THE CSTE WASHINGTON REPORT

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INSIDE THIS ISSUE

EDITOR'S NOTE: New data on racial disparities in health care -- black women have three to four times the risk of a pregnancy-related death when compared with white women, says a report from the Centers for Disease Control and Prevention (CDC), Pregnancy-Related Mortality Surveillance—United States, 1991-1999, released February 20. The pregnancy-related mortality ratio for all women for the years 1991 through 1998 was 11.8 deaths per 100,000 live births. The risk of death from complications related to pregnancy remains higher than the nation's Healthy People 2010 objective: no more than 3.3 maternal deaths per 100,000 live births. Pregnancy-related deaths are rare; 525 occurred in 1999. However, significant racial disparities persist. During the nine-year study period, the pregnancy-related mortality ratio for black women was 30.0 deaths per 100,000 live births, compared with 8.1 for white women. This is the largest racial gap of any indicator in the field of maternal and child health and has persisted for more than 60 years. Changing these outcomes is an important challenge in the years ahead.

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. Legislation cited in the report can be accessed via http://www.thomas.loc.gov Regulations cited can be accessed via http://www.gpo.gov

LEGISLATIVE UPDATE – The Energy and Commerce Committee marked up and reported out the Patient Safety and Quality Improvement Act on 2/12. The Act amends the Public Health Service Act to make "patient safety work product" privileged information. Defines "patient safety work product" as a record concerning patient information either reported to a patient safety organization by a health care provider (doctor, hospital, etc.) or created by a patient safety organization. Defines a "patient safety organization" as an organization, certified under this Act, that collects such information with the goal of improving patient safety and the quality of health care delivery. Imposes a civil penalty on providers who violate the privileged status of patient safety work product.

Directs the Secretary of Health and Human Services to establish and maintain a database to receive relevant nonidentifiable patient safety work product, consistent, if practicable, with the administrative simplification provisions of the Social Security Act. Permits the Secretary to provide to patient safety organizations and to States technical assistance with reporting systems for health care errors.

Directs the Secretary to establish a process for the Secretary or another approved Federal or State governmental organization to certify patient safety organizations.

Requires the Secretary to develop or adopt voluntary national standards promoting the interoperability of information technology systems involved with health care delivery.

Requires the Secretary to issue and periodically revise regulations requiring the manufacturer of any drug or biological product that is subject to regulation by the Food and Drug Administration, or the packager or labeler of such a product, to include a unique product identifier on the packaging.

A similar patient safety bill which amends the Social Security Act was introduced by Rep. Nancy Johnson (R-CT) who chairs the Health Subcommittee of the Ways and Means Committee (H.R. 663). This bill, among other provisions, and as it did last year, creates a Medical Information Technology Advisory Board, whose chairman must serve on the Committee for Vital Statistics, and specifies that 17 representatives will serve on the board from various aspects of the health care field, but public health is not among them. The two bills will need to be reconciled before final passage.

The IMPACT bill addressing obesity has been re-introduced in the House (H.R. 716). Called the Improved Nutrition and Physical Activity Act, the bill amends the Public Health Service Act to address issues of overweight and obesity. Expands certain existing grant programs for health professional training to include the treatment of overweight and obesity. Creates grant programs at the state and local level to promote increased physical

activity and improved nutrition. Expands an existing coordinated school health program to include grants for the development of programs which focus on healthy lifestyle, including balanced diet and physical activity. Authorizes the collection and analysis of data concerning the fitness levels of children and youth. Requires a study of the food and nutrition assistance programs run by the Department of Agriculture to determine how they can be improved or altered to help prevent obesity and overweight. Requires an evidence report study on the effectiveness of weight reduction programs. Permits the use of preventive health and health services block grants for community education programs which promote healthy eating and exercise habits. Creates a Medicare demonstration project to reduce obesity and other chronic disease risks in older Americans. Makes grants available to local healthcare delivery systems for overweight and obesity treatment and prevention demonstration programs. Provides grants and contracts for a national youth media campaign to change children's health behaviors.

The state and local grants section of the bill is authorized at $40 million. The bill was introduced by Rep. Mary Bono (R-CA) and has 10 bipartisan co-sponsors.

APPROPRIATIONS UPDATE – Below is some additional detail from the recently completed FY 2003 omnibus appropriations bill:

BRFSS
FY 2002 $1.803 million
FY 2003 $6.903 million *
Diff 02/03 +$5.100 million

Division of Nutrition and Physical Activity
FY 2002 $24.680 million
FY 2003 $34.372 million *
Diff 02/03 +$ 9.692 million

Asthma
FY 2002 $35.063 million
FY 2003 $37.127 million *
Diff 02/03 +$ 2.064 million

Health Track
FY 2002 $17.5 million
FY 2003 $28.0 million *
Diff 02/03 +$10.5 million

Childhood lead poisoning
FY 2002 $41.490 million
FY 2003 $42.272 million *
Diff 02/03 +$ .782 million

HIV/AIDS prevention

FY 2002	$691.198 million
FY 2003	$704.198 million ($8 million of the increase is for the Minority AIDS initiative and $5 million of the increase for general programs) *
Diff 02/03	+$ 13.0 million

* All FY 2003 appropriations subject to .65% across-the-board cut

HHS ADOPTS FINAL SECURITY STANDARDS, TRANSACTION MODIFICATIONS FOR ELECTRONIC HEALTH INFORMATION UNDER HIPAA --HHS Secretary Tommy G. Thompson February 13 announced the adoption of final security standards for protecting individually identifiable health information when it is maintained or transmitted electronically. At the same time, he also announced the adoption of modifications to a number of the electronic transactions and code sets adopted as national standards. Both final regulations are required as part of the administrative simplification provisions included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

"Overall, these national standards required under HIPAA will make it easier and less costly for the health care industry to process health claims and handle other transactions while assuring patients that their information will remain secure and confidential," Secretary Thompson said. "The security standards in particular will help safeguard confidential health information as the industry increasingly relies on computers for processing health care transactions."

Under the security standards announced February 13, health insurers, certain health care providers and health care clearinghouses must establish procedures and mechanisms to protect the confidentiality, integrity and availability of electronic protected health information. The rule requires covered entities to implement administrative, physical and technical safeguards to protect electronic protected health information in their care. The security standards work in concert with the final privacy standards adopted by HHS last year and scheduled to take effect for most covered entities on April 14. The two sets of standards use many of the same terms and definitions in order to make it easier for covered entities to comply.

"We took great care to address every detail and produce a rule that health care providers will find easy to understand and implement," said Tom Scully, administrator of HHS' Centers for Medicare & Medicaid Services (CMS).

The security standards were published as a final rule in the Feb. 20 Federal Register with an effective date of April 21, 2003. Most covered entities will have two full years -- until April 21, 2005 -- to comply with the standards; small health plans will have an additional year to comply, as HIPAA requires.

In a separate final regulation, HHS adopted modifications to the transaction standards, which health plans, certain health care providers and health care clearinghouses by law

must use for electronic health care transactions. Covered entities must comply with these modified transaction standards by Oct. 16, 2003.

The final transaction modifications rule, which was also published in the Federal Register on Feb. 20, combines two proposed rules published May 31, 2002. HHS worked extensively with the Designated Standards Maintenance Organizations (DSMOs) to revise the proposed changes to the standards, as required by Congress as part of HIPAA. Major provisions of the final rule include:

* Repealing the National Drug Code (NDC) as the standard medical data code set for reporting drugs and biologics in all non-retail pharmacy transactions.

* Adopting the proposed Addenda to the implementation guides with some technical revisions based upon comments received and consultation with the DSMOs.
* For retail pharmacy transactions:
* Adopting the National Council for Prescription Drug Programs (NCPDP) Batch Version 1.1 to support the Telecommunications Version 5.1.
* Adopting the Accredited Standards Committee (ASC) X12N 835 as the standard for payment and remittance advice and the NCPDP Telecommunications Version 5.1 and NCPDP Batch Version 1.1. Implementation Guides as the standard for the referral certification and authorization transaction.
* Continuing the use of the NDC code set for the reporting of drugs and biologics.

The rule also adopts modified standards for two transactions that were not included in the proposed rules -- premium payments, and coordination of benefits. The modifications were approved by the DMSOs and merely provide explanatory guidance.
CMS is responsible for implementing and enforcing the security standards, the transactions standards and other HIPAA administrative simplification provisions, except for the privacy standards. HHS' Office for Civil Rights is responsible for implementing and enforcing the privacy rule.

The complete text of both final rules will be available at the CMS website at http://www.cms.hhs.gov/hipaa/hipaa2. The full text of the Addenda to the transaction modifications rule will be available at http://hipaa.wpc-edi.com/HIPAAAddenda_40.asp. More information about HIPAA standards is available at http://www.cms.hhs.gov/hipaa and http://www.aspe.hhs.gov/admnsimp/. A fact sheet summarizing the administrative simplification standards required by HIPAA is available at http://www.hhs.gov/news/press/2002pres/hipaa.html.

AHRQ LAUNCHES NEW WEB-BASED QUALITY MEASURES RESOURCE -- The Agency for Healthcare Research and Quality February 20 launched its Web-based National Quality Measures Clearinghouse at http://www.qualitymeasures.ahrq.gov. The

NQMC will contain the most current evidence-based quality measures and measure sets available to evaluate and improve the quality of health care.

The site is designed to be a one-stop shop for physicians, hospitals, health plans, and others who may be interested in quality measures. Users can search the NQMC for measures that target a particular disease/condition, treatment/intervention, age range, gender, vulnerable population, setting of care, or contributing organization. Visitors also can compare attributes of two or more quality measures side by side to determine which measures best suit their needs. The site also provides material on how to select, use, apply, and interpret a measure.

"This new clearinghouse is an important resource for anyone who wants to improve the quality of health care for patients," said HHS Secretary Tommy G. Thompson. "Ultimately, this interactive online resource will serve as the primary source for the most up-to-date, clinically proven quality measures."

The NQMC builds on AHRQ's previous initiatives in quality measurement and will be part of a larger Web site of quality, clinical information, and decision tool components that will include the National Guideline Clearinghouse at http://www.guideline.gov. The NQMC and NGC will be linked for those who wish to coordinate their search for both quality measures and guidelines. AHRQ's quality initiatives include the *National Healthcare Quality Report* and the *National Healthcare Disparities Report*, which will be available in the fall of 2003.

Measures to be considered for inclusion in the NQMC can be submitted on an ongoing basis but must meet a set of criteria that can be found at http://www.qualitymeasures.ahrq.gov/contact/coninclusion.aspx. Organizations interested in contributing quality measures should contact NQMC at info@qualitymeasures.ahrq.gov.

CDC REPORTS PREGNANCY-RELATED DEATHS STILL HIGHER IN BLACK WOMEN THAN WHITE WOMEN --Black women have three to four times the risk of a pregnancy-related death when compared with white women, says a report from the Centers for Disease Control and Prevention (CDC), Pregnancy-Related Mortality Surveillance—United States, 1991-1999, released February 20.

The pregnancy-related mortality ratio for all women for the years 1991 through 1998 was 11.8 deaths per 100,000 live births. The risk of death from complications related to pregnancy remains higher than the nation’s Healthy People 2010 objective: no more than 3.3 maternal deaths per 100,000 live births.

Pregnancy-related deaths are rare; 525 occurred in 1999. However, significant racial disparities persist. During the nine-year study period, the pregnancy-related mortality ratio for black women was 30.0 deaths per 100,000 live births, compared with 8.1 for

white women. This is the largest racial gap of any indicator in the field of maternal and child health and has persisted for more than 60 years.

“Any pregnancy-related death is one too many,” said HHS Secretary Tommy G. Thompson. “We must focus our research on finding ways to reduce these deaths. We especially need to concentrate on eliminating racial disparities in pregnancy-related deaths.”

The CDC report also found a greater risk of pregnancy-related deaths among older women and those who received no prenatal care. The risk for pregnancy-related death increased sharply for women aged 35 and older, and the risk for women 40 and older was four times the risk for women aged 30-34. For each age category, black women were at a higher risk of death than white women. Among all age groups, women who received no prenatal care were three to four times more likely to die of pregnancy-related causes than women who received any care; that risk was even higher for black women.

Data published in the report are from CDC’s Pregnancy Mortality Surveillance System (PMSS). PMSS collects data on pregnancy-related deaths through state health departments, maternal mortality review committees, the media, and individual providers. Improved identification of pregnancy-related deaths in recent years has likely led to the reported increase in the pregnancy-related mortality ratio. However, the report authors say that pregnancy-related deaths are still underreported and that the number of deaths related to pregnancy may increase significantly with more active surveillance.
“Complete and consistent reporting involves a thorough review of the medical and social circumstances of every pregnancy-related death so that we can better understand the effects of medical care, socioeconomic status, prenatal care, social environment, and lifestyle,” said Jeani Chang, an epidemiologist with CDC's reproductive health program and senior author of the report.

CDC is responding to the problem of complications and deaths related to pregnancy by collaborating with The Safe Motherhood Initiative, a broad coalition of agencies, organizations, and professionals to address research and policy issues on this topic. Learn more at http://www.safemotherhood.org/

Strategies to Reduce Pregnancy-Related Deaths: From Identification to Action is a guide to help states identify maternal deaths and develop prevention programs (for information on how to order, visit: http://www.cdc.gov/nccdphp/drh/02_pub_descript.htm#Strategies). Research continues on why black women are at greater risk than white women for maternal death.
For more information about CDC’s reproductive health program, visit www.cdc.gov/nccdphp/drh.

CDC RELEASES ATLAS OF STROKE MORTALITY --African-Americans are 1.4 times more likely to die of a stroke than whites, and more than twice as likely as

Hispanics and Native Americans to die of stroke, according to a new report released February 20 by the Centers for Disease Control and Prevention (CDC).

The *Atlas of Stroke Mortality* provides an extensive series of national and state maps depicting disparities in county-level stroke death rates for the five largest racial and ethnic groups in the United States – African-Americans, American Indians and Alaska Natives, Asians and Pacific Islanders, Hispanics and Caucasians. It presents data for adults ages 35 and older during the years 1991-1998, and shows geographic disparities in stroke deaths varied substantially among racial and ethnic groups.

"Stroke is the third leading cause of death in the United States, and these data highlight the disparities in stroke that exist in the United States," said HHS Secretary Tommy G. Thompson. "Prevention is key. It is important for all Americans to know the signs and symptoms of a stroke, to have their blood pressure measured and controlled if necessary, and to have the opportunity to engage in other activities which could reduce their risk of stroke including quitting smoking, being physically active and eating plenty of fruits and vegetables."

African-Americans are also more likely to die of stroke at an earlier age than other racial and ethnic groups. Among African-Americans, almost half of stroke deaths occurred before age 75, compared to 45 percent for Asians and Pacific Islanders, and 25 percent of stroke deaths among whites.

“Disparities as large as those reported in the *Atlas* tell us that scientific knowledge about the prevention of stroke is not yet being applied widely enough to communities,” said Dr. Julie Gerberding, CDC director. The *Atlas* provides health professionals and policy-makers an essential tool to target stroke prevention programs.”

The *Atlas* reports that the overall stroke death rate for adults ages 35 and older was 121 per 100,000 from 1991 to 1998. Stroke death rates for states ranged from a high of 169 per 100,000 in South Carolina to a low of 89 per 100,000 in New York State. On average, stroke death rates fell only 0.8 percent per year during 1991-1998.

The *Atlas* also highlights the differences in geographic patterns that exist among the racial and ethnic groups. For both blacks and whites the largest concentrations of counties with the highest stroke death rates were found in the Southeastern states and the Mississippi Delta region. Among Hispanics, the largest concentration of high-rate counties was observed in much of Texas and New Mexico. The highest rate of stroke deaths among American Indians and Alaska Natives was found in parts of Alaska, Oregon, Idaho and Montana. For Asians and Pacific Islanders the highest rates were found among counties in California, Nevada and the Pacific Northwest.

“This landmark document supports the elimination of health disparities, one of the two goals of the national health agenda, Healthy People 2010,” said Dr. George A. Mensah, head of the cardiovascular program at CDC. “With this information, public health

professionals will be able to tailor prevention policies and programs to the needs of communities with the greatest burden of deaths from stroke."

The *Atlas of Stroke Mortality* is the third in a series of CDC atlases on cardiovascular diseases published in collaboration with West Virginia University and the University of South Florida. Together with *Women and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality* (February 2000) and *Men and Heart Disease: An Atlas of Racial and Ethnic Disparities in Mortality* (June 2001). The publications inform concerned citizens, policy makers, and researchers at the local, state and national levels about the disparities in stroke and heart disease mortality.

For a free copy of the *Atlas of Stroke Mortality*, write to the National Center for Chronic Disease Prevention and Health Promotion, Stroke Atlas Project, Division of Adult and Community Health, 4770 Buford Highway, NE, MS K-47, Atlanta, Georgia 30341-3717; email cdcinfo@cdc.gov; or call 1-888-232-2306 (toll free inside the United States). To view interactive maps of stroke mortality or download sections of the Atlas, visit www.cdc.gov/cvh/maps.