THE CSTE WASHINGTON REPORT

Marcia S. Mabee, MPH, PhD
Editor
11479 Waterview
Reston, Virginia 20190
mmabee@ix.netcom.com
703-709-3001

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INSIDE THIS ISSUE

EDITOR'S NOTE: The Centers for Disease Control and Prevention (CDC) July 17 released new guidelines aimed at helping healthcare professionals communicate with their HIV infected patients about what they can do to prevent transmitting the virus to others. The guidelines, the first of their kind, were published in the July 18, 2003, issue of *Morbidity and Mortality Weekly Report*. "It's time we merge prevention services for HIV-infected persons into the mainstream of medical care," said Julie L. Gerberding, MD, MPH, CDC director. "These guidelines provide a much-needed roadmap for medical

professionals that allows them to work more closely with their HIV-infected patients to reduce HIV transmission." Details about the new guidelines are provided in this Washington Report.

Due to the August Congressional recess, the next Washington Report will be published in September

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

SENATE TO ACT IN SEPTEMBER ON APPROPRIATIONS – The Senate FY 2004 Labor-HHS-Education Appropriations bill (S. 1356), which funds all of CDC and most of the other public health agencies, will not take up the bill on the floor until after the traditional August Congressional recess. The House adjourned for the recess on July 25th, the Senate is expected to adjourn on August 1st. The Senate had planned to take up the bill last week, but controversy over an amendment to block implementation of new Labor Department regulations changing worker eligibility for overtime payment held up the bill. It is now expected to be taken up early in September. The House passed its corresponding bill (H.R. 2660) on July 10th.

PATIENT SAFETY LEGISLATION PASSES SENATE HELP COMMITTEE – The Senate Health, Education, Labor and Pensions (HELP) Committee unanimously voted out S. 720, the "Patient Safety and Quality Improvement Act of 2003." The bill is similar to a House bill (H.R. 663) which passed the House on March 12th. Both bills include provisions requiring the Secretary to develop or adopt voluntary national standards that promote interoperability of health care information technology systems. The House sets an 18 month deadline for this provision; the Senate 36 months. The House bill is generally more detailed, creating a grant program to foster provider adoption of technology, and to test standards. It also creates a Medical Information Technology Advisory Board whose Chairman must be a member of the National Committee on Vital Statistics and whose 17 members must be drawn from various provider and industry categories, but does not include a state or local public health representative. The Senate bill is likely to be altered on the Senate floor to comport more closely with the House bill.

Meanwhile, Rep. Nancy Johnson (R-CT), Chair of the House Ways and Means Health Subcommittee introduced H.R. 2915 on July 25th which provides for a National Health Information Infrastructure and data communications standards for health information system interoperability. Provisions of the bill call for the appointment of a national health information officer who will be responsible for developing and maintaining on-going national leadership in the planning, development and adoption of a national health information infrastructure. The officer, in conjunction with stakeholders, is tasked with developing a strategic plan that will include a national agenda to guide policymaking, technology investments, research and integration with ongoing public health, healthcare, and health information technology activities. One of the specific goals of the national health information infrastructure is the following: "(5)

to establish a compatible information technology architecture that increases health care quality and cost-savings, enhances security of information, and avoids the financing and development of health information technology systems that are not readily compatible." The list of collaborating stakeholders includes a representative of a state or local health department. The bill has been referred to the House Energy and Commerce Committee.

SENATE HELP COMMITTEE HOLDS HEARING ON FEDERAL BIODEFENSE READINESS – CDC's Director, Dr. Julie Gerberding, testified before the Senate Health, Education, Labor and Pensions (HELP) Committee on July 24th on progress CDC has made in preparing for terrorist attacks involving biological, chemical, or radiological agents, or mass trauma. Her full testimony can be read at: http://labor.senate.gov/testimony/072_tes.html Her remarks on the Public Health Workforce follow. CSTE is working with Sen. Hillary Rodham Clinton (D-NY), a member of the HELP Committee, on a possible public health workforce amendment to the FY 2004 Labor-HHS-Education Appropriations bill.

"The recently released report of the Partnership for Public Service entitled "Homeland Insecurity: Building the Expertise to Defend America from Bioterrorism" pointed to the critical need of addressing the Biodefense Workforce. CDC recognizes that a significant challenge exists in developing and retaining a qualified and competent workforce to address the needs both at CDC and within Local and State Health Departments. In fact, nearly half of CDC's physicians and biologists will be eligible, although only 10% will actually take early retirement, for retirement in the next five years and it has been estimated that one-quarter of all government employees will be eligible within that same time period. In order to prepare for these retirements and to increase the overall number of qualified and competent workers in public health preparedness and research, we are looking to new strategies for recruitment and retention of scientists, physicians, emergency planners/responders, and managers. Successful programs like the Epidemic Intelligence Service, the Preventive Medicine Residency and the Public Health Prevention Service can assist in addressing this issue and we are looking into new strategies to reach out to fill laboratory diagnostic and critical research positions.

Prior to September 11, 2001, CDC had a total of 174 FTEs designated to support bioterrorism activities. Internally at CDC in FY03, 444 staff are now employed in various skills sets to support terrorism preparedness and response. In FY04, this will increase to 529. CDC has increased to 64 the number of field staff (epidemiologists and public health advisors) assigned to State and Local Health Departments. CDC is planning to move additional staff into the field and has been given authority to assign CDC staff to State and Local Health Departments as FTE exempt. Through the state and local grant program, at least 3,850 people have been funded (in part or whole) within the past 18 months to support (scientific, programmatic, administrative) public health preparedness activities.

A competent and sustainable workforce is one of the strategic imperatives within CDC's National Strategy for Terrorism Preparedness and Emergency Response. CDC's support to address this imperative will focus on:

• Increasing the number and type of professionals that comprise a preparedness and response workforce.

• Delivery of certification and competency based training.

• Recruitment and retention of the highest quality workforce.

• Evaluation of the impact of training on workforce competency.

• Support for Schools of Public Health, Medicine and other Academic partners to increase the number of individuals entering the field and trained throughout their career. Currently, CDC funds Academic Centers for Public Health Preparedness at Schools of Public Health to address workforce training and "workforce pipeline" issues."

Through the CDC State and Local Preparedness Program, CDC made funds available to each grantee, and charged them with training and educating their public health workforce regarding preparedness and response activities. CDC is also the home of the Public Health Training Network (PHTN) and National Laboratory Training Network (NLTN) using distance learning mechanisms as the framework for delivery of training to the widest possible audience across the public health system. CDC also provides funds through the National Association of City and County Health Officials (NACCHO) to support "Public Health Ready," a pilot program to develop and test competencies of the local public health workforce, in 11 local health agencies.

UPDATE TO SARS CASE DEFINITION REDUCES US CASES BY HALF --The Centers for Disease Control and Prevention (CDC) has dropped the number of SARS cases in the United States by half (49.5%) to a total of 211. The new tally, reported in the July 17 Morbidity and Mortality Weekly Report (MMWR), includes 175 suspect cases and 36 probable cases, down from 344 suspect and 74 probable cases reported on July 15. The change results from excluding cases in which blood specimens that were collected more than 21 days after the onset of illness test negative for SARS-associated coronavirus (SARS-CoV). Exclusion of these cases with negative convalescent serum provides a more accurate accounting of the epidemic in the US.

The Council of State and Territorial Epidemiologists, an association of public health professionals in US states and territories, recommended the change in the US SARS case definition to allow for exclusion of cases with negative convalescent serum specimens. This recommendation is based on scientific data which indicate that 95% of SARS patients mount a detectable convalescent antibody response.

Additionally, the MMWR recommends changing the timing for collecting convalescent-phase serum specimens to test for antibody to SARS-CoV from 21 or more days to 28 or more days after the onset of illness. This recommendation comes following analysis of

recent data which indicate that some persons with SARS-CoV infection may not mount a detectable antibody response until 28 days after the onset of illness. However, testing results from serum previously collected between 22 and 28 days are acceptable and will not require collection of an additional sample.

CDC lifted all travel alerts related to SARS between July 1 and 15. With removal of all SARS travel alerts and completion of an incubation period (10 days), U.S. travelers with respiratory illness will no longer meet the current case definition for SARS. Reports of suspect or probable cases, therefore, are expected to end by July 31, 2003.
For more information about the SARS case definitions, see the CDC web site at http://www.cdc.gov.

HHS CREATES FOOD SECURITY RESEARCH PROGRAM, INCREASES IMPORT EXAMS MORE THAN FIVE TIMES TO PROTECT NATION'S FOOD SUPPLY -- HHS Secretary Tommy G. Thompson July 23 announced $5 million in funding to support a new research program to develop technologies and strategies to prevent and minimize potential threats to the safety and security of the nation's food supply. The announcement came as HHS' Food and Drug Administration (FDA) issued a new report highlighting the department's progress toward enhancing the nation's food security -- including a more-than-five-fold increase in the number of imported food examinations.

"Americans need to feel secure that the food they eat is safe and healthy," Secretary Thompson said. "We are investing unprecedented time, energy and resources to make sure the food that goes from our nation's ports and food facilities to our families' dinner tables is safe. While we have made significant improvements over the last two years, we are building on our success by working harder to enhance security, including many more food inspections at our borders."

The new report, submitted by FDA Commissioner Mark D. McClellan to Secretary Thompson, highlights the department's progress in making the food supply safer and more secure, in 10 critical focus areas.

For example, for fiscal year 2003, FDA has quintupled the number of imported food examinations it conducted in fiscal year 2001 -- reaching 62,000 inspections so far this year, compared with 12,000 in all of fiscal year 2001. The increase exceeds the agency's goal.

The increased coverage reflects a steep increase in the number of ports of entry with FDA staffing from 40 to 90; FDA's intensive efforts during a period of heightened security alert earlier this year (Operation Liberty Shield); and enhanced collaboration with other government agencies to protect the food supply more efficiently.
This progress stems in large measure from the $96 million increase in the agency's food-security budget achieved by Secretary Thompson in fiscal years 2002 and 2003. Those additional resources enabled FDA to hire 655 new field personnel that work almost

exclusively on food security and food safety. President Bush's fiscal year 2004 budget requests another $116.3 million to further protect the nation's food supply.

"We will continue to maximize our efforts to give Americans the most protection possible from deliberate or accidental food risks," Dr. McClellan said. "That includes not only using the best ideas that science has to offer, but seeking out still better ideas and methods."

The $5 million in new research funding is being made available from the post-9/11 Emergency Response Fund. The White House Office of Management and Budget is allocating these funds to the FDA, which will use them for food security research, including efforts to develop new prevention and mitigation technologies and to improve the ability to assess foods for contamination with chemical, biological and radiological agents.

The research program, expanded food inspections and border resources are part of Secretary Thompson's comprehensive approach to enhancing food security. FDA's progress report highlights efforts in 10 critical focus areas, reflecting a five-pronged strategy to ensure the safety and security of the roughly 80 percent of the nation's food supply under its jurisdiction.

The strategy involves (1) developing increased awareness among federal, state, local and tribal governments and the private sector by collecting, analyzing and disseminating information and knowledge to reduce vulnerabilities; (2) developing capacity for rapid identification of a specific threat or attack on the food supply if one occurs; (3) developing effective protection strategies to "shield" the food supply from terrorist threats; (4) developing capacity for rapid, coordinated response to a foodborne terrorist attack, including "surge capacity" and the ability to contain the attack quickly; and (5) developing capacity for rapid, coordinated recovery from a foodborne terrorist attack.

The events of September 11, 2001, heightened the nation's awareness and placed a renewed focus on ensuring the protection of the nation's critical infrastructures such as the food supply. One of the first actions FDA undertook was to increase surveillance and inspections of food imports and food establishments. Of the new 655 field personnel trained in food safety activities, 300 are specifically involved in investigations at U.S. ports of entry.

Other highlights from the progress report include:

* HHS has already proposed four regulations to implement provisions of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 and is working to finalize them based on the public comments received. The proposals would require registration of food facilities, advance notice of food imports and improved record-keeping for imported foods and would provide FDA with the authority to detain food

when there is credible evidence that it poses a threat of serious adverse health consequences or death.

* In order to assist industry and involve them in FDA's mission of protecting the food supply, the agency has issued five guidance documents which recommend steps companies throughout the food industry, from the largest manufacturers to the smallest retailers, can consider to minimize the risk that food under their control will be subject to any criminal or terrorist attack.

* FDA has redirected existing research and laboratory staff to ensure that appropriate resources are focused on key food safety and security issues. The agency has also developed laboratory methods involving priority biological and chemical agents in food.

* FDA has expanded its collaborations with the Department of Homeland Security and other law enforcement and intelligence agencies on research, emergency response and information exchange. This includes new collaboration with Customs and Border Control to collect and exchange information on imports, and to work more closely together on evaluating imports.

The full progress report is available at http://www.fda.gov/oc/initiatives/foodsecurity/.

NEW GUIDELINES AIM TO HELP HEALTH CARE PROVIDERS INCORPORATE HIV PREVENTION INTO ONGOING CARE OF PERSONS LIVING WITH HIV -- The Centers for Disease Control and Prevention (CDC) July 17 released new guidelines aimed at helping healthcare professionals communicate with their HIV infected patients about what they can do to prevent transmitting the virus to others. The guidelines, the first of their kind, were published in the July 18, 2003, issue of *Morbidity and Mortality Weekly Report*.

"It's time we merge prevention services for HIV-infected persons into the mainstream of medical care," said Julie L. Gerberding, MD, MPH, CDC director. "These guidelines provide a much-needed roadmap for medical professionals that allows them to work more closely with their HIV-infected patients to reduce HIV transmission."
The guidelines resulted from a collaboration of three Department of Health and Human Services agencies: CDC, the National Institutes of Health (NIH), and the Health Resources and Services Administration (HRSA), and the HIV Medicine Association of the Infectious Diseases Society of America.
The audience for the new guidelines includes physicians and physician assistants, nurses, social workers and others who work in medical settings and provide care to persons living with HIV. The guidelines call for:

* **Screening patients for risk of HIV transmission.** Recommended screening practices include using questionnaires and interviews to assess risk behaviors as well as testing for sexually transmitted diseases (STDs) when appropriate. The guidelines

recommend talking to female patients about the possibility of pregnancy to help prevent mother-to-child HIV transmission.

* **Delivering prevention interventions.** Health care providers can help reduce their patients' risk of transmitting HIV through such strategies as delivering prevention messages, providing condoms and printed information, and, when appropriate, referring patients to outside prevention services.

* **Partner counseling and referral services.** The guidelines encourage health care professionals to determine whether patients have notified partners of their infections and to help patients contact local health departments to arrange for partners who have not already been informed to be notified. The guidelines emphasize the importance of reaching partners with counseling and testing services.

"With an estimated 900,000 people in our country living with HIV, prevention strategies for HIV-infected individuals are essential," said Harold Jaffe, MD, director of CDC's National Center for HIV, STD and TB Prevention. "Health care professionals provide a critical link to HIV prevention information and services. They can help equip HIV-infected individuals with the best tools to protect their health and the health of their partners."

While research has shown that some people who are aware of their HIV infections tend to reduce risky behavior, recent reports suggest that many have difficulty sustaining those behavior changes. At the same time, medical professionals who care for HIV-infected patients have not had clear guidance on how to help patients maintain safe behaviors and protect their partners.

HHS TO LAUNCH MEDICARE DEMONSTRATION TO PROMOTE HIGH QUALITY CARE IN HOSPITALS -- HHS Secretary Tommy G. Thompson July 10 announced a new Medicare demonstration program that will use financial incentives to encourage hospitals to provide high quality inpatient care.

The demonstration involves Premier Inc., a nationwide organization of not-for-profit hospitals, and will reward participating hospitals that provide high quality care by increasing their payment for Medicare patients. Participating hospitals will report quality data that CMS will use to determine high-performing hospitals.
"We are expanding our hospital quality initiative by creating a new demonstration program that will actually reward hospitals with higher Medicare payments when they deliver the best quality care," Secretary Tommy G. Thompson said. "There is no more pressing concern for the American health care system than improving the quality of care we provide. Improving quality of care not only enhances patients' lives. It saves lives."
Under the demonstration, a hospital can receive bonuses based on quality measures selected for inpatients with specific clinical conditions: heart attack, heart failure, pneumonia, coronary artery bypass graft and hip and knee replacements. Measures include prescription of aspirin for heart attack and bypass graft patients and timely

administration of antibiotics for pneumonia patients, which are commonly accepted as relevant to improved outcomes.

Hospitals will be scored on the quality measures related to each condition, and those hospitals in the top 10 percent for a given condition will be given a 2 percent bonus on their Medicare payments. Hospitals in the second 10 percent will be given a 1 percent bonus. Hospitals in the remainder of the top 50 percent will be given recognition for their quality but no bonus.

Medicare will pay bonuses totaling $7 million per year for a total of $21 million during the life of the three-year demonstration. HHS' Centers for Medicare & Medicaid Services (CMS) will oversee the demonstration.

"The costs of this demonstration will be partly offset by reductions in medical costs, especially in reductions of unnecessary hospital readmissions because of better care in the initial inpatient stay," CMS Administrator Tom Scully said. "At the same time patients will be getting better care, so everybody wins, the patients, the hospitals and the Medicare program."

Information about participating hospitals' performance under the demonstration will be posted on the CMS Web site and made available to health care professionals and consumers.

Premier Inc. is a group purchasing organization of about 1,500 hospital facilities. About 500 of those facilities currently track and report quality of care data through Premier's system. Premier expects about 300 hospitals to participate in the Medicare demonstration.

HHS, REPUBLIC OF KOREA EXPAND COOPERATION ON INFECTIOUS DISEASES RESEARCH -- HHS Secretary Tommy G. Thompson July 22 signed a Memorandum of Understanding (MOU) with Korean Minister of Health and Welfare Hwa-Joong Kim to promote enhanced United States-Korea cooperation in vaccine-preventable and infectious disease research.

The MOU, signed during Minister Kim's visit to Washington, D.C., calls for an expansion of collaboration across a broad range of mutual interests, including laboratory science and research, tuberculosis, vaccine-preventable and other infectious diseases, epidemic investigation and surveillance, bioterrorism, gender and global health, chronic diseases, environmental and occupational health and public health law.

"Today, we strengthen the ties of our friendship with this Memorandum of Understanding," Secretary Thompson said. "As we jointly tackle enhanced infectious disease research, we'll be doing more than just strengthening our own ties -- we'll be creating a healthier global community."

In the MOU, specific actions include development of a joint working group to discuss public health emergency preparedness and bioterrorism, exchanges of scientists and trainees, and other coordinated scientific research programs.