Condition	Prioritization Classification	Situations which change the prioritization classification* (Note: The classification may increase to high if an outbreak or nosocomial transmission is suspected.)	Type
Typhoid fever	high		enteric
Shiga toxin-producing *E. coli*	high		enteric
Cholera	high		enteric
Domoic acid poisoning	high		enteric
Paralytic shellfish poisoning	high		enteric
Foodborne and waterborne outbreaks	high	Classification decreases if illness is not severe or ongoing	enteric
Shigellosis	medium-high	Classification increases if case works in a sensitive occupation	enteric
Vibriosis	medium-high		enteric
Salmonellosis	medium-high	Classification increases if case works in a sensitive occupation	enteric
Listeriosis	medium		enteric
Campylobacteriosis	low		enteric
Giardiasis	low		enteric
Cryptosporidiosis	low		enteric
Cyclosporiasis	low		enteric
Trichinosis	low	Classification increases if a commercial food source is suspected	enteric
Yersiniosis	low		enteric
Hepatitis B, surface antigen mom	high		hepatitis
Hepatitis A	high		hepatitis
Hepatitis C, acute	medium		hepatitis
Hepatitis B, acute	medium		hepatitis
Hepatitis C, chronic	low-medium		hepatitis
Hepatitis B, chronic	low-medium		hepatitis
Hepatitis D	low		hepatitis
Hepatitis E	low	Classification increases if case did not travel outside US	hepatitis
HIV/AIDS	high		HIV
VRSA	high		misc
Botulism	high		misc
SARS	high		misc
Legionellosis	medium		misc
Prion disease	low	Classification increases if case is <55 years old	misc
Unexplained critical illness or death	low		misc
Syphilis	high		STD
Chancroid	high		STD
Granuloma inguinale	high		STD
Lymphogranuloma venereum	medium-high		STD
Gonorrhea	medium		STD
Chlamydia	low-medium		STD
Herpes, neonatal and genital	low		STD
Tuberculosis	high		TB

Meningococcal disease	high		VPD
H. flu invasive disease	high		VPD
Measles	high		VPD
Diphtheria	high		VPD
Poliomyelitis	high		VPD
Pertussis	medium-high	Classification increases if case spent time in high risk setting while infectious (e.g., childcare with kids <1y.o., setting with pregnant women)	VPD
Mumps	medium		VPD
Rubella	medium	Classification increases if case possibly exposed a pregnant woman	VPD
Influenza death	low	Classification increases if case recently traveled to country with avian	VPD
Varicella death	low		VPD
Tetanus	low		VPD
Anthrax	high		zoonotic
Plague	high		zoonotic
Rabies	high		zoonotic
Yellow fever	high		zoonotic
Suspected rabies esposure	high		zoonotic
Tularemia	medium-high	Classification increases if bioterrorism concern or lab expsoure	zoonotic
Brucellosis	medium-high	Classification increases if bioterrorism concern or lab expsoure	zoonotic
Burkholderia mallei/pseudomallei	medium	Classification increases if bioterrorism concern or lab expsoure	zoonotic
Relapsing fever	medium		zoonotic
Q fever	medium		zoonotic
Hantavirus pulmonary syndrome	medium		zoonotic
Leptospirosis	medium		zoonotic
Psittacosis	medium		zoonotic
Malaria	low		zoonotic
Lyme disease	low		zoonotic
Arboviral disease	low		zoonotic
West Nile Virus	low		zoonotic

Table 2: Proposed Guidance for Prioritizing Surveillance and Response Activities for High Volume Notifiable Conditions

Condition	Primary Goal(s)*	Surveillance and Response Activities	
		Priority 1 (Activities which should be pursued to the greatest extent possible when resources are limited)	**Priority 2** (Activities which could be curtailed or temporarily suspended when resources are limited)
STDs			
Chlamydia	Decrease transmission Prevent complications (e.g., PID, ectopic pregnancy and infertility) Identify persons with undiagnosed HIV infection	Complete and enter data from provider case report form into PHIMS-STD Perform case investigation and partner management per state guideline for the following: • Untreated patients • Random ~5% sample of patients (DOH/some LHJs)[†] *([†]This activity is priority 1 for DOH and some LHJs but may not be priority 1 for all LHJs. The size of the random sample will vary by LHJ. DOH can perform these investigations for LHJs with limited resources.)* Maintain Expedited Partner Therapy (EPT) medication supply (DOH/some LHJs) Educate providers in community regarding EPT use and availability	Case investigation and partner management per state guideline for the following (LHJ/DOH): • All men who have sex with men (MSM) but particularly HIV-uninfected MSM • HIV-infected persons who are out of medical care • Persons referred by providers for partner services (including ER patients) • Pregnant women HIV testing in MSM with Chlamydia and their partners.
Gonorrhea	Decrease transmission Prevent complications (e.g., PID, ectopic pregnancy and infertility Identify persons with undiagnosed HIV infection Decrease transmission of *N. gonorrhoeae* with decreased susceptibility to cephalosporins	Complete and enter data from provider case report form into PHIMS-STD Perform case investigation and partner management per state guideline for the following (DOH/LHJs): • Untreated patients • All MSM but particularly HIV-uninfected MSM (10% risk of HIV) • Cases infected with *N. gonorrhoeae* with decreased susceptibility to cephalosporins • Random ~5% sample of patients (DOH/some LHJs)[†] • Cases with disseminated gonococcal infection *([†]This activity is priority 1 for DOH and some LHJs but may not be priority 1 for all LHJs. The size of the random sample will vary by LHJ. DOH can perform these investigations for LHJs with limited resources.)* Maintain EPT medication supply (DOH/some LHJs) Educate providers in community regarding EPT use and availability	Case investigation and partner management per state guideline for the following (LHJ/DOH): • HIV-infected persons who are out of medical care • Heterosexual men • Persons referred by providers for partner services (including ER patients) • Pregnant women • All women HIV testing in MSM with gonorrhea and their partners.

Table 2: Proposed Guidance for Prioritizing Surveillance and Response Activities for High Volume Notifiable Conditions

Syphilis	Eliminate transmission Prevent complications (e.g., neurosyphilis or congenital syphilis) Identify persons with undiagnosed HIV infection Ensure HIV co-infected persons are engaged in HIV care	Perform case investigation and partner management per state guideline for all early syphilis cases (LHJ/DOH) Ensure treatment of patients with all stages of syphilis Test and treat all contacts exposed to early syphilis cases within previous 90 days (LHJ/DOH) Test cases and their contacts for HIV infection Maintain statewide syphilis central registry (DOH)	
Enteric Diseases			
Campylobac-teriosis	Detect outbreaks / identify and control source	Collect basic case information, including demographic data and hospitalization/death status, and enter data into PHIMS Monitor case reports for outbreaks; investigate outbreaks	*Individual case investigations and education of cases are <u>optional</u> activities.*
Giardiasis	Detect outbreaks / identify and control source	Collect basic case information, including demographic data and hospitalization/death status, and enter data into PHIMS Monitor case reports for outbreaks; investigate outbreaks	*Individual case investigations and education of cases are <u>optional</u> activities.*
Salmonellosis	Detect outbreaks / identify and control source (e.g., contaminated commercial food product) Prevent further transmission from case	Perform case investigation for all lab-confirmed (confirmed) cases per state guideline Identify and exclude persons who work in sensitive occupations while symptomatic Perform PFGE analysis on all isolates (DOH) Monitor case reports and PFGE results for outbreaks; investigate outbreaks (DOH/LHJ)	Collection of detailed food histories on all confirmed cases Case investigations for all epi-linked (probable) cases per state guideline
Shigellosis	Prevent further transmission from case Detect outbreaks / control transmission	Perform case investigation for all lab-confirmed (confirmed) cases per state guideline Identify and exclude persons who work in sensitive occupations Monitor case reports for outbreaks; investigate outbreaks (DOH/LHJ)	Case investigations for all epi-linked (probable) cases per state guideline
Shiga toxin-producing *E. coli* infections	Prevent further transmission from case Detect outbreaks / identify and control source (e.g., contaminated commercial food product)	Perform case investigation for all lab-confirmed (confirmed) and epi-linked (probable) cases per state guideline Collect detailed food histories on all lab-confirmed cases Identify and exclude persons who work in sensitive occupations Perform PFGE analysis on all isolates (DOH) Monitor case reports and PFGE results for outbreaks; investigate outbreaks (DOH/LHJ)	

Table 2: Proposed Guidance for Prioritizing Surveillance and Response Activities for High Volume Notifiable Conditions

Multi-state foodborne outbreaks	Identify and control source (e.g., contaminated commercial food product)	Re-interview cases as part of multi-state outbreak investigations[§] *([§]This activity is priority 1 for DOH and CDC but may not be priority 1 for LHJs. CDC and DOH usually have resources to perform these interviews. LHJs can participate in these investigations if interested as resources permit.)*	
Foodborne illness complaints	Identify and correct food safety hazards	Receive and document basic information from complainants Review complaints and perform further investigation in high risk situations. Factors which increase the public health risk of a complaint(s) include: • Illness is severe (e.g., hospitalization or death in 1 or more people, marine neurotoxin, mushroom poisoning, hepatitis) • Illness is suggestive of bacterial source (e.g., bloody diarrhea, toxin) • Outbreak is large (involves ≥10 ill people) or ongoing • Illness is associated with shellfish from a commercial source or growing area • Exposures have occurred in a setting with a vulnerable population • Illness is suspected to be associated with a commercially-distributed food Facilitate collection of laboratory specimens when indicated	Investigation of other situations in which illness is associated with a common source reported by ≥2 unrelated households/parties
Institutional norovirus reports	Rule out ongoing foodborne source Prevent further transmission	Rule out a bacterial pathogen and foodborne source Provide infection control guidance (written, by phone or in person) to facilities	
VPDs			
Pertussis	Prevent severe illness and deaths in infants Prevent transmission in high risk settings	Perform case investigation per state guidelines for the following: • Culture- or PCR-positive patients (includes those whose illness does not yet meet the clinical case definition) • Epi-linked cases that meet the clinical case definition Identify and manage high risk contacts of these cases	Case investigation per state guidelines for the following*: 1. Cases that meet the clinical case definition but have no epi-link or lab confirmation (probable) 2. Cases with classic symptoms (paroxysmal cough post-tussive emesis, or whooping) and less than a two week cough duration **Note: For any report with an indication of a high-risk contact/setting the priority status will increase.*
Chronic Hep			
Hepatitis C, chronic	Prevent further transmission Reduce morbidity and mortality of those currently infected	Report available data on all cases to DOH Collect surveillance and program evaluation data (through fax to provider or patient interview) on a random sample of newly diagnosed cases *(Note: The details and feasibility of this new activity need to be determined.)* Establish a data management system to efficiently identify newly diagnosed cases (DOH)	Education of all newly diagnosed cases via mail or phone regarding transmission and reducing morbidity but particularly those who may not know test result (e.g., ER patients, blood donors) Education of providers on available resources

Table 2: Proposed Guidance for Prioritizing Surveillance and Response Activities for High Volume Notifiable Conditions

Hepatitis B, chronic	Prevent further transmission Reduce morbidity and mortality of those currently infected	Report available data on all cases to DOH Collect surveillance and program evaluation data (through fax to provider or patient interview) on a random sample of newly diagnosed cases *(Note: The details and feasibility of this new activity need to be determined.)* Establish a data management system to efficiently identify newly diagnosed cases (DOH)	Education of all newly diagnosed cases via mail or phone regarding transmission, reducing morbidity, and vaccination of contacts Vaccination of household and sexual contacts
Hepatitis B sAg+ pregnant women	Prevent transmission to infant	Perform follow-up on pregnant women and their infants per state guidelines	Vaccination of household and sexual contacts
Tuberculosis			
Tuberculosis	Reduce morbidity and mortality Prevent transmission	Active case finding Ensure all cases of active TB complete treatment per state guidelines Perform timely contact investigations for all pulmonary TB cases per state guidelines Maintain the ability to treat newly identified contacts with latent TB infection at an LHJ clinic or identify a community provider willing to treat newly identified contacts with LTBI where patients can be referred Review overseas medical records and chest radiograph on all class B immigrants; if needed, perform additional evaluation to ensure active disease is ruled out Maintain access to consultation with a public health physician with experience in diagnosis and treatment of TB as well as contact investigations (DOH) Maintain the capacity to perform isolation, molecular diagnostic testing, and antibiotic susceptibility testing for *M. tuberculosis* (DOH) Create a statewide fund to cover the medication costs for all TB medications, including medications for MDR and XDR TB	Treating other patients with LTBI at an LHJ clinic or in the community Education and consultation to community providers around TB
HIV/AIDS			
HIV/AIDS	Prevent further transmission Ensure that persons with HIV receive sustained medical care, thereby reducing the morbidity and mortality of HIV infection	Ensure newly diagnosed HIV-positive patients are aware of their diagnoses and understand how to prevent further transmission Elicit information about partners who may have been exposed to newly diagnosed HIV cases, and follow-up with those individuals for counseling and testing Link newly diagnosed cases to care (either directly, through referral to case manager, or other mechanism) Follow-up to determine if newly diagnosed HIV-positive patients entered care; notify DOH of those not in care (shared DOH/LHJ activity) Provide data for case reporting and partner services reporting	Ensuring newly diagnosed HIV-positive patients are engaged in sustained medical care (i.e., >2 visits at least 3 months apart in the year following HIV diagnosis) Relinking prevalent cases who are out of medical care to HIV care

Table 2: Proposed Guidance for Prioritizing Surveillance and Response Activities for High Volume Notifiable Conditions

Zoonotic Disease			
Suspected rabies exposure	Prevent human rabies	Advise clinicians on rabies risk related to suspected exposures and guidance on administration of PEP Facilitate submission of animal heads for testing when indicated Maintain the capacity to perform animal rabies testing after human exposures (DOH)	

*For all conditions, one goal is to perform descriptive epidemiology for prevention and planning purposes.

Agenda for Change Communicable Disease Prioritization Work Group

Core Work Group Members:
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Background:

Public health agencies in Washington State are facing ongoing severe funding reductions. In order to confront this challenge, a work group with representatives from the Washington State Department of Health (DOH) and local health jurisdictions in Washington was formed in 2010 to reshape public health practice in the state. The collaborative effort of this group resulted in an Agenda for Change which identified the need to focus our communicable disease capacity on and enhance the most effective and important elements of prevention, early detection, and swift response to protect Washington residents from communicable disease and other health threats. In October 2011, an Agenda for Change Communicable Disease and Other Health Threats Subgroup was convened to determine objectives and strategies for addressing this need. One strategy identified was to prioritize our communicable disease surveillance and response activities.

Work Group Goal and Objectives:

In January 2012, a Communicable Disease Prioritization work group was formed with representatives from DOH and local health jurisdictions. The primary goal of this work group was to provide recommendations around prioritizing communicable disease surveillance and response activities so that when public health resources are insufficient, health agency activities focus on the most effective and important elements of communicable disease control. In order to accomplish this goal, the work group pursued the following two objectives:

Objective 1: Provide a prioritization classification for surveillance and response activities for each notifiable condition.

Objective 2: For the highest volume conditions, identify the surveillance and response activities which should be pursued to the greatest extent possible when resources are limited and those activities which could be curtailed or temporarily suspended when resources are limited.

Implementation of this guidance and prioritization decisions may change depending on available resources, the current work load for the various diseases, and overall agency resource demands.

Work Group Activities:

During January 2012 through April 2012, the work group held several conference calls to develop and accomplish the following objectives.

Objective 1: Provide a prioritization classification for surveillance and response activities for each notifiable condition.

The work group assigned the surveillance and response activities for each notifiable condition a high, high-medium, medium, medium-low, or low priority classification. The primary criteria used to determine priority classification included:

- Impact of the disease on individuals and populations (severe morbidity or mortality; transmissibility to others in the community)
- Effectiveness of public health interventions in preventing disease

Table 1 shows the priority classification assigned to each notifiable condition. The work group acknowledged that the priority classification for many conditions may increase if an outbreak or nosocomial transmission is suspected. The work group also acknowledged that conditions may have a different priority classification in different situations. Those situations which would increase or decrease the priority classification of a condition are also indicated in Table 1. Since the importance of responding to a notifiable condition case is partially determined by the context in which the case occurs, local health jurisdictions must maintain the capacity to rapidly assess the public health impact of all reported notifiable condition cases.

The work group also acknowledged that public concern and local events can temporarily influence the prioritization of surveillance and response activities.

Objective 2: For the highest volume conditions, identify the surveillance and response activities which should be pursued to the greatest extent possible when resources are limited and those activities which could be curtailed or temporarily suspended when resources are limited.

The work group discussed the importance of specific surveillance and response activities for certain high volume notifiable conditions (Table 2). Specific surveillance and response activities for high volume conditions were classified as either priority 1 or priority 2. Priority 1 activities were defined as activities which should be pursued to the greatest extent possible even when resources are severely limited. Priority 2 activities were defined as activities which could be curtailed or temporarily suspended when resources are limited.

The priority status of specific surveillance and response activities was discussed for the following high volume notifiable conditions:

- Sexually transmitted diseases: chlamydia, gonorrhea, syphilis

- Enteric diseases: campylobacteriosis, giardiasis, salmonellosis, shigellosis, Shiga toxin-producing *E. coli* infections, foodborne illness complaints, norovirus outbreaks, multi-state foodborne outbreaks
- Vaccine preventable diseases: pertussis
- Hepatitis: chronic hepatitis C, chronic hepatitis B, hepatitis B surface antigen + pregnant women
- Zoonotic diseases: suspected rabies exposure
- Tuberculosis
- HIV/AIDS

DOH has the capacity to assist local health jurisdictions with certain priority 1 activities. Activities for which DOH can provide assistance are noted in Table 2.

The work group also discussed general surveillance and response activities which should be pursued to the greatest extent possible by DOH and local health jurisdictions even when resources are severely limited.

In June 2012, the work group distributed draft recommendations to DOH and local health leadership for review. Comments from stakeholders were reviewed by the work group members and incorporated into work group materials as appropriate.

Recommendations:

The following recommendations were developed through a statewide consensus process and are intended to provide guidance around prioritizing communicable disease surveillance and response activities. Local health officers have the authority to tailor the prioritization of communicable disease activities based on local circumstances.

1) All local health jurisdictions and DOH should maintain a 24/7 system for receiving communicable disease reports and responding to communicable disease emergencies even when resources are severely limited.

2) After receiving a notifiable condition case report, all local health jurisdictions should perform a rapid assessment to determine the potential public health impact of the case.

3) While planning for continuity of operations during emergencies, all local health jurisdictions should maintain the capacity to rapidly assess the public health impact of all notifiable condition cases.

4) After performing a rapid public health assessment, when resources are insufficient to carry out all optimal public health activities, local health jurisdictions may prioritize surveillance and response activities according to the priority classification assigned in Table 1.

5) Local health jurisdictions and DOH should pursue all priority 1 activities shown in Table 2 to the greatest extent possible even when resources are severely limited. Priority 2 activities should also be pursued as resources permit.

6) Local health jurisdictions and DOH should pursue the following general surveillance and response activities to the greatest extent possible even when resources are severely limited:

- Maintain an up-to-date list of all providers in the jurisdiction and means to rapidly communicate with these providers
- Provide alerts to the public and healthcare providers around public health issues affecting the community
- Periodically analyze, interpret, and disseminate aggregate morbidity and mortality data to the public and other stakeholders

7) DOH should require all healthcare providers to provide an email address and other contact information at the time of licensing and renewal and provide this information to local health jurisdictions on an annual basis.

8) Recommendations on priority 1 and 2 activities from Table 2 should be incorporated into the DOH Notifiable Conditions Surveillance and Reporting Guidelines after approval by stakeholders throughout the state.

9) Local health jurisdictions should report available data on all reported notifiable conditions to DOH even if resources are insufficient to perform a case investigation. DOH can assist with investigations as resources permit.