



November 20, 2017

Jeffrey Engel, MD
Executive Director
Council of State and Territorial Epidemiologists
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Atlanta, Georgia 30341

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Dear Dr. ^{Jeff}Engel:

I am responding to your letter to Centers for Disease Control and Prevention (CDC) Director Dr. Brenda Fitzgerald 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 CDC's response to the CSTE position statements listed below. Each of these statements was reviewed by one or more of the following centers: the National Center for Emerging and Zoonotic Infectious Diseases; the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention; the National Center for Immunization and Respiratory Diseases; the National Center for Environmental Health/Agency for Toxic Substances and Disease Registry; the Office for State, Tribal, Local and Territorial Support; and the Center for Surveillance, Epidemiology, and Laboratory Services in the Office of Public Health Scientific Services.

Position statements

17-CC-01: "Support for Use of the CDC's Model Aquatic Health Code (MAHC) as a Resource and Guidance Document by State, Territorial, and Local Jurisdictions Regulating Public Aquatic Facilities"

17-ID-01: "Revision to the Standardized Surveillance and Case Definition for Acute Flaccid Myelitis"

17-ID-02: "Revision for the Standardized Case Definition, Case Classification, and National Surveillance for Anthrax"

17-ID-03: "Standardized Case Definition for *Candida auris* Causing Clinical Infection and Colonization in People"

17-ID-04: "Public Health Reporting and National Notification of Carbapenemase Producing Carbapenem-Resistant Enterobacteriaceae (CP-CRE) for *E. coli*, *Klebsiella* spp. and *Enterobacter* spp."

17-ID-05: "Surveillance for Perinatal HIV Exposure: Update"

17-ID-06: "Transgender HIV Surveillance"

17-ID-07: "Standardized Case Definition for Extrapulmonary Nontuberculous Mycobacteria Infections"

17-ID-08: "Public Health Reporting and National Notification of Perinatal Hepatitis C Virus Infection"

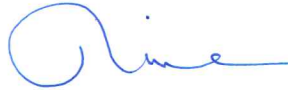
17-ID-09: "Establishing a Case Definition for Latent TB Infection (TB Infection)"

17-ID-10: "Public Health Reporting and National Notification for Shiga Toxin-Producing *Escherichia coli* (STEC)"

17-ID-11: "Update to Public Health Reporting and National Notification for Syphilis"

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, MD
Director, National Center for Emerging
and Zoonotic Infectious Diseases
Acting CDC Deputy Director for
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Acting Director, Office of Infectious
Diseases

Enclosure

cc:

Dr. Jonathan Mermin, NCHHSTP

Dr. Nancy Messonnier, NCIRD

Dr. Patrick Breysse, NCEH

Dr. José Montero, OSTLTS

Dr. Michael Iademarco, CSELS

**The Centers for Disease Control and Prevention's Comments
Regarding the
2017 Council of State and Territorial Epidemiologists (CSTE)
Position Statements**

CSTE Position Statement 17-CC-01

Title: Support for Use of the CDC's Model Aquatic Health Code (MAHC) as a Resource and Guidance Document by State, Territorial, and Local Jurisdictions Regulating Public Aquatic Facilities

Statement of the desired action(s) to be taken

1. CSTE endorses state, territorial, and/or local jurisdictions using CDC's Model Aquatic Health Code (MAHC) as a resource and guide when creating, revising, or updating state and local aquatic program regulations, guidance, and policy. The MAHC development process involved stakeholders from all sectors relevant to aquatics and was modeled on the successful development process of the FDA Model Food Code.⁸ The Council for the Model Aquatic Health Code (CMAHC)'s partnership with CDC to develop MAHC update recommendations is modeled after the Conference for Food Protection's successful partnership with FDA to recommend updates to its Model Food Code.⁹
2. CSTE supports voluntary sharing of public health and first responder/hazardous material incident data (e.g., epidemiologic; laboratory; environmental health; pool and hot tub/spa inspection; and illness and injury [including drowning, aquatic venue (e.g., pools, interactive water play venues/water playgrounds, and hot tubs/spas) chemical-associated health event, and spinal cord injury] investigation data) with CMAHC and/or CDC to support data-driven updates to the MAHC and, ultimately, optimize prevention and control of public aquatic facility-associated illness and injury.
3. CSTE supports CDC regularly updating the MAHC based on the most recent evidence and best practices.
4. CSTE supports use and analysis of public health data to develop recommended updates to the MAHC that could be submitted to the CMAHC, which collects and assesses advice from public health and aquatic sector experts and develops national MAHC update recommendations for consideration by CDC every 2 years.
5. CDC will work with the CMAHC and other interested partners to provide technical consultations to facilitate interpretation or use of the MAHC.
6. CDC will continue to monitor voluntary use of the MAHC as a resource and guide when creating, revising, or updating state and local aquatic program regulations, guidance, and policy by state, territorial, and local jurisdictions.
7. CDC will continue to conduct voluntary national surveillance of aquatic facility-associated outbreaks and aquatic venue chemical-associated health events in collaboration with state, territorial, and local public health partners.

8. CDC will continue to analyze inspection data collected through the voluntary Network for Aquatic Facility Inspection Surveillance (NAFIS) in collaboration with state, territorial, and local public health collaborators.¹⁰

* Aquatic venue means an artificially constructed structure or modified natural structure where the general public is exposed to water intended for recreational or therapeutic purpose. Such structures do not necessarily contain standing water, so water exposure may occur via contact, ingestion, or aerosolization. Examples include swimming pools, wave pools, lazy rivers, surf pools, spas (including spa pools and hot tubs), therapy pools, waterslide landing pools, spray pads, and other interactive water venues.

References

1. Hlavsa MC, Gerth TR, Collier SA, et al. Immediate Closures and Violations Identified During Routine Inspections of Public Aquatic Facilities - Network for Aquatic Facility Inspection Surveillance, Five States, 2013. MMWR Surveill Summ. 2016 May 20;65(5):1-26. Available from: <http://www.cdc.gov/mmwr/>
2. Hlavsa MC, Roberts VA, Kahler AM, et al. Outbreaks of Illness Associated with Recreational Water--United States, 2011-2012. MMWR Morb Mortal Wkly Rep. 2015 Jun 26;64(24):668-72. Available from: <http://www.cdc.gov/mmwr/>
3. Xu J. Unintentional drowning deaths in the United States, 1999-2010. NCHS Data Brief 2014;149:1-8.
4. Hlavsa MC, Robinson TJ, Collier SA, Beach MJ. Pool chemical-associated health events in public and residential settings—United States, 2003-2012, and Minnesota, 2013. MMWR Morb Mortal Wkly Rep 2014;63:427-30.
5. Kohlhammer Y, Heinrich J. Chlorine, Chlorination By-Products and their Allergic and Respiratory Health Effects. Current Respiratory Medicine Reviews 2007; 3: 39-47.
6. Council of State and Territorial Epidemiologists (CSTE). Prevention and Control of Recreational Water Illnesses. CSTE position statement 04-ID-03. Atlanta: CSTE; June 2004. Available from: <http://www.cste.org>.
7. CDC. The Model Aquatic Health Code. www.cdc.gov/MAHC
8. Council of State and Territorial Epidemiologists (CSTE). Adoption of the FDA Model Food Code by State and Local Food Regulatory Agencies. CSTE/NASPHV position statement 98-ID-15. Atlanta: CSTE; June 1998. Available from: <http://www.cste.org>.
9. CMAHC. The Council for the Model Aquatic Health Code. www.cmahc.org
10. Network for Aquatic Facility Inspection Surveillance (NAFIS). www.cdc.gov/mahc/nafis.html

CDC Comments:

CDC concurs with this position statement.

CSTE Position Statement 17-ID-01

Title: Revision to the Standardized Surveillance and Case Definition for Acute Flaccid Myelitis

Statement of the desired action(s) to be taken

1. Utilize standard sources (e.g. reporting*) for case ascertainment for acute flaccid myelitis (AFM). Surveillance for AFM should use the following recommended sources of data to the extent of coverage presented in Table III.

Table III. Recommended sources of data and extent of coverage for ascertainment of cases of Acute Flaccid Myelitis (AFM).

Source of data for case ascertainment	Coverage	
	Population-wide	Sentinel sites
Clinician reporting	X	
Laboratory reporting	X	
Reporting by other entities (e.g., hospitals, veterinarians, pharmacies, poison centers)	X	
Death certificates	X	
Hospital discharge, neurology or infectious disease consult notes, MRI reports and images, or outpatient records	X	
Extracts from electronic medical records	X	
Telephone survey		
School-based survey		
Other _____		

2. Utilize standardized criteria for case identification and classification (Sections VI and VII) for acute flaccid myelitis (AFM) but do not add AFM to the *Nationally Notifiable Condition List*. If requested by CDC, jurisdictions (e.g. States and Territories) conducting surveillance according to these methods may submit case information to CDC.

Terminology:

* Reporting: process of a healthcare provider or other entity submitting a report (case information) of a condition under public health surveillance TO local or state public health.

**Notification: process of a local or state public health authority submitting a report (case information) of a condition on the Nationally Notifiable Condition List TO CDC.

CDC Comments:

CDC concurs with this position statement. We look forward to continuing to work with our jurisdictional partners to address this important public health issue. This standardized case definition provides an opportunity to better define the spectrum of illness seen with AFM and to determine baseline rates of AFM in the United States. During review of the position statement, a few minor edits were identified as necessary for clarification, and we are working with the author to make these changes.

CSTE Position Statement 17-ID-02

Title: Revision for the Standardized Case Definition, Case Classification, and National Surveillance for Anthrax

Statement of the desired action(s) to be taken

1. Utilize standard sources (e.g. reporting*) for case ascertainment for anthrax. Surveillance for anthrax should use the following recommended sources of data to the extent of coverage presented in Table III.

Table III. Recommended sources of data and extent of coverage for ascertainment of cases of anthrax.

Source of data for case ascertainment	Coverage	
	Population-wide	Sentinel sites
Clinician reporting	x	
Laboratory reporting	x	
Reporting by other entities (e.g., hospitals, veterinarians, pharmacies, poison centers)	x	
Death certificates	x	
Hospital discharge or outpatient records	x	
Extracts from electronic medical records		
Telephone survey		
School-based survey		
Other <u>reports from other federal agencies</u>	x	

2. Utilize standardized criteria for case identification and classification (Sections VI and VII) for anthrax and add anthrax to the *Nationally Notifiable Condition List*.

2a. **Immediately notifiable, extremely urgent** (within 4 hours)—If the source of the infection is not recognized or is recognized as one of BT or potential mass exposure, or if the case or cases involve serious illness of naturally-occurring anthrax, such as with systemic involvement where medical countermeasures available through CDC may be requested for therapy.

2b. **Immediately notifiable, urgent** (within 24 hours)—If the source of infection can be attributed to a naturally-occurring or occupational exposure and the case or cases are responding to current medical management, CDC requests **immediate (urgent)** notification for confirmed and probable cases.

CSTE recommends that all States and Territories enact laws (statute or rule/regulation as appropriate) to make this disease or condition reportable in their jurisdiction. Jurisdictions (e.g. States and Territories) conducting surveillance (according to these methods) should submit case notifications** to CDC.

Due to the rarity of anthrax, it is currently not prioritized for development of a Message Mapping Guide; outside of an anthrax mass casualty event, case notification will place a minimal burden on reporting jurisdictions.

3. CDC should publish data on anthrax as appropriate in *MMWR* and other venues (see Section IX).

CSTE recommends that all jurisdictions (e.g. States or Territories) with legal authority to conduct public health surveillance follow the recommended methods as outlined above.

4. CSTE recommends that all jurisdictions, states and territories send isolates from incident infections to CDC for whole genome sequencing and other advanced molecular diagnostics, which assists with the epidemiologic investigation. In cases associated with a natural or intentional outbreak or cluster, CDC will work with state and local health officials to determine the number of isolates needed for characterization.

Terminology:

* Reporting: process of a healthcare provider or other entity submitting a report (case information) of a condition under public health surveillance TO local or state public health.

**Notification: process of a local or state public health authority submitting a report (case information) of a condition on the Nationally Notifiable Condition List TO CDC.

CDC Comments:

CDC concurs with this position statement and notes that while anthrax has not been prioritized for disease-specific message mapping guide (MMG) development at this time, anthrax cases can be reported as Generic v2 HL7 case notifications and through legacy reporting mechanisms.

CSTE Position Statement 17-ID-03

Title: Standardized Case Definition for *Candida auris* Causing Clinical Infection and Colonization in People

Statement of the desired action(s) to be taken

1. Utilize standard sources (e.g. reporting*) for case ascertainment for *Candida auris*. Surveillance for *Candida auris* should use the following recommended sources of data to the extent of coverage presented in Table III.

Table III. Recommended sources of data and extent of coverage for ascertainment of cases of *Candida auris*.

Source of data for case ascertainment	Coverage	
	Population-wide	Sentinel sites
Clinician reporting	X	X
Laboratory reporting	X	X
Reporting by other entities (e.g., hospitals, veterinarians, pharmacies, poison centers)	X	X
Death certificates	X	X
Hospital discharge or outpatient records	X	X
Extracts from electronic medical records	X	X
Telephone survey		
School-based survey		
Other _____		

2. Utilize standardized criteria for case identification and classification (Sections VI and VII) for *Candida auris* but do not add *C. auris* to the *Nationally Notifiable Condition List*. If requested by CDC,

jurisdictions (e.g. States and Territories) conducting surveillance according to these methods may submit case information to CDC.

CDC Comments:

CDC recommends expanding the clinical specimen source row in the Laboratory Evidence section of Table VII-B: Criteria for defining a case of *Candida auris*, on page 5. Currently the specimen sources listed are: normally sterile site (e.g., blood, CSF), respiratory tract, or urine. CDC recommends revising this to include additional samples collected for clinical purposes: normally sterile site (e.g., blood, CSF), respiratory tract, urine, or other sample collected for clinical purposes (e.g., wounds).

CSTE Position Statement 17-ID-04

Title: Public Health Reporting and National Notification of Carbapenemase Producing Carbapenem-Resistant Enterobacteriaceae (CP-CRE) for *E. coli*, *Klebsiella* spp. and *Enterobacter* spp.

Statement of the desired action(s) to be taken

1. Utilize standard sources (e.g. reporting*) for case ascertainment for CP-CRE. Surveillance for CP-CRE should use the following recommended sources of data to the extent of coverage presented in Table III.

Table III. Recommended sources of data and extent of coverage for ascertainment of cases of CP-CRE.

Source of data for case ascertainment	Coverage	
	Population-wide	Sentinel sites
Clinician reporting	X	
Laboratory reporting	X	
Reporting by other entities (e.g., hospitals, veterinarians, pharmacies, poison centers)	X	
Death certificates		
Hospital discharge or outpatient records		
Extracts from electronic medical records	X	
Telephone survey		
School-based survey		
Other		

2. Utilize standardized criteria for case identification and classification (Sections VI and VII) for CP-CRE and add CP-CRE to the *Nationally Notifiable Condition List*.

- ☐ 2a. Immediately notifiable, extremely urgent (within 4 hours)
- ☐ 2b. Immediately notifiable, urgent (within 24 hours)
- ☒ 2c. Routinely notifiable

CSTE recommends that all States and Territories enact laws (statute or rule/regulation as appropriate) to make this disease or condition reportable in their jurisdiction. Jurisdictions (e.g.

States and Territories) conducting surveillance (according to these methods) should submit case notifications** to CDC.

Expectations for Message Mapping Guide (MMG) development for a newly notifiable condition: NNDSS is transitioning to HL7-based messages for case notifications; the specifications for these messages are presented in MMGs. When CSTE recommends that a new condition be made nationally notifiable, CDC must obtain OMB PRA approval prior to accepting case notifications for the new condition. Under anticipated timelines, notification using the Generic V2 MMG would support transmission of the basic demographic and epidemiologic information common to all cases and could begin with the new *MMWR* year following the CSTE annual conference. Input from CDC programs and CSTE would prioritize development of a disease-specific MMG for the new condition among other conditions waiting for MMGs.

3. CDC should publish data on CP-CRE as appropriate in *MMWR* and other venues (see Section IX).

CSTE recommends that all jurisdictions (e.g. States or Territories) with legal authority to conduct public health surveillance follow the recommended methods as outlined above.

Terminology:

* Reporting: process of a healthcare provider or other entity submitting a report (case information) of a condition under public health surveillance TO local or state public health.

**Notification: process of a local or state public health authority submitting a report (case information) of a condition on the Nationally Notifiable Condition List TO CDC.

4. Jurisdictions should stratify reports of cases of CP-CRE using the methods outlined in Section VII.
5. CSTE recommends that health departments and public health laboratories should work with clinical laboratories to collaborate for the identification and timely reporting of CP-CRE to infection control and public health authorities to ensure timely communication and intervention. Interfacility communication should be strongly encouraged (also see CSTE position statement 16-ID-09: Interfacility Communication to prevent and control healthcare-associated infections and antimicrobial resistant pathogens across healthcare settings (10)).
6. CSTE recommends that a working group be established that includes CSTE and CDC members to develop a message mapping guide.

CDC Comments:

CDC concurs with this position statement and notes that a CSTE/CDC CP-CRE working group is in the process of developing a list of data elements so that an MMG for this high-priority condition can be developed.

CSTE Position Statement 17-ID-05

Title: Surveillance for Perinatal HIV Exposure: Update

Statement of the desired action(s) to be taken

1. CSTE recommends that CDC should provide the technical guidance and resources needed to ensure that all jurisdictions can conduct perinatal HIV exposure surveillance (PHES) as part of NHSS activities, regardless of disease burden.
2. CSTE recommends that CDC support and report on minimum standards for PHES within NHSS, including: determining frequencies and rates of perinatal HIV exposure and transmission, reporting complete HIV laboratory results on infants and children, developing criteria for presumptive negative status for exposed infants whose status remains indeterminate five years after birth, reporting perinatal HIV exposure data to CDC, and using perinatal HIV exposure reporting in Data to Care activities. Completion of recommendations must be feasible in the context of jurisdictional laws and regulations as well as available and anticipated resources.
3. CSTE recommends that:
 - a. in jurisdictions where matching HIV surveillance data to vital statistics birth records is permissible by law, CDC provide technical guidance and support (through development of SAS programs, best practices, inclusion on annual progress reports, etc.) to ensure annual matching of HIV/AIDS surveillance data to vital statistics birth records are conducted so that infant HIV exposure status can be identified (without follow-back to mother). This matching would enable jurisdictions to assess the completeness of their perinatal HIV exposure reporting and provide a lower bound estimate of the number of perinatal HIV exposures in the US. CDC should work with the National Association for Public Health Statistics and Information Systems (NAPHSIS) to develop and disseminate model data sharing agreements between HIV surveillance programs and vital statistics programs.
 - b. in jurisdictions where matching to vital statistics birth records is not permissible by law, CDC provide technical guidance and support for assessing the completeness of perinatal HIV exposure reporting and identifying and developing other tools for calculating lower bound estimates of the number of perinatal HIV exposures.
4. CSTE recommends CDC provide technical support and guidance to jurisdictions for conducting PHES to support the identification of pregnancy in HIV-infected women and HIV-exposed infants through reporting mechanisms that involve laboratories, health care providers, and/or active data collection.
5. CSTE recommends CDC receive PHES data from jurisdictions collecting PHES data. PHES data include the information collected on the Perinatal HIV Exposure Reporting (PHER) form used in NHSS.⁷ CDC should provide appropriate resources, training, and guidance to jurisdictions to ensure data collection and transfer is feasible.

6. CSTE recommends that CDC establish and distribute standardized technical guidance for conducting Data to Care activities in pregnant and postpartum women, which include and prioritize pregnant or postpartum women and mother-infant pairs who are identified through perinatal exposure reporting. Data to Care activities could be used to identify:

- a. HIV-infected pregnant women who have fallen out of care,
- b. Infants whose HIV status remains indeterminate, and
- c. Postpartum women who have fallen out of care

In all cases, PHES data could be used to locate individuals, and link them to appropriate services.

CDC Comments:

CDC concurs with this position statement.

CSTE Position Statement 17-ID-06

Title: Transgender HIV Surveillance

Statement of the desired action(s) to be taken

1. CSTE recommends that a workgroup of CDC and jurisdictional HIV surveillance experts and consultant experts in transgender and non-binary health issues be convened by the CDC and CSTE to review available data on HIV risk factors in transgender and non-binary identified populations, and develop a set of actionable recommendations to make HIV case surveillance and reporting more inclusive of transgender and non-binary persons at both the jurisdictional and national level.
2. CSTE recommends that CDC review, update, and disseminate the existing CDC guidance to jurisdictions about collection of transgender data in HIV surveillance. Appropriate training and resources should be made available to jurisdictions to make this data collection feasible.
3. CSTE recommends that, in order to more accurately reflect gender identities and transmission risk categories, CDC should report transgender status in addition to sex at birth, and update the NHSS algorithm used to calculate HIV-related risk factors and HIV transmission category to include gender identity in the hierarchy of HIV-related risk factors.
4. CSTE recommends that CDC publish data on HIV infections among transgender and non-binary persons as appropriate in MMWR and other venues and, at minimum, in yearly surveillance reports.
5. CSTE recommends that jurisdictions, where resources are available, reinvestigate all living HIV cases identified as transgender or are potentially transgender, if this has not already been done. The purposes of reinvestigation are to confirm sex at birth and current gender identity, identify additional name(s), and check the accuracy of existing risk factor information. CSTE also recommends that CDC (re)state its encouragement to jurisdictions to carefully ascertain transgender persons at first report, and develop a standardized, routine quality assurance check (such as CDC developed SAS programs) to ensure continued high quality data collection for transgender and non-binary HIV cases.

6. CSTE recommends that CDC and jurisdictions, where resources and sufficient data are available, include transgender and non-binary data analysis in their Epidemiological Profiles and/or annual HIV surveillance reports.

7. CSTE recommends that CDC appropriate resources to the National HIV Behavioral Surveillance (NHBS) system and the Medical Monitoring Project (MMP) for transgender- and non-binary-specific data collection and analysis to better understand the HIV prevention and care needs of these populations. NHBS and MMP data collection of transgender and non-binary populations should be inclusive of all transgender and non-binary individuals, and not only those who were assigned male sex at birth. CDC should also review current procedures for screening during the MSM cycle, as current procedures accidentally screen in some transgender individuals.

CDC Comments:

CDC concurs that data collection on non-binary populations should be inclusive of all transgender and non-binary individuals where appropriate. Currently, in both the Medical Monitoring Project (MMP) and National HIV Behavioral Surveillance among Men who have Sex with Men (NHBS-MSM) gender is assessed.

CDC is open to expanding response options to include non-binary gender options and to stratifying data beyond the current three gender categories in the MMP and NHBS-IDU cycles as the data allow. The U.S. Office of Management and Budget/Office of Information and Regulatory Affairs approves the response options available for questions about gender identity in federal information collection requests.

In addition to current CDC surveillance activities related to transgender persons, CDC will begin implementation of a transgender-specific cycle of NHBS in 2018 (NHBS-Trans). Due to the need for data on transgender persons and the increased risk of HIV infection for transgender women, CDC will use NHBS methods in 7 cities currently funded for core NHBS activities to also interview and offer HIV testing to 200 transwomen in each city for a total of 1,400 participants. A specialized questionnaire has been developed through consultation with a community advisory board consisting of community members and researchers in the field.

CDC recognizes that limiting eligibility for NHBS-Trans to transgender persons identifying as women or transwomen excludes persons who do not identify as one of these two genders (e.g., non-binary, gender queer). To address this limitation, the gender question is “check all that apply.” This strategy was adopted as a compromise by which participants who are not exclusively women or transwomen can be eligible (e.g., a person who identifies as a “woman” and “gender queer”).

CDC agrees that collection of data on all transgender and non-binary populations should be inclusive of all persons, not only those assigned male sex at birth where feasible. Within MMP, due to sampling from the National HIV Surveillance System among persons diagnosed with HIV, the numbers of such persons included is very small and meaningful analyses cannot be conducted without combining data from several cycles. Within NHBS, in order to accommodate a broad array of potential risk behaviors, the interview would become extremely long. For these reasons, CDC believes that data collection in these populations would be accomplished best using special surveillance studies or other publicly

available data sets. Limited data on these populations are available in the Behavioral Risk Factor Surveillance System (BRFSS).

CSTE Position Statement 17-ID-07

Title: Standardized Case Definition for Extrapulmonary Nontuberculous Mycobacteria Infections

Statement of the desired action(s) to be taken

1. Utilize standard sources (e.g. reporting*) for case ascertainment for extrapulmonary nontuberculous mycobacteria (NTM). Surveillance for extrapulmonary NTM should use the following recommended sources of data to the extent of coverage presented in Table III.

Table III. Recommended sources of data and extent of coverage for ascertainment of cases of extrapulmonary nontuberculous mycobacteria.

Source of data for case ascertainment	Coverage	
	Population-wide	Sentinel sites
Clinician reporting	X	X
Laboratory reporting	X	X
Reporting by other entities (e.g., hospitals, veterinarians, pharmacies, poison centers)	X	X
Death certificates	X	X
Hospital discharge or outpatient records	X	X
Extracts from electronic medical records	X	X
Telephone survey		
School-based survey		
Other		

2. Utilize standardized criteria for case identification and classification (Sections VI and VII) for extrapulmonary NTM but do not add extrapulmonary NTM to the *Nationally Notifiable Condition List*. If requested by CDC, jurisdictions (e.g. States and Territories) conducting surveillance according to these methods may submit case information to CDC.

Terminology:

* Reporting: process of a healthcare provider or other entity submitting a report (case information) of a condition under public health surveillance TO local or state public health.

**Notification: process of a local or state public health authority submitting a report (case information) of a condition on the Nationally Notifiable Condition List TO CDC.

CDC Comments:

Extrapulmonary NTM (xNTM) infections appear to be increasing and are often associated with severe disease, treatment challenges, and poor outcomes. CDC encourages health departments to strongly consider making xNTM reportable in their respective jurisdictions. Jurisdictions that adopt the new CSTE standardized case definition will be better positioned to monitor the incidence of xNTM and identify, investigate, and control outbreaks.

Currently, less than 15 states have NTM reportable, and among those, only two have specifically made xNTM reportable. As part of CDC's efforts to raise awareness of the need for enhanced xNTM surveillance, DHQP hosted a 50-states webinar on September 25, 2017. The webinar promoted uptake of the newly approved CSTE standardized case definition and included descriptions of recent xNTM outbreaks related to medical care. Representatives from Oregon and Tennessee shared their experiences in the implementation of making xNTM infections reportable and described outbreaks that were detected because of their surveillance.

Additionally, CDC's Division of Healthcare Quality Promotion (DHQP) has also promoted the CSTE standardized case definition on CSTE healthcare-associated infections (HAI) subcommittee calls and has worked with states to answer questions and concerns. DHQP looks forward to continuing to promote adoption of the standardized xNTM case definition and working with states to help assess prevention needs and coordinate the investigation of potential multistate outbreaks of xNTM.

In regards to the position statement language, CDC notes that *Mycobacterium gordonae* cultures are excluded from the case definition; however, as noted in the statement, this organism does have the ability to cause nonpathogenic extrapulmonary disease. Given similarly opportunistic NTMs are not specifically excluded in the document, CDC recommends including *M. gordonae* in the case definition as it would contribute more to understanding the epidemiology of NTMs.

CSTE Position Statement 17-ID-08

Title: Public Health Reporting and National Notification of Perinatal Hepatitis C Virus Infection

Statement of the desired action(s) to be taken

1. Utilize standard sources (e.g. reporting*) for case ascertainment for perinatal HCV infection. Surveillance for perinatal hepatitis C virus should use the following recommended sources of data to the extent of coverage presented in Table III.

Table III. Recommended sources of data and extent of coverage for ascertainment of cases of perinatal HCV.

Source of data for case ascertainment	Coverage	
	Population-wide	Sentinel sites
Clinician reporting	X	
Laboratory reporting	X	
Reporting by other entities (e.g., hospitals, veterinarians, pharmacies, poison centers)	X	
Death certificates		
Hospital discharge or outpatient records	X	
Extracts from electronic medical records	X	
Telephone survey		
School-based survey		
Other _____		

2. Utilize standardized criteria for case identification and classification (Sections VI and VII) for perinatal HCV infection and add perinatal HCV infection to the *Nationally Notifiable Condition List*.

- ☐ 2a. Immediately notifiable, extremely urgent (within 4 hours)
- ☐ 2b. Immediately notifiable, urgent (within 24 hours)
- ☒ 2c. Routinely notifiable

CSTE recommends that all States and Territories enact laws (statute or rule/regulation as appropriate) to make this disease or condition reportable in their jurisdiction. Jurisdictions (e.g. States and Territories) conducting surveillance (according to these methods) should submit case notifications** to CDC.

Expectations for Message Mapping Guide (MMG) development for a newly notifiable condition: NNDSS is transitioning to HL7-based messages for case notifications; the specifications for these messages are presented in MMGs. When CSTE recommends that a new condition be made nationally notifiable, CDC must obtain OMB PRA approval prior to accepting case notifications for the new condition. Under anticipated timelines, notification using the Generic V2 MMG would support transmission of the basic demographic and epidemiologic information common to all cases and could begin with the new *MMWR* year following the CSTE annual conference. Input from CDC programs and CSTE would prioritize development of a disease-specific MMG for the new condition among other conditions waiting for MMGs.

3. CDC should publish data on perinatal HCV infection as appropriate in *MMWR* and other venues (see Section IX).

CSTE recommends that all jurisdictions (e.g. States or Territories) with legal authority to conduct public health surveillance follow the recommended methods as outlined above

Terminology:

* Reporting: process of a healthcare provider or other entity submitting a report (case information) of a condition under public health surveillance TO local or state public health.

**Notification: process of a local or state public health authority submitting a report (case information) of a condition on the Nationally Notifiable Condition List TO CDC.

CDC Comments:

CDC recommends the following edits to this position statement:

- Add another “Goal of Surveillance”: Identify women so that they can be treated after pregnancy and before a subsequent pregnancy, thereby eliminating the risk for transmission to future pregnancies.
- Under Background and Justification, 1st paragraph, it says that perinatal HCV may be transmitted during childbirth, but it may also be transmitted in utero. Please edit the paragraph to add that perinatal HCV may be transmitted in utero.
- Also under Background and Justification, 1st paragraph, it says there are no measures to prevent perinatal HCV transmission. However, there are some (non-pharmacological) measures recommended: avoid internal fetal monitoring, avoid prolonged rupture of the membranes, avoid episiotomy. The paragraph should be edited to indicate there are recommended non-pharmacological measures.

- Table VI-B: Column headings appear to be missing.
- Throughout document: Be consistent about the 36-month cut-off (is it less than or equal to 36 months and then greater than 36 months for non-perinatal; sometimes 36 months fell under the perinatal definition and sometimes not with the way the equal sign was).
- The case definition for perinatal HCV does not include an option for reporting based on antibody testing alone, which will result in the omissions of cases with only this testing.

Relevant Activities: CDC has specified the reporting of perinatal HCV in 2017 surveillance funding for 14 states.

Note: CDC's Center for Surveillance, Epidemiology, and Laboratory Services (CSELS) is in the process of updating the finalized Hepatitis MMG to address changes needed for perinatal hepatitis C.

CSTE Position Statement 17-ID-09

Title: Establishing a Case Definition for Latent TB Infection (TB Infection)

Statement of the desired action(s) to be taken

1. Utilize standard sources (e.g. reporting*) for case ascertainment for Latent Tuberculosis Infection (TB Infection). Surveillance for TB Infection should use the following recommended sources of data to the extent of coverage presented in Table III.

Table III. Recommended sources of data and extent of coverage for ascertainment of cases of TB Infection.

Source of data for case ascertainment	Coverage	
	Population-wide	Sentinel sites
Clinician reporting	X	
Laboratory reporting	X	
Reporting by other entities (e.g., hospitals, veterinarians, pharmacies, poison centers)	X	
Death certificates		
Hospital discharge or outpatient records	X	
Extracts from electronic medical records	X	
Telephone survey		
School-based survey		
Other		

2. Utilize standardized criteria for case identification and classification (Sections VI and VII) for TB Infection but do not add TB Infection to the *Nationally Notifiable Condition List*. If requested by CDC, jurisdictions (e.g. States and Territories) conducting surveillance according to these methods may submit case information to CDC.

CDC Comments:

CDC supports the goal of establishing a standardized surveillance case definition for latent tuberculosis infection (LTBI) as a first step toward uniform surveillance for this condition in the United States. In cooperation with the National Tuberculosis Controllers' Association and the Society for Epidemiology in Tuberculosis Control, CDC has been developing a data collection instrument to serve as the basis for uniform national surveillance for this condition. Once the data collection instrument is agreed upon, next steps include developing data transmission strategies and evaluating potential sampling methodologies. Current resource constraints do not support conducting LTBI surveillance nationwide in the same model as for tuberculosis disease cases, so CDC and its partners are considering alternative models such as sentinel surveillance in selected sites.

CDC's TB elimination strategy is to test and treat reservoir of LTBI among high-risk populations with effective new regimens but not at the expense of addressing transmission of active TB.

Health departments' first priority is to find and treat active cases of TB disease then to identify the contacts to these active cases and treat them. However, 86% of active TB cases reported annually arise from reactivation of LTBI, rather than recent transmission of the disease. The plurality of these cases were infected 10 or more years ago. We must find and treat many more persons with LTBI than those we are finding through the routine public health effort of contact investigation.

New treatments for LTBI with shorter completion times could allow for increased treatment rates, which could help reduce TB burden. Targeted testing and treatment of LTBI will be necessary given the large numbers of infected individuals (estimated to be up to 13 million).

CSTE Position Statement 17-ID-10

Title: Public Health Reporting and National Notification for Shiga Toxin-Producing *Escherichia coli* (STEC)

Statement of the desired action(s) to be taken

1. Utilize standard sources (e.g. reporting*) for case ascertainment for STEC. Surveillance for STEC should use the following recommended sources of data to the extent of coverage presented in Table III.

Table III. Recommended sources of data and extent of coverage for ascertainment of cases of STEC.

Source of data for case ascertainment	Coverage	
	Population-wide	Sentinel sites
Clinician reporting	X	
Laboratory reporting	X	
Reporting by other entities (e.g., hospitals, veterinarians, pharmacies, poison centers)	X	
Death certificates	X	
Hospital discharge or outpatient records	X	
Extracts from electronic medical records	X	
Telephone survey		
School-based survey		
Other _____		

2. Utilize standardized criteria for case identification and classification (Sections VI and VII) for STEC and add STEC to the *Nationally Notifiable Condition List*.

- ☐ 3a. Immediately notifiable, extremely urgent (within 4 hours)
- ☐ 3b. Immediately notifiable, urgent (within 24 hours)
- ☒ 3c. Routinely notifiable

CSTE recommends that all States and Territories enact laws (statue or rule/regulation as appropriate) to make this disease or condition reportable in their jurisdiction. Jurisdictions (e.g. States and Territories) conducting surveillance (according to these methods) should submit case notifications** to CDC.

CSTE recommends that CDC collaborates with CSTE to incorporate the necessary data elements into a Message Mapping Guide (MMG) for this disease/condition to allow states to transmit disease-specific data elements to CDC through states' routine NNDSS data transmission mechanisms. CSTE recommends that the CDC enteric program office continue to work with the CDC NNDSS program office to ensure data delivery from NNDSS to the enterics program. CSTE requests that CDC finalize the MMG for this disease/condition and be prepared to receive data sent via that MMG within one year following the approval of this position statement. Prior to implementation of the MMG for this disease/condition, notification to CDC should occur using the Generic V2 MMG which will support transmission of the basic demographic and epidemiologic information common to all cases.

3. CDC should publish data on STEC as appropriate in *MMWR* and other venues (see Section IX).

CSTE recommends that all jurisdictions (e.g., States or Territories) with legal authority to conduct public health surveillance follow the recommended methods as outlined above.

Terminology:

* Reporting: process of a healthcare provider or other entity submitting a report (case information) of a condition under public health surveillance TO local or state public health.

**Notification: process of a local or state public health authority submitting a report (case information) of a condition on the Nationally Notifiable Condition List TO CDC.

4. State health departments should create a variable to distinguish laboratory-diagnosed probable cases from probable cases that are based on an epidemiologic linkage. This differentiation of probable cases will facilitate assessment of the impact of CIDT on surveillance.

5. CDC should include a variable to distinguish laboratory-diagnosed probable cases from probable cases that are based on an epidemiologic linkage in the disease-specific MMG, to assess the impact of CIDT on surveillance.

6. State health departments should attempt to capture the type(s) of testing performed for reported STEC cases. This could include surveys of laboratory testing practices, capture of LOINC and SNOMED codes from electronic laboratory reporting, or other methods.

7. When available, STEC serotype characterization should be reported.

CDC Comments:

CDC concurs with this position statement and notes that data elements for STEC are included in the Foodborne and Diarrheal Diseases MMG, which is under development.

CSTE Position Statement 17-ID-11

Title: Update to Public Health Reporting and National Notification for Syphilis

Statement of the desired action(s) to be taken

1. Utilize standard sources (e.g. reporting*) for case ascertainment for syphilis. Surveillance for syphilis should use the following recommended sources of data to the extent of coverage presented in Table III.

Table III. Recommended sources of data and extent of coverage for ascertainment of cases of syphilis.

Source of data for case ascertainment	Coverage	
	Population-wide	Sentinel sites
Clinician reporting	x	
Laboratory reporting	x	
Reporting by other entities (e.g., hospitals, veterinarians, pharmacies, poison centers)	x	X (STD Clinics)
Death certificates	x	
Hospital discharge or outpatient records	x	
Extracts from electronic medical records	x	
Telephone survey		
School-based survey		
Other		

2016 Template

2. Utilize standardized criteria for case identification and classification (Sections VI and VII) for syphilis and add syphilis to the *Nationally Notifiable Condition List*.

- ☐ 2a. Immediately notifiable, extremely urgent (within 4 hours)
- ☐ 2b. Immediately notifiable, urgent (within 24 hours)
- ☒ 2c. Routinely notifiable

CSTE recommends that all States and Territories enact laws (statute or rule/regulation as appropriate) to make this disease or condition reportable in their jurisdiction. Jurisdictions (e.g. States and Territories) conducting surveillance (according to these methods) should submit case notifications** to CDC.

Expectations for Message Mapping Guide (MMG) development for a newly notifiable condition: NNDSS is transitioning to HL7-based messages for case notifications; the specifications for these messages are presented in MMGs. When CSTE recommends that a new condition be made nationally notifiable, CDC must obtain OMB PRA approval prior to accepting case notifications for the new condition. Under anticipated timelines, notification using the Generic V2 MMG would support transmission of the basic demographic and epidemiologic information common to all cases and could begin with the new *MMWR* year following the CSTE annual conference. Input from CDC programs and CSTE would prioritize development of a disease-specific MMG for the new condition among other conditions waiting for MMGs.

3. CDC should publish data on syphilis as appropriate in *MMWR* and other venues (see Section IX).

CSTE recommends that all jurisdictions (e.g. States or Territories) with legal authority to conduct public health surveillance follow the recommended methods as outlined above.

Terminology:

* Reporting: process of a healthcare provider or other entity submitting a report (case information) of a condition under public health surveillance TO local or state public health.

**Notification: process of a local or state public health authority submitting a report (case information) of a condition on the Nationally Notifiable Condition List TO CDC.

CSTE requests that CDC adopt this revised, standardized reporting definition for syphilis, including the following changes:

1. Add data elements and guidance related to clinical manifestations of syphilis (i.e., ocular manifestation, otic manifestations, and late clinical manifestations) and their classification
2. Revise the nomenclature for some of the clinical stages of syphilis
3. Clarify language used in previous version of the case definitions

CDC Comments:

CDC concurs with this position statement and notes that CSELS is in the process of updating the STD MMG with data element and value set changes needed for syphilis.

