NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

13-07

STATEMENT OF POLICY

Foodborne Disease Outbreak Response

Policy

The National Association of County and City Health Officials (NACCHO) supports building local health department foodborne disease surveillance, investigation, and control capacities to promote and improve evidence-based public health practice that reduces foodborne disease.

Foodborne Disease Outbreak Response

NACCHO supports the following:

- Ongoing interaction and involvement among local health departments and state and federal agencies to respond rapidly and effectively to multi-jurisdictional and multi-state outbreaks and recalls.
- A team approach to foodborne outbreak response that fully engages epidemiology, environmental health, laboratory, public health nursing, agriculture departments and other food regulatory agencies and allows for participation from emergency response and industry, as appropriate.
- Enhanced local health department workforce training around surveillance, investigation, and response activities, including cross-training of staff.
- Policies that enhance federal, state, and local laboratory capacity for testing clinical, food, and environmental specimens to identify and respond quickly to foodborne disease outbreaks.
- Local health department representation on national food safety and response initiatives that enhance or impact the ability of local health departments to conduct food safety response activities, such as the Council to Improve Foodborne Outbreak Response, Conference for Food Protection, and the Partnership for Food Protection.
- Training for public health students to fulfill surge capacity interviewing needs during an outbreak.
- Policies and training that enhance healthcare providers' ability to properly diagnose and report incidents of foodborne disease.
- A coordinated communication response for keeping the public well-informed and the message consistent in the event of a multijurisdictional outbreak.
- Paid sick leave because it promotes health by encouraging sick employees to stay home and limit the spread of foodborne disease (see NACCHO's policy statement 11-07 Paid Sick Leave).
- Preventive action along the farm-to-fork continuum aimed at improving the safety of the food system (see NACCHO's policy statement 99-08 Food System Safety).

- Federal efforts to phase out the non-therapeutic use of critical antimicrobial drugs and growth hormones in food-producing animals (see NACCHO's policy statement 12-09 Antimicrobials in Animals).
- Policies and training that support local and state health department reporting of data from outbreak investigations to CDC's foodborne illness outbreak surveillance systems (National Outbreak Reporting System (NORS); National Environmental Assessment Reporting System (NEARS)).[1,2]

Foodborne Disease Response Funding

In funding for foodborne disease response, NACCHO:

- Supports the development of methods for reimbursement from federal and state governments to local health departments for special requests and assistance during foodborne disease outbreaks and recalls.
- Supports enhanced federal, state, and local funding for local health departments' food safety capacity and infrastructure and for routine public health activities related to foodborne-illness surveillance, investigation, and control.
- Supports additional federal, state, and local funding to build and improve communication, coordination, and partnerships to improve foodborne disease outbreak response (for example federal agencies, state and local health departments, emergency preparedness programs, food industry, consumers, and public health professional organizations).
- Urges Congress to appropriate funds authorized in the Food Safety Modernization Act for activities related to foodborne disease outbreak response.
- Endorses the inspector/inspection ratio as described in the FDA Voluntary National Retail Food Regulatory Program Standards' (Retail Program Standards) Standard 8: Program Support and Resources.

Justification

The extent of the problem is difficult to accurately define because foodborne disease incidence in general is probably under-reported. However, foodborne illness in the United States is estimated to cause 48 million cases of illness, over 128,000 hospitalizations, and 3,000 deaths each year.[3] A specific pathogen cause can be identified in only 20 percent of the [48 million] cases (9.4 million illnesses). In the cases when a pathogen can be identified, over 90 percent of these cases are caused by only 15 pathogens. According to a report from the United States Department of Agriculture/Economic Research Service, foodborne illnesses pose an annual economic burden of over $15.5 billion.[4] Foodborne illness remains a major threat to public health and local health departments serve as the frontline defense against foodborne disease outbreaks.

Foodborne illnesses are diseases or infections caused by consuming contaminated food or drink. While single cases of foodborne illness are common, the true number of foodborne outbreaks is not known because of underreporting and or misdiagnosis. The proportion of cases of foodborne illness reported to public health authorities can depend on the severity of the case, medical provider and consumer reporting rates to health officials, and surveillance capacity at the state and local levels.[5] Improving consumer education, strengthening reporting requirements, and building local health department capacity to respond to foodborne disease outbreaks will continue to be critical to reducing the impact of foodborne illness.

Each reported case of foodborne illness is identified, investigated, and controlled primarily at the local and state levels. State and local governments investigate the majority of foodborne illnesses and are responsible for sampling food products for contamination during an outbreak investigation.[6] According to the CDC, of the 4,163 foodborne outbreaks in 2010–2014, 120 (or about 3%) were multistate.[7] The first steps taken by local and state health departments are critical to preventing and responding to foodborne illness in the United States. Furthermore, coordinating foodborne surveillance, investigations, and control efforts between the local, state, and federal levels is crucial because a disproportionate amount of outbreak-associated hospitalization and death are attributed to multistate foodborne outbreaks compared with single state outbreaks in the United States. Multistate foodborne outbreaks cause 11% of outbreak – associated illnesses, 34% of hospitalizations, and 56% of deaths.[7]

Paid sick leave for food service workers and health department inspection staff could help limit the spread of foodborne disease in retail food establishments. For example, the CDC found that infected food workers transmitted 70 percent of foodborne noroviruses.[8] According to the Department of Labor, 75 percent of hospitality and food service workers do not have paid sick leave.[9] In a survey conducted of food workers, nearly 90 percent responded that they went to work sick. Of those who went to work sick, 45 percent said they worked because they could not afford to lose the pay.[10]

According to a 2013 survey of local health departments conducted by NACCHO, 78 percent of local health departments conduct environmental health surveillance. Since September 2010, 25 percent of local health departments responded to a major foodborne disease outbreak. [11] Expanding resources at the local level may prevent potential foodborne outbreaks and control the spread of illness. In 2012, seven percent of local health departments reduced or eliminated their food safety programs and their epidemiology and surveillance programs.[12]Federal funds allocated to local health departments for food safety have been modest. Increased financial support is necessary to help local health departments continue to further enhance their surveillance, investigation, and control of foodborne disease outbreaks. In addition, the FDA Retail Program Standards recommend a staffing level of one full-time equivalent devoted to food for every 280 – 320 inspections performed. Inspections for purposes of this calculation include routine inspections, re-inspections, complaint investigations, outbreak investigations, compliance follow-up inspections, risk assessment reviews, process reviews, variance process reviews and other direct establishment contact time such as on-site training.[13]

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Record of Action

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