immunity). Consideration should be given to revaccinating in unaffected schools at risk of measles transmission.

3. Measles in preschool children in areas with recurrent measles transmission. Lower the age of vaccination from 15 months to 12 months in counties or areas of counties at risk of preschool transmission (e.g., a county with more than 5 cases among preschool-aged children during each of the last 5 years; a county with a recent outbreak among unvaccinated preschool-aged children; or a county with a large inner city urban population.)

4. College entrants. For persons born in or after 1957 two doses of live measles vaccine on or after the first birthday, or other evidence of measles immunity (i.e., prior physician diagnosed measles disease or laboratory evidence of immunity) should be required.

5. New hospital employees with direct patient contact. For persons born in or after 1957 two doses of live measles vaccine on or after the first birthday, or other evidence of measles immunity (i.e., prior physician diagnosed measles disease or laboratory evidence of immunity) should be required prior to employment. Since

some medical personnel who have acquired measles in medical facilities were born before 1957, requiring at least one dose of measles vaccine may be considered for older employees who are at risk of occupational exposure to measles.

6. Quarantine. Imposing quarantine measures for outbreak control is both difficult and disruptive to schools and other organizations. Under special circumstances restriction of an event might be warranted. However, this is not recommended as a routine measure for outbreak control."

In addition, the same MMWR will have a statement which discusses priorities for implementation for states which do not have adequate resources (which probably includes most of us) for implementing the full set of recommendations. It should be noted that the CDC, CSTE, and ASTHO will be working to obtain full federal funding for these recommendations, but in the meantime priorities will have to be set. The following priorities are recommended by CDC:

"Some localities may not be able to implement the two dose schedule until adequate resources can be obtained. Current federal grant funds were appropriated based on a single dose schedule. Thus, at the present time, projects cannot rely on federal support to implement the new schedule. As localities seek resources, the highest priority should be to continue the one dose schedule. This program should not be compromised. The second priority should be

The above statement of priorities does not appear in the ACIP statement itself. However, it will be published in MMWR in a report on measles surveillance in the United States during the first 26 weeks of 1989. This report should be published at approximately the same time as the ACIP statement."

1990 CSTE ANNUAL MEETING: APRIL 8-12, 1990, ALBANY, NEW YORK

Send your ideas, comments, and news items for this newsletter to Greg Istre (Oklahoma State Health Department, 1000 N. E. 10th, Oklahoma City, OK 73152.

FROM THE ADVISORY COMMITTEE ON THE ELIMINATION OF TB (Jim Hadler, Connecticut)

"The DHHS Advisory Committee for Elimination of Tuberculosis met in Atlanta on October 11-12, 1989. CSTE is represented on the ACET by Jim Hadler, Connecticut State Epidemiologist.

Pending new tuberculin skin test interpretation recommendations were discussed, as forshadowed in the CDC "How to Mantoux" Videotape. Practical and theoretical concerns raised by state epidemiologists and State TB control personnel regarding the new recommendations were the main focus of the discussion. The ACET felt that the scientific merit of the pending changes outweighs the concerns raised, and that while implementing changes will pose problems, the changes are necessary. The thrust of the recommendations will be: a. to increase the sensitivity of the tuberculin test in persons with strong risk factors for development of tuberculosis by lowering the cut point for a positive test to 5 mm induration; and b. to increase the specificity of the test for low tuberculous infection prevalence (e.g., less than 5%) population groups at risk for isoniazid hepatotoxicity (>20 yo), for whom personal risk factors for progression of tuberculous infection to disease are absent. Specificity of the test and, correspondingly, positive predictive value will be greatly improved by increasing the cut point to > 15 mm induration for such groups. CDC is developing a memorandum to states providing the main rationale for the changes.

Draft statements on screening, on preventive therapy and on control of tuberculosis in the foreign born and in nursing homes were discussed and revised. All but the statement on TB control in the foreign born are nearing completion. Anyone with an interest in seeing the current versions of these statements or in discussing the skin testing recommendations should feel free to contact either the TB Control Division at CDC or Jim Hadler."

NEW STATE EPIDEMIOLOGISTS

Congratulations to M. Geoffrey Smith and Fritz Dixon who were both recently named State Epidemiologists in New Hampshire and Idaho, respectively.

1990 CSTE MEETING - ALBANY, NEW YORK
APRIL 8-12, 1990

Don't forget next year's (1990) CSTE annual meeting to be held Monday, April 8 through Thursday, April 12 at the Sagamore Lake George, about 60 miles north of Albany, New York. Further details will be forthcoming from Dale Morse.

ERRATUM NOTED IN SEPTEMBER 1989 CSTE UPDATE

About CDC PMR-Field Assignments by John Horan last month should have read "...Due to a recent change in the procedure for selecting PMR assignments, the state-based positions selected by residents this year will NOT be available for residents to select next year.

Send ideas and reports for this newsletter to Greg Istre (Epidemiology, Oklahoma State Department of Health, 1000 N. E. 10th, Oklahoma City, OK 73152.)