

# Statement for the Record

submitted by

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on behalf of

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for

**U.S. House of Representatives**

**Committee on Veterans' Affairs**

**Subcommittee on Oversight and Investigations**

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Mr. Chairman and Members of the Subcommittee—

The Council of State and Territorial Epidemiologists (CSTE) welcomes the opportunity to provide the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations this written statement for the record on legislation to enhance infectious disease reporting by the U.S. Department of Veterans Affairs (VA) including, H.R. 1490, H.R. 1792, and H.R. 1804. CSTE represents more than 1,100 members comprised of the epidemiology and surveillance workforce in federal, state, and local health departments. We work on the front lines of public health, investigating and controlling communicable diseases nationwide.<sup>1</sup>

A critical step in the ability to respond appropriately to outbreaks and other threats is the prompt notification of public health authorities on diseases posing a potential risk to our communities. Virtually all health care providers, in all states, are required to report communicable diseases to their local health authorities for additional investigation. Unfortunately, VA health care facilities are exceptions to this rule, which has led to some substantial problems that may have been averted were this not the case. The legislation introduced to hold VA health care facilities to the same standards as other health care providers will help address this problem, and CSTE heartily supports these efforts.

### **Disease Surveillance Rooted in Effective Federalism<sup>2</sup>**

The long-standing history of infectious disease reporting in the United States serves as an example of effective federalism that has been refined over 135 years. Beginning in 1878, Congress authorized the U.S. Marine Hospital Service (forerunner of the Public Health Service or PHS) to collect reports from U.S. consuls overseas about local occurrences of diseases such as cholera, smallpox, plague, and yellow fever. This information was used to institute quarantine measures to prevent introducing or spreading these diseases in the United States. In 1879, Congress funded the collection and publishing of reports of these notifiable diseases and in 1893 expanded the authority for weekly reporting and publishing of these cases to include data from states and municipal authorities.

To improve the uniformity of the data, Congress in 1902 directed the Surgeon General to provide specific forms to be used for collecting and compiling these data and for publishing reports at the national level. In 1903, the PHS convened the first annual conference of state and territorial health officers to begin implementation of the congressional act, thus marking the dawn of national surveillance for communicable, infectious diseases of public health

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<sup>1</sup> Epidemiologists are best known for detecting, monitoring, controlling, and preventing infectious disease outbreaks. Perhaps less known, but equally important, is epidemiologists' work to monitor chronic disease, injuries, and environmental health threats; identify factors that put individuals at greater health risk; implement prevention strategies; and prepare for and respond to natural disasters.

<sup>2</sup> "A Brief History of the National Notifiable Disease Surveillance System," Centers for Disease Control and Prevention. Available at <http://wwwn.cdc.gov/nndss/script/history.aspx>, accessed May 30, 2013.

importance. By 1928, all states, the District of Columbia, Hawaii, and Puerto Rico were participants in the national reporting of 29 specified diseases.

In 1950, a new federal agency, then named the Centers for Disease Control (now the Centers for Disease Control and Prevention or CDC), recognized the importance of state input in reporting communicable diseases, and asked the Association of State and Territorial Health Officials (ASTHO)—the national nonprofit organization representing U.S. public health agencies and their employees—to convene state epidemiologists and charge them with the responsibility of deciding which diseases should be reported nationally. A conference of state and territorial epidemiologists generated a fully documented list of nationally notifiable diseases. Ten years later, CDC assumed responsibility for collecting data on these nationally notifiable diseases and began publishing the *Morbidity and Mortality Weekly Report (MMWR)* with data reported by state health departments.<sup>3</sup>

Today, these data are the foundation of the National Notifiable Diseases Surveillance System (NNDSS), a multifaceted public health disease surveillance system that gives public health officials powerful capabilities to monitor the occurrence and spread of diseases. Fifty-seven jurisdictions contribute to the NNDSS: the 50 states, New York City, the District of Columbia, and 5 territories including Guam, Commonwealth of Northern Mariana Islands, American Samoa, U.S. Virgin Islands and Puerto Rico. As the voice of these state, territorial, and local epidemiologists, CSTE maintains responsibility for defining and recommending which diseases and conditions are reportable within states and localities, and which of these diseases and conditions will be voluntarily reported to CDC. In collaboration with CDC, CSTE works to determine changes to the list of nationally notifiable conditions and to enhance processes and procedures of the NNDSS.

### **Disease Reporting Governed by State, Local Laws and Rules**

Effective public health surveillance begins with the local- and state-health departments. Mandatory disease reporting of individual patients and corresponding health records with personal identifying information is thus governed by state and local laws and rules, which vary by jurisdiction. These data provide the direction and scope of many state and local health department activities, from detecting individual cases and controlling outbreaks to implementing prevention and intervention activities. Because of the Health Information Portability and Accountability Act (HIPAA) exemptions for public health reporting, health department staff is able to identify persons affected by the diseases of concern to investigate and institute control measures to prevent further spread of disease. State health departments

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<sup>3</sup> Based on weekly reports to CDC by state health departments, the *MMWR* series is CDC's primary vehicle for scientific publication of timely, reliable, authoritative, accurate, objective, and useful public health information and recommendations. *MMWR* readership predominantly consists of physicians, nurses, public health practitioners, epidemiologists and other scientists, researchers, educators, and laboratorians.

support national public health surveillance by voluntarily sharing their notifiable disease reports using *de-identified* data with CDC.

### *Health Care Providers Are Critical Partners in Surveillance*

State and local public health departments are reliant on their partners in the health care community—those who interact directly with patients—to obtain case reports on many infectious and non-infectious diseases. While public health reporting laws and rules differ by locale, they are similar in that these health care providers—including physicians, laboratories, and other providers of care—are required to report legally notifiable diseases to their jurisdiction's public health authorities when they reasonably suspect a patient of having a disease or condition of concern. Once reported, assigning residence (by state, county, etc.), de-duplicating reports, and other reconciliations are responsibilities of the public health agency.

Health care facilities, including acute care hospitals, long-term care facilities, and outpatient facilities generally also fall under mandated reporting requirements. In practice, physicians often assume that the acute care hospital infection control staff will initiate a report to the public health agency on a patient for whom the physician is caring. Notably, for health care facility reporting mandates, a specific individual responsible for reporting is not named in the law or rule, but rather it is expected that the *facility shall report*. Other individuals or entities may also be mandated to report events of potential public health concern. For example, in many places school principals or restaurant owners must report when outbreaks occur that may be associated with their establishments (e.g. influenza-like illness, foodborne disease).

Failure of an individual or entity to report is frequently a crime and potentially punishable as a misdemeanor offense with imprisonment, de-licensing, or fines. In practice, however, criminal penalties are exceedingly rarely used; compliance is encouraged by continuing education and public health relationships with health care providers.

### *Public Health Agencies Collect, Investigate Disease Reports*

The public health agency to which disease reports are sent depends on the jurisdiction, but is generally the state or local health department where the disease is diagnosed. In most cases, medical providers and health care facilities report directly to the local or county health department where they are located, or in the absence of local health departments, directly to the state. Large, multistate laboratories usually send electronic lab reports to the state health department where the patient or ordering facility is located. All states have mechanisms to share reports with other jurisdictions as appropriate, depending on where a disease was contracted or treated, and where and how measures to investigate and control them must be implemented.

Generally, state and local health departments are responsible for investigating these communicable diseases reports, and responding appropriately. Depending on the situation,

such responsibilities may involve compiling of data for routine reporting, or investigating outbreaks or emergent events which require an immediate and vigorous response to protect the public's health. Rapid access to information is critical to accurately and promptly investigating such reports.

### **Consistent and Complete Disease Reporting Necessary to Protect Public Health**

State and local laws and rules require reporting of a list of diseases and conditions designated as notifiable by CSTE and CDC. Jurisdictions may make minor changes to the list of reportable diseases to fit local or regional needs, such as the addition of "Valley Fever," which is caused by a fungus (*Coccidioidomycosis*) that is endemic only to the Southwest region of the United States.

The goal of public health reporting is to detect, investigate and prevent diseases and conditions that pose a potential threat to others in the local, state, regional, national or even international communities. Many examples of this are well-known. A report of a case of tuberculosis leads to provision of treatment for the patient to render them no longer infectious, identification and notification of close contacts for evaluation and treatment, and occasionally quarantine or other public health measures as necessary to prevent additional spread of disease. Persons with sexually transmitted diseases are promptly treated, and their close contacts are identified and treated to prevent further spread. Persons who have had close contact with a patient with meningococcal meningitis are traced and urgently treated to prevent them from contracting disease. Clusters of illness associated with restaurants are investigated immediately in order to ensure that conditions at the implicated establishment are corrected immediately or it is closed until that is accomplished. Foodborne disease outbreaks often lead to traceback of foods, with recalls of many thousands of pounds of product, preventing potential illness over very large areas of distribution. Other prominent recent examples include a nationwide outbreak of fungal meningitis, in which identification and recall of a contaminated pharmaceutical product prevented potentially hundreds of additional deaths.

It is not at all uncommon for public health agencies to receive several reports of illness from various sources, which to an individual clinician or institution may appear isolated or sporadic, but which in aggregate signify an important cluster or outbreak. This is an example of the critical importance of all health care providers and facilities consistently and promptly reporting diseases to their local authorities.

While many cases of reportable diseases are "sporadic," or unrelated to others and require little additional follow-up, some extent of public health investigation is necessary to ensure that they are not a sign of a potentially more widespread situation requiring interventions to mitigate additional spread. Unfortunately, it is not uncommon for public health investigations to identify causes of disease involving such things as widely disseminated food products, contaminated medications, malfunctioning equipment, unsafe food-handling or manufacturing processes, intentionally perpetrated acts, or unsafe environmental conditions to which the public may be exposed (sometimes including, unfortunately, health care facilities). In the large

majority of cases, persons or establishments potentially involved in an outbreak are extremely cooperative with public health authorities in working toward identifying and eliminating the sources of health threats. Rarely, however, concerns such as legal culpability, economic sequelae, or adverse publicity can hinder investigations and response. Uniform adherence to legal reporting requirements is essential to ensure that there are no such barriers to protecting the public's health and safety.

Public health authorities work closely with private and institutional health care providers in this capacity. Confidentiality is rigorously protected by public health laws at all times. Authorities make every effort not to interfere with personal physician-patient relationships and individual treatment decisions, but rather work to provide additional services and resources which a physician or institution would not otherwise have available. This can include performing investigations in the broader community, coordination with other public health and regulatory agencies, provision of services otherwise inaccessible to high-risk populations, public information management, and occasionally use of public health legal authorities to overcome barriers to appropriate disease control.

### **Breakdowns in VA Reporting Necessitate New Legislation**

A recent VA Office of the Inspector General report regarding an outbreak of Legionnaire's Disease associated with a VA hospital in Pennsylvania highlighted the importance of a prompt and thorough response to disease control.<sup>4</sup> In that instance, improved coordination with state and local public health authorities might have helped prevent infections and deaths associated with the outbreak. But unfortunately, the Pennsylvania Legionnaire's case is not an isolated incident. There are other examples of suboptimal coordination of disease reporting with VA institutions and state and local public health agencies.

I have been involved in investigations of known outbreaks in VA hospitals in which the state health department's participation was rather abruptly curtailed due to concerns about jurisdictional authorities. Lack of prompt notification of cases of tuberculosis has hampered control efforts outside the institution in which the person was housed. Lack of information regarding communication with large numbers of persons potentially exposed to infection control lapses within a health care facility have made it challenging to respond to public inquiries from many of those persons once they were back out in our communities. We once learned of a dramatic cluster of illnesses (one resulting in several cases of blindness) associated with preparation of medications in a health care institution, only indirectly when notified unofficially by personal acquaintances.

These examples do not reflect malintent, dereliction of duties, or purposeful avoidance of responsibilities, per se. To the contrary, in many of these situations, well-meaning VA staff were

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<sup>4</sup> *Healthcare Inspection: Legionnaire's Disease at the VA Pittsburg Healthcare System, Pittsburg, PA.* Department of Veterans Affairs Office of Inspector General, Office of Healthcare Inspections. April 23, 2013.

equally frustrated about the effect of variable interpretations of the applicability of state public health requirements in these federal institutions. Over many years, efforts to address such barriers have been quite variable, often appearing to depend highly on particular individual interpretations of regulations and policies.

CSTE subject matter experts have reviewed the current versions of the VA reporting bills and in principle, are very supportive of these efforts. CSTE believes that federal legislation will enhance VA reporting to the NNDSS, and thus is in the best interest of public health. CSTE feels strongly that the best way to craft legislation that will ensure that VA health care facilities will be on a level playing field with other reporting health care facilities is to mandate that VA facilities comply with jurisdictional, i.e., state and local reporting laws, rules, and procedures. Referring federal requirements to these laws, rules, and procedures will ensure VA facilities remain on equal footing with private health care facilities as these rules evolve over time. Similarly, requiring that VA adhere to existing standards will enhance, rather than reinvent, the already effective NNDSS; requiring the VA to diverge from existing standards could place an unnecessary administrative burden on the system.

CSTE experts have reviewed many scenarios, including the Pennsylvania VA Legionnaires outbreak, and believe that if VA facilities comply with jurisdictional reporting laws, many facility-based outbreaks will be detected, investigated, and stopped earlier than they may be otherwise. In addition, no patient of any health care institution is a resident of an encapsulated universe. Patients, staff, and families are active members of the communities surrounding those facilities, and their inevitable interactions have important public health implications both inside and outside those buildings. It is impossible to separate a health care facility from its community, and vice versa. Public health law must acknowledge this, and facilitate and require VA health care facilities to follow the same laws that govern all other institutions in our states, which protect the health of us all.

CSTE appreciates the opportunity to submit this statement for the record and looks forward to working with the Subcommittee as it seeks to strengthen public health law in the interest of our nation's veterans and citizens. If you have questions about this statement, please do not hesitate to contact me at [Tim.F.Jones@tn.gov](mailto:Tim.F.Jones@tn.gov) or (615) 532-1408. You may also contact CSTE's Executive Director, Dr. Jeffrey Engel, at [JEngel@cste.org](mailto:JEngel@cste.org) or (770) 458-3811.