THE CSTE WASHINGTON REPORT

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INSIDE THIS ISSUE

EDITOR'S NOTE: Domestic violence in the United States exacts a high cost --the health-related costs of rape, physical assault, stalking, and homicide by intimate partners exceed $5.8 billion each year. Of this total, nearly $4.1 billion are for direct medical and mental health care services and productivity losses account for nearly $1.8 billion, according to a report by the Centers for Disease Control and Prevention (CDC). Adressing these costs should be a high priority in the months and years ahead. Details are provided in this Washington Report.

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

HEARING HELD ON PUBLIC HEALTH SURVEILLANCE – The House Subcommittee on National Security, Emerging Threats and International Relations held a hearing earlier this week on pubic health surveillance. CSTE was invited to testify, but was unable to provide a suitable witness in the timeframe allotted. CSTE did, however, provide testimony for the hearing record. Other witnesses included Dave Fleming, MD, Deputy Director for Science, CDC; Mary Selecky, Secretary, Washington State Department of Health and President of ASTHO; Seth Foldy, MD, Commissioner Medical Director, City of Milwaukee and Chair of NACCHO's Information Technology Committee. The focus of the hearing was the status of U.S. public health surveillance, especially the status of a fully electronic disease reporting system. Subcommittee Members expressed concern that the nation is not fully prepared for a bioterrorist event and implied that they may mandate completion of a fully electronic, national public health surveillance system in 1-2 years via legislation. A possible vehicle for such legislation may be the Project Bioshield Act of 2003 (no bill number yet) which is due to be marked up in the House Energy and Commerce Committee on May 15th. Follow-up contact with Subcommittee staff indicated action this soon is probably unlikely – that the Subcommittee is more likely to give CDC additional time to implement NEDSS, PHIN, etc. However, CSTE will carefully monitor the situation.

OTHER LEGISLATIVE NEWS – On May 1st the House passed **H.R. 1298, the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003** which provides $15 billion from FY 2004-2008 to combat the global spread of these diseases, but particularly HIV/AIDS. Controversy surrounded the bill with regard to the emphasis on abstinence versus other preventive measures. Faith-based organizations are eligible for grants. The Senate will take up the measure soon.

Rep. Diana DeGette (D-CO), on May 1st, introduced **H.R. 1916**, **a bill to prevent and cure diabetes** and to promote and improve the care of individuals with diabetes for the reduction of health disparities within racial and ethnic minority groups. The bill already has 65 co-sponsors. It was referred to the Energy and Commerce Committee. No specific appropriation is provided for the CDC section of the bill, which is as follows:

(b) CENTERS FOR DISEASE CONTROL AND PREVENTION.
(1) IN GENERAL- The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall carry out culturally appropriate diabetes health promotion and prevention programs for minority populations.
(2) CERTAIN ACTIVITIES- Activities under paragraph (1) regarding culturally appropriate diabetes health promotion and prevention programs for minority populations shall include the following:

(A) Expanding the Diabetes Control Program (currently existing in all the States and territories).

`(B) Providing funds for the Diabetes Today program to adapt community planning tools within such populations.

`(C) Providing funds for Racial and Ethnic Approaches to Community Health (REACH 2010) grants to develop and evaluate diabetes prevention and control community programs focused on such populations.
`(D) Providing funds to community health centers for a monthly diabetes week program of diabetes services, including screenings.
`(E) Providing funds for free diabetes self-management education classes in hospitals, clinics, and community health centers.
`(F) Providing funds for education and community outreach on diabetes.
`(G) Providing funds for the United States and Mexico Border Diabetes project to develop culturally appropriate diabetes prevention and control interventions for Minority populations in the border region.
`(H) Providing funds for an aggressive prevention campaign that focuses on physical inactivity and diet and its relation to type 2 diabetes within such populations.
`(I) Providing funds for surveillance systems and strategies for strengthening existing systems to improve the quality, accuracy, and timelines of morbidity and mortality diabetes data for such populations.

Rep. Frank Pallone (D-NJ) introduced **H.R. 1496 , the Consumer Food Safety Act**, which has been referred to the Energy and Commerce Subcommittee on Health. The bill establishes a comprehensive program to ensure the safety of food products intended for human consumption which are regulated by the Food and Drug Administration. It declares that persons who produce or process food for human consumption are responsible for preventing or minimizing food safety hazards and mandates a national program to protect human health by ensuring that the food industry has effective safety programs for food consumed in the United States. It authorizes assistance to states to establish an enhanced food safety program and mandates inclusion of food in an active surveillance system and more accurate assessment of the frequency and sources of U.S. human illness associated with food. While Rep. Pallone is a member of the Subcommittee on Health , the bill currently has no Republican co-sponsors and does not have a Senate companion measure; it will need both to see additional action.

There has been no action on the following bills which have been covered in previous reports:

- H.R. 716 --Improved Nutrition and Physical Activity Act (IMPACT Act) - Amends the Public Health Service Act to address issues of overweight and obesity.
- H.R. 877, H.R. 663/S. 720 – Patient Safety measures

HHS TO RELEASE $100 MILLION TO ASSIST STATES WITH SMALLPOX VACCINATION PROGRAMS -- HHS Secretary Tommy G. Thompson announced May 5 that the department will release $100 million to the states to help them better prepare our nation for a possible smallpox attack and strengthen the public health infrastructure. The money from HHS' Centers and Disease Control and Prevention will be made available immediately. These funds are in addition to the $1.1 billion in fiscal year 2002 funds sent to states last year and the $1.4 billion in fiscal year 2003 money. Secretary Thompson will send letters to governors soon notifying them of the availability of the smallpox funds.

In March, Secretary Thompson announced that 20 percent ($280 million) of the $1.4 billion to be provided to states this year is available immediately to help them enhance preparations against terrorism or other public health emergencies, including smallpox vaccination for selected health workers and emergency responders. The remaining 80 percent will be released once states submit and HHS reviews work plans outlining their public health and hospital preparedness activities.

Overall, HHS is spending $3.5 billion this year for bioterrorism preparedness, including research into potential bioterror disease agents and potential treatments and vaccines. The fiscal year 2003 funding is up from about $1.8 billion for such activities in 2002.
"We continue to make unprecedented investments in our public health infrastructure," Secretary Thompson said. "This commitment better prepares America for any public health emergency, whether it is a smallpox attack or an emerging disease like SARS."
In December, President Bush announced the smallpox vaccination program in which HHS is working with state and local governments to vaccinate health care workers and other crucial personnel, as part of Smallpox Response Teams.

HHS OFFERS GUIDANCE ON AIR-FILTRATION, AIR-CLEANING SYSTEMS TO GUARD BUILDINGS AGAINST ATTACKS --HHS Secretary Tommy G. Thompson May 2 announced the release of new guidance to help facility specialists in business and government strategically select and use air-filtration and air-cleaning systems to protect occupants in buildings from chemical, biological, or radiological attacks.

Air-filtration and air-cleaning systems are critical tools for protecting workers and other building occupants from hazardous airborne materials. The guidelines will help building designers, building engineers, and others who make technical decisions to improve air filtration in buildings such as offices, retail facilities, schools, transportation terminals, indoor malls and sports arenas.

"This new document offers practical guidance for our partners in government and the private sector on selecting appropriate air-filtration and air-cleaning systems," Secretary Thompson said. "It is part of our broader, ongoing efforts to help strengthen emergency preparedness and protect public health across the country."

The HHS document, "Guidance for Filtration and Air-Cleaning Systems to Protect Building Environments from Airborne Chemical, Biological, or Radiological Attacks," was developed by the Centers for Disease Control and Prevention's (CDC) National Institute for Occupational Safety and Health (NIOSH), in collaboration with a working group at the White House Office of Homeland Security, now the Department of Homeland Security.

"In addition to enhancing emergency preparedness, these guidelines also have value for reducing risks of occupational respiratory illnesses, improving indoor air quality and reducing maintenance and operating costs," NIOSH Director Dr. John Howard said. "By selecting and maintaining the right filtration and cleaning systems, building operators can keep the air inside their workplaces cleaner, improve the efficiency of their ventilation systems and help reduce workers' risks for occupational asthma, allergy and other respiratory illnesses," he said.

The document recognizes the many complicated issues involved in choosing an appropriate filtration and cleaning system. Decisions appropriate for one building may not be appropriate for all buildings. Building engineers and managers need to assess different factors that will help them make the best decisions for particular situations. These factors include the intended use of the system, prevention of "filter bypass" or leakage around filters, life-cycle costs for the system and the potential for air leakage through the walls of the building.

According to the guidance, key steps for selecting and using appropriate filtration and cleaning include:

* Identifying the types of filtration and cleaning systems that are effective against various chemical, biological and radiological agents, and determining what types are appropriate for use at a given location.
* Identifying the types of systems that can be added on to an existing heating, ventilation and air-conditioning system to increase protection against chemical, biological and radiological agents.
* Determining the types of systems that can be added on to existing buildings when the buildings undergo comprehensive renovation.
* Deciding how to maintain filtration and cleaning systems properly once they are installed.

The guidelines supplement a May 2002 HHS report on safeguarding buildings against chemical, biological and radiological threats. The earlier report provided broad guidance about many aspects of ventilation systems; the new guidelines focus specifically on filtration systems, which remove particles from the air, and cleaning systems, which remove gases and vapors.

The new document, DHHS (NIOSH) Publication No. 2003-136, is available on the NIOSH Web site at www.cdc.gov/niosh. Printed copies will be available shortly by

calling toll-free 1-800-35-NIOSH (1-800-356-4674) or e-mail pubstaft@cdc.gov. The May 2002 report, "Guidance for Protecting Building Environments from Airborne Chemical, Biological, or Radiological Attacks," DHHS (NIOSH) Publication No. 2002-139, is available at http://www.cdc.gov/niosh/bldvent/2002-139.html.

HHS TO AWARD $80 MILLION TO STATES TO OFFSET COSTS OF INSURANCE FOR RESIDENTS TOO SICK FOR CONVENTIONAL COVERAGE --HHS Secretary Tommy G. Thompson April 28 announced the availability of $80 million in grants for states that provide health insurance to residents who cannot get conventional health coverage because they are too sick.

The grants would be used by states to offset losses they may incur operating high-risk pools, which are typically state-created non-profit association that offers health coverage to individuals with serious medical conditions. Enrollment in these pools is growing, with more than 153,000 individuals enrolled in state pools.

"These grants will make it more affordable for states to expand access to health care through high risk pools for the uninsured," Secretary Thompson said. "Individuals who benefit from these pools usually have a history of health problems that make it extremely difficult to find affordable health coverage in the individual market."

The funding announced today will be awarded over two years, as authorized in the Trade Adjustment Assistance Reform Act of 2002. To be eligible, a state must have a "qualified" high-risk pool that meets the criteria specified in the Trade Act and must follow such rules as capping premiums at no higher than 150 percent of the standard charge in the state. States may be eligible for a grant that matches up to 50 percent of the losses incurred in the operation of the risk pools. Funds will be distributed based on the number of uninsured individuals in each state. HHS' Center for Medicare & Medicaid Services (CMS) will administer the program.

To date, 22 states have high-risk pools that meet the "qualified" criteria. In November, HHS also announced the availability of grants of up to $1 million each for states to use as seed money to establish high-risk pools. A total of $20 million is available under that program.

The grants to support state high-risks pools are one piece in the Bush Administration's broad strategy for expanding access to health care for the more than 40 million Americans without health insurance. The President's fiscal year 2004 budget plan would expand community health centers that care for the uninsured, strengthen and modernize the Medicaid program, offer health tax credits to help individuals obtain insurance, and extend Medicaid and State Children's Health Insurance Program (SCHIP) coverage to more Americans who otherwise would go without coverage.

"Getting health insurance to the uninsured has been a high priority of the Bush Administration," said CMS Administrator Tom Scully. "These new grants for high-risk

pools will help get coverage to people who otherwise would not have access to health care."

Information about this new program and how states may apply for a grant will be included in a final rule with comment period to be published May 2 in the Federal Register. More information about risk pools is available at www.cms.hhs.gov/riskpool. More information about the President's initiatives to help the uninsured is available at http://www.hhs.gov/news/press/2003pres/20030211.html

CDC REPORTS THE HEALTH-RELATED COSTS OF INTIMATE PARTNER VIOLENCE AGAINST WOMEN EXCEEDS $5.8 BILLION EACH YEAR IN THE UNITED STATES --The health-related costs of rape, physical assault, stalking, and homicide by intimate partners exceed $5.8 billion each year. Of this total, nearly $4.1 billion are for direct medical and mental health care services and productivity losses account for nearly $1.8 billion, according to a report by the Centers for Disease Control and Prevention (CDC). The report is being released in conjunction with the CDC Injury Center's national conference, "Safety in Numbers."

"Violence against women harms more than its direct victim. It also harms the children, the abuser and the entire health of all our families and communities. For the health of our country, it is critical that we stop this cycle now," Health and Human Services Secretary Tommy G. Thompson stated. "Just last week, the Department hosted a meeting of the National Advisory Committee on Violence Against Women and shared the many Department programs that are making a profound difference, providing the support and healing they need to rebuild their lives."

CDC Director Dr. Julie Gerberding added, "Violent acts against women don't end with visits to the emergency room. They are a major public health problem that we are committed to preventing. Intimate partner violence costs women and their families a high-price financially, physically and emotionally. We must continue to do all we can to prevent the pain, anguish and health problems that result from intimate partner violence." The report estimates the incidence, prevalence and health-related costs of non-fatal and fatal Intimate Partner Violence (IPV) against women. It also identifies future research needs and highlights CDC priorities for IPV prevention research. IPV is defined as violence committed by a spouse, ex-spouse, current or former boyfriend or girlfriend. "CDC is actively involved in ongoing efforts to prevent violence against women," said Sue Binder, M.D., CDC Injury Center Director." This report provides information that is crucial in helping communities demonstrate the impact violence against women has on society."

CDC researchers examined the data from the 1995 National Violence Against Women Survey for the incidents of IPV, the costs, how health care was used, and how much work-related time was lost for women who were assaulted by intimate partners. This report reflects the most current and reliable data that is available on IPV and its related health costs.

Because of the data limitations, the costs presented in the report likely underestimate the economic burden of IPV in the United States. The report points out that these cost figures are not comprehensive, excluding such important costs as those related to the legal and justice systems. Therefore, the costs should not be used for analyzing benefit-cost ratios for IPV prevention programs. However, the report may be useful in calculating the health-related cost savings from reducing IPV and associated injuries and for evaluating the impact of IPV on specific sub-sectors of the economy, such as consumption of medical resources.

The full report on the Costs of Intimate Partner Violence Against Women in the United States is available online at: http://www.cdc.gov/ncipc/pub-res/ipv_cost/ipv.htm.

FDA AND LINCOLN TECHNOLOGIES, INC. TO COLLABORATE ON DEVELOPING TOOLS FOR SAFETY DATA MINING --The Food and Drug Administration (FDA) announced May 1 the establishment of a Cooperative Research and Development Agreement (CRADA) with Lincoln Technologies, Inc. The purpose of this partnership is to use data mining—a promising new technology–to enhance FDA's ability to monitor the safety of drugs, biologics and vaccines after they have been approved for use.

Data mining is a technique for extracting meaningful, organized information from large complex databases. The CRADA involves data that FDA already collects about adverse events involving approved drugs, biologics and vaccines. The specific data set used for data mining purposes does not include patient names, addresses, social security numbers or similar information.

Data collected from suspected drug-related adverse event reports and other electronic medical information could aid the FDA in identifying "signals" of adverse events and the patterns in which they occur. The more effective the tools FDA can use to detect such patterns, the faster it can act to evaluate and act on these reports as appropriate. For example, more effective data mining might allow the agency to identify a pattern of adverse events in a specific population of patients taking a drug, or in patients who take a certain combination of drugs, and the agency could then communicate this knowledge sooner to medical professionals and patients – preventing more adverse events. "Preventing adverse events associated with medical products is one of FDA's top priorities," said the Commissioner of Food and Drugs, Mark B. McClellan, M.D., Ph.D. "By making greater use of state-of-the-art statistical tools coupled with 21st-century medical information systems, we can act more quickly and effectively to prevent adverse events."

FDA will continue to monitor the marketplace to ensure that products purporting to be dietary supplements are labeled properly and that claims being made for these types of products are not false or misleading.

The CRADA is expected to improve the utility of safety data mining technology. The FDA's Center for Drug Evaluation and Research (CDER) and Center for Biologics Evaluation and Research (CBER) will work with Lincoln Technologies, Inc., to develop new and innovative ways for extracting information related to drug safety and risk assessment.

AHRQ REPORT DESCRIBES ENHANCEMENTS TO HEALTH CARE WORKING CONDITIONS THAT COULD IMPROVE PATIENT SAFETY -- Increasing nurse staffing levels in acute-care hospitals and nursing homes and enhancing systems for communicating between hospitals and other health care settings are among the strategies that are likely to lead to improved patient safety, according to a new evidence report summary released today by the Agency for Healthcare Research and Quality. A summary of the report is available on the AHRQ Web site at http://www.ahrq.gov/clinic/epcsums/worksum.htm and from the National Guideline Clearinghouse™ at http://www.guideline.gov (select "NGC Resources"). The full report will be available later this spring.

The report, developed for AHRQ by the Oregon Health & Science University Evidence-based Practice Center, details the effects of health care working conditions on patient safety. Based on a review of 115 existing studies conducted in health care and non-health care settings, the report concluded that there is enough evidence in the scientific literature to make specific recommendations about these strategies for improving patient safety. The researchers also found that when complex procedures are performed by physicians who do them frequently, preventable complications are less likely. In addition, they found that fewer interruptions and distractions to staff can reduce errors and that systems to improve information exchange and "handing off" care between hospital and nonhospital settings can decrease medication errors.

However, researchers found that there is insufficient evidence to draw clear conclusions for several other specific working conditions, including workplace stress, lighting conditions, and several organizational factors.

Beginning in 2001, AHRQ began funding a large portfolio of patient safety research projects to address key unanswered questions about how errors occur and provide science-based information on what patients, clinicians, hospital leaders, policymakers and others can do to make the health care system safer. The results of this research will identify strategies to improve the quality of care in hospitals, doctors' offices, nursing homes, and other health care settings across the nation, including home care. Prominent among these projects are a number focusing specifically on working conditions that will address some of the issues this new report cites as needing further research. For example, some projects are examining the impact of nurses' stress and fatigue on patient safety and potential interventions that could enhance patient safety. AHRQ has published a fact sheet summarizing the working conditions research projects in AHRQ's portfolio, which is available at http://www.ahrq.gov/news/workfact.htm.