THE CSTE WASHINGTON REPORT

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INSIDE THIS ISSUE…

EDITOR'S NOTE: The CSTE Washington Report will resume publication in September, following the return of Congress to Washington.

The CSTE Washington Report is provided as an information resource for members of the Council of State and Territorial Epidemiologists on federal legislation and regulation affecting public health and epidemiology in the U.S. Regulations cited can be accessed via http://www.gpo.gov

APPROPRIATIONS UPDATE – As Congress adjourned for the traditional month long August recess, the Senate Appropriations Committee had completed action on the FY 2003 Labor-HHS-Education Appropriations bill (S. 2766; Report 107-216; also see Volume 6, No. 14 Washington Report), but the full Senate will not act until September. The House Labor-HHS-Education Subcommittee on Appropriations is expected to mark up its FY 2003 bill on September 5th. The mark up is expected to look like the President's budget request, since the Subcommittee's allocation is only $2.5 billion above the FY 2002 spending level and must be spread across all three federal departments.

Given that FY 2003 is the final year of the five year doubling effort for the NIH, fully $3.7 billion of the $2.5 billion increase is already committed for one agency This, plus the President's requested increases for education programs, although far below what advocates inside and outside Congress want, means many programs must be cut or level funded. It is hoped and expected that such a bill will ultimately fail on the House floor and more money will need to be found to increase funding levels for programs in the bill.

In a piece of good news, the conferees finally finished the FY 2002 supplemental appropriations bill before the August recess. Contained in the final conference report is an $11.3 million increase for ATSDR, with fully $9.5 million of the increase slated for ATSDR's state cooperative agreements. This nearly doubles the $9+ million the program now provides to 34 states. The President must declare an emergency for all of the supplemental funds to be released and has 30 days to do so. This was a major conflict between the President and Senator Byrd who chairs the Senate Appropriations Committee. While it is possible the President will find a way around this stipulation, he is expected to declare an emergency and the funds are expected to be released. CSTE led the effort to secure the increased funding for ATSDR's state cooperative agreements and is working on getting this increase built into the base for FY 2003.

UPDATE ON HOMELAND SECURITY – As the national news sources have reported, the rush to finish legislation establishing the new Department of Homeland Security in both Houses of Congress before the August recess failed. Sen. Byrd and Sen. Lieberman are defying the White House's stipulation that the final bill must permit the Director of the new department flexibility in hiring, moving, and firing federal workers who have civil service protections against such actions. The House passed its version of the bill (See Vol. 6, No. 14 CSTE Washington Report) before the recess, but the Senate will not debate its bill until September. Both bills do not transfer CDC public health bioterrorism activities to the new department.

UPDATE ON CLINTON HEALTH TRACK BILL – CSTE staff have been meeting with Senate Health, Education, Labor and Pension staff on S. 2054, a bill to establish a Nationwide Health Tracking Network introduced by Senator Hillary Clinton. The bill seeks to set up state surveillance systems that will track priority chronic diseases like asthma, birth defects, and cancer and relevant environmental, behavioral, socioeconomic, demographic, and other risk factors. The state grant program would be authorized at $100 million for FY 2005-2009. It creates a federal commission which will establish minimum standards and procedures regarding priority chronic conditions and relevant environmental and other risk factors. The bill also expands the EIS program at CDC to include environmental health officers who can aide states in investigating urgent incidents involving environmental hazards and exposure or elevated incidence or prevalence of chronic disease. The bill also expands the current biomonitoring program at the CDC. Finally the bill creates Centers of Excellence to study the links between environmental exposure and chronic disease and train environmental health professionals.

While many aspects of the bill are helpful to building environmental health capacity in states, other aspects are problematic. Many of CSTE's concerns have also been

expressed by other public health organizations, and the CDC. HELP Committee staff, and Senator Clinton's staff, have been fairly receptive to these concerns and CSTE is hopeful a better constructed bill will eventually emerge. A scheduled mark up of the bill in the HELP Committee before the August recess was postponed, in part, so that key groups, like CSTE, could make its views known. While there is little legislative time left in the 107th Congress, the bill still could make progress – at least in the Senate. A House companion bill, sponsored by Rep. Nancy Pelosi (D-CA) has had no committee action.

STUDY OFFERS NEW INSIGHTS INTO OVERCOMING DISPARITIES IN HEALTH -- Socioeconomic disparities in health can be reduced and possibly even eliminated in some cases by specific interventions, such as adoption of a rigid treatment plan and intensive patient monitoring, that help patients better manage their own treatment, according to a new study by researchers at RAND. The study, which showed an association between a patient's level of education and adherence to complex treatment regimens for two diseases — HIV and diabetes — found that income, age, race, and gender were not as important as education in influencing health, but that differences associated with less education could be effectively overcome, resulting in improved compliance and improved health outcomes.

"Lower socioeconomic status (SES) — less education and lower income and wealth — has for some time been strongly linked with poorer health," says James P. Smith, Ph.D., RAND, who conducted the research with colleague Dana P. Goldman, Ph.D. "This research offers a new and practical explanation for why these differences in health may occur and how we might address them." Smith notes that experts have looked at a number of possible explanations for health disparities associated with SES, including differences in access to health care and insurance or in smoking and drinking among high and low SES groups, but exactly how these factors contribute to differences in health is unclear. Goldman and Smith's report appears in the July 22-26, 2002, online issue of the *Proceedings of the National Academy of Sciences (PNAS).* The research was supported by the National Institute on Aging (NIA), part of the National Institutes of Health, U.S. Department of Health and Human Services.

"This report takes a clever and useful approach to looking at health disparities," says Richard M. Suzman, Ph.D., Associate NIA Director, Behavioral and Social Research Program. "We knew that education was one of the most important contributors to health and life expectancy, but were not sure exactly why. These analyses give us hope that we can define strategies to help improve the health of people with less education, using interventions for illnesses that require adherence to complex regimens."

The study evaluated treatment and health status for two diseases: HIV and diabetes. These conditions were selected by the researchers because treatments are complex but highly effective in maintaining or improving health. National studies on the two diseases provide a wealth of information for characterizing people with the diseases, the details of their treatment, and results of the treatment. HIV data were obtained from the HIV Cost and Services Utilization Study (HCSUS), which followed patients receiving highly active

antiretroviral therapy, or HAART. Data on diabetes came from the national Health and Retirement Study (HRS) and the Diabetes Control and Complications Trial (DCCT), a clinical trial looking at the effectiveness of diabetes treatments.

For both diseases, Goldman and Smith found, there were large differences in adherence to treatment regimens by education and that differences in complying with treatment significantly affected overall health status. The HAART data on HIV showed, for example, that 57 percent of college graduates always stuck with their treatment plan, while only 37 percent of high school dropouts did so. The study showed that income did not appear to affect adhering to treatment, while education level consistently mattered. Further analysis demonstrated that complete adherence to treatment was the single most important factor in improving health outcomes and that the role of education made a difference only in affecting adherence.

The study of people with diabetes went a step further, comparing patient behaviors in the DCCT diabetes trial. When the researchers compared the conventional therapies with a more intensive therapeutic approach, they found that education no longer had an effect on outcome. There was little difference in health status among people in different educational groups using the more intensive, enforced treatment, showing that imposing strict adherence to a treatment regimen helped the less educated more than those with higher education.

“These analyses show that the ability to adhere to a treatment regimen, while it can be influenced by education, is the bottom line for better health,” points out RAND’s Goldman. “Our study suggests to health providers that not all patients are alike in their ability to adhere to and maintain complicated medical regimens. But we also demonstrate that SES effects are amenable to change with training, monitoring, and possibly other approaches.”

It is important to know why education matters, since related factors like income did not appear to influence adherence to health regimens or, ultimately, health status. It may be that certain features of education itself could play a role. Higher level reasoning skills and instruction in how to obtain and process complex information, components of higher education, might help patients make judgments about symptoms and treatments. In addition, personality traits and personal habits, including those that may prove useful in schooling or which schooling could help develop, might also influence adherence to health regimens. For example, the self-discipline it takes to complete assignments may prepare people for following a doctor's orders. Greater understanding of the role that these factors play will enable development of a variety of useful interventions, Suzman suggests.

HHS ANNOUNCES INITIATIVE TO REDUCE RACIAL AND ETHNIC DISPARITIES IN ADULT IMMUNIZATION -- HHS Deputy Secretary Claude A. Allen July 31 announced a new adult immunization initiative to reduce racial and ethnic

disparities in influenza and pneumococcal vaccination coverage for adults 65 years of age and older.

Through the Racial and Ethnic Adult Disparities in Immunization Initiative (READII), HHS will conduct two-year demonstration projects in five sites to improve influenza and pneumococcal vaccination rates in African-American and Hispanic communities. "We know immunizations work, yet still far too many Americans -- especially Hispanics and African Americans -- are not getting the shots that can prevent pneumonia and flu," Deputy Secretary Claude Allen said. "This initiative will help us identify the most effective ways to increase immunization rates in minority populations -- ultimately helping us close the gaps and improve the health for these groups."

The HHS project will be implemented by the Centers for Disease Control and Prevention (CDC), with support from the Centers for Medicare & Medicaid Services (CMS), the Health Resources and Services Administration (HRSA) and other federal agencies. Over two years, the READII project sites will collaborate with stakeholders to develop and implement a community-based plan utilizing existing and innovative approaches. To develop the plans, demonstration sites will organize partnerships of public health professionals, medical providers and community members (e.g., large health plans, insurers, minority health professional organization, churches, local community groups, and civic leaders) to identify strategies to increase immunization levels. Interventions will vary based on state and local choice, but will particularly focus on working with immunization providers because research indicates this is key to improving coverage. Strategies implemented in the first year that are shown to be effective will be used to further develop second year activities.

HHS hopes to widely disseminate lessons learned from this project. The sites for the READII project include Rochester, N.Y.; Chicago, Ill.; Milwaukee, Wis.; San Antonio, Texas; and rural counties in Mississippi. The awards are expected to be made by Sept. 1, and will range from $250,000 -- $400,000.

In 2000, 67 percent of older white persons received influenza vaccination, compared to only 48 percent and 56 percent of older African-American and Hispanic persons, respectively. Disparities for pneumococcal vaccination coverage were even wider, with 57 percent for whites, 31 percent for African-Americans and 30 percent for Hispanics.

STUDY FINDS EVIDENCE PRENATAL SCREENING IS MOST EFFECTIVE STRATEGY TO PREVENT NEWBORN STREP B INFECTIONS --The Centers for Disease Control and Prevention (CDC) July 24 released data indicating routine screening for group B streptococcus late in pregnancy is the most effective way to prevent transmission of the bacteria from mother to child during delivery. The data were published in the July 25, 2002 issue of the New England Journal of Medicine.

"Group B streptococcal disease remains a leading infectious cause of illness and death among newborns in the United States, resulting in approximately 1,600 illnesses and 80

deaths each year," said CDC Director Dr. Julie Gerberding. "It's hoped that the results of this study will lead to more doctors and other health care providers routinely screening women late in pregnancy for this bacteria, which can lead to long-term developmental disabilities, such as mental retardation, or hearing or vision loss in children who survive an infection."

Guidelines issued in 1996 to prevent transmission of the bacteria from mother to newborn recommend that health care providers use one of two methods -

1. offer antibiotics to women with clinical risk factors for disease transmission at the time of labor (fever, prolonged interval between rupture of the membranes and delivery, or preterm delivery)

2. screen women for carriage of group B streptococci between week 35 and 37 of their pregnancy and then to offer antibiotics during delivery to those who have the bacteria.

The data released today show that the prenatal screening method was more than 50 percent more effective in preventing transmission than the clinical risk factor method. "The main reason for the benefit of routine screening over the risk-based approach is that prenatal screening identifies silent carriers who can pass on the infection to newborns even when no clinical risk factors are present during labor," said Dr. Stephanie Schrag, a CDC epidemiologist and lead author of the study. "This is the first time we have a large multi-state study comparing the two methods and we believe that this study will soon lead to new guidelines that will call for routine screening late in pregnancy."

CDC, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics are all updating their previous recommendations in light of these new data. CDC's guidelines will be published in Morbidity and Mortality Weekly Report in August. For more information on group B streptococcal disease go to http://www.cdc.gov/ncidod/dbmd/gbs/.