

THE CSTE WASHINGTON REPORT

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

September 11, 2003

Volume 7, Number 17

INSIDE THIS ISSUE

... SENATE FINISHES FY04 LABOR-HHS-ED APPROPRIATIONS

... NEW BILLS INTRODUCED

... HHS ANNOUNCES NEW REGIONAL CENTERS FOR BIODEFENSE
RESEARCH

... INFLUENZA VACCINE SUPPLY EXPECTED TO MEET DEMAND

... 22 MILLION IN U.S. SUFFER FROM SUBSTANCE DEPENDENCE OR ABUSE

... AHRQ STUDY IDENTIFIES KEY SYMPTOMS DIFFERENTIATING INHALED
ANTHRAX FROM FLU

... DR. HENRY FALK TO LEAD CDC'S NATIONAL CENTER FOR
ENVIRONMENTAL HEALTH/ATSDR

EDITOR'S NOTE: In 2002, an estimated 22 million Americans suffered from substance dependence or abuse due to drugs, alcohol or both, according to the newest results of the Household Survey released September 5 by the Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services (HHS). There were 19.5 million Americans, 8.3 percent of the population ages 12 or older, who currently used illicit drugs, 54 million who participated in binge drinking in the previous 30 days, and 15.9 million who were heavy drinkers. The report highlights that 7.7 million people, 3.3 percent of the total population ages 12 and older, needed treatment for a diagnosable drug problem and 18.6 million, 7.9 per cent of the population, needed treatment for a serious alcohol problem. Only 1.4 million received specialized substance abuse treatment for an illicit drug problem and 1.5 million received treatment for alcohol problems. Over 94 percent of people with substance use disorders who did not receive

treatment did not believe they needed treatment. Additional details on this important new study 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>

SENATE FINISHES FY04 LABOR-HHS-ED APPROPRIATIONS – The Senate finished work on its version of the FY 2004 Labor-HHS-Education Appropriations bill last night and voted for the final bill 94-0. The House finished work on its bill July 10th. The differing versions will now need to be worked out in conference. The biggest stumbling block to the conference work is an amendment adopted into the Senate bill which eliminates funding for the Labor Department to implement new overtime regulations. Proposed regulations had been strongly opposed by Labor organizations. The White House has vowed to veto any final bill which includes the labor provision. A similar amendment offered during the House debate failed by only three votes.

During the Senate debate a large number of amendments were offered. Most of those addressing health programs failed including a Clinton (D-NY) amendment to add \$93.2 million to CDC and HRSA to bolster public health workforce training. CSTE had expressed its support for the effort which was aimed, in part, at increasing the numbers of state-based epidemiologists. Other amendments that failed would have added \$400 million for the Ryan White AIDS programs, and \$50 million for the Section 317 immunization program. An amendment by Sen. Landrieu (D-LA) to increase funding for West Nile Virus and the newly enacted Mosquito Abatement Safety and Health Act (P.L. 108-75) failed. An amendment to add an additional \$1.5 billion for the National Institutes of Health by designating the increase emergency spending and therefore not subject to the spending caps, also failed. A few, small health amendments did succeed including a \$10 million increase for the newborn and child screening for heritable disorders; \$5 million to fund the rural emergency medical services training and equipment program; funding to prevent mother to child HIV transmission, \$500,000 for an IOM and a GAO study of the program established under the Mammography Quality Standards Act.

Meanwhile the House of Representatives debated the FY 2004 Transportation/Treasury Appropriations Bill this week. Public health groups joined recreation and environmental groups to oppose an effort by Subcommittee Chairman Ernest Istook (R-OK) to repeal a long-standing provision in transportation law requiring minimum set asides for rail trails, pedestrian walkways and historic preservation. The outcry that ensued caused Istook to withdraw the repeal, but then he worked to eliminate all funding for the provision. An amendment on the House floor to restore the funding won by an overwhelming majority of 327 to 90.

NEW BILLS INTRODUCED – Rep. Sherrod Brown (D-OH) Ranking Minority Member of the House Subcommittee on Health introduced the School Nutrition

Antibiotic Safety Act (H.R. 3022) on September 5th. The bill requires the Secretary to establish procedures that will ensure that chickens and chicken products purchased for the federal school breakfast, lunch and summer food service programs have not been fed or administered a fluoroquinolone. The bill has been referred to the House Education and the Workforce Committee.

Sen. Snowe (R-ME) has introduced the Harmful Algal Blooms and Hypoxia Research Control Act (S. 247). The bill would reauthorize and amend the original Act, providing funding totally approximately \$50 million for FY 2004 through 2008. It also would make the Inter-Agency Task Force on Harmful Algal Blooms and Hypoxia (created in the 1998 Act) permanent, require that a Prediction and Response Plan be submitted to Congress within 12 months of enactment, and authorize the Secretary of Commerce to assist with local and regional assessments of hypoxia, toxic algae, and harmful algal blooms. It also would require the Inter-Agency Task Force on Harmful Algal Blooms and Hypoxia to conduct a scientific assessment of Great Lakes harmful algal blooms within 24 months of enactment and a scientific assessment of hypoxia in United States coastal waters, including the Great Lakes, not less than once every five years, with the first assessment within 24 months of enactment. A similar House bill (H.R. 1856), introduced by Rep. Ehlers (R-MI) has been referred to two Committees, with the Science Committee reporting it out on 7/22. The bill is awaiting action in the House Resources Committee and is seeking comment from the House Energy and Commerce Committee.

HHS ANNOUNCES NEW REGIONAL CENTERS FOR BIODEFENSE

RESEARCH -- HHS Secretary Tommy G. Thompson September 4 announced grants totaling approximately \$350 million spread over five years to establish eight Regional Centers of Excellence for Biodefense and Emerging Infectious Diseases Research (RCE). This nationwide group of multidisciplinary centers is a key element in HHS' strategic plan for biodefense research.

"We have moved with unprecedented speed and determination to prepare for a bioterror attack or any other public health crisis since the terrorist attacks of 2001," Secretary Thompson said. "These new grants add to this effort and will not only better prepare us for a bioterrorism attack, but will also enhance our ability to deal with any public health crisis, such as SARS and West Nile virus." The National Institute of Allergy and Infectious Diseases (NIAID), a part of HHS' National Institutes of Health, is providing the grants and will administer the RCE program.

"Since the terrorist attacks on American soil in 2001, NIAID has moved rapidly to bolster basic biomedical research and the development of countermeasures to defend the United States against deliberately released agents of bioterrorism as well as naturally occurring infectious diseases," said Anthony S. Fauci, M.D., NIAID director. "The new RCE program provides a coordinated and comprehensive mechanism to support the interdisciplinary research that will lead to new and improved therapies, vaccines, diagnostics and other tools to protect the citizens of our country and the world against the threat of bioterrorism and other emerging and re-emerging diseases."

The RCE program's primary role is to foster the physical and intellectual environments in which wide-ranging research on infectious diseases can proceed productively and safely. All RCEs will:

- * Support investigator-directed research
- * Train researchers and other personnel for biodefense research activities
- * Create and maintain supporting resources, including scientific equipment and trained support personnel, for use by the RCEs and other researchers in the region
- * Emphasize research focused on development and testing of vaccine, therapeutic and diagnostic concepts
- * Make available core facilities to approved investigators from academia, government, biotech companies and the pharmaceutical industry
- * Provide facilities and scientific support to first responders in the event of a national biodefense emergency

Each center comprises a lead institution and affiliated institutions located primarily in the same geographical region. The eight institutions receiving an RCE grant and the principal investigator at each are:

- * Duke University, Barton Haynes, M.D.
- * Harvard Medical School, Dennis Kasper, M.D.
- * New York State Department of Health, Ian Lipkin, M.D.
- * University of Chicago, Olaf Schneewind, Ph.D.
- * University of Maryland, Baltimore, Myron Levine, M.D.
- * University of Texas Medical Branch (Galveston), David Walker, M.D.
- * University of Washington, Samuel Miller, M.D.
- * Washington University in St. Louis, Samuel Stanley, M.D.

Research to be conducted in the RCE program includes:

- * Developing new approaches to blocking the action of anthrax, botulinum and cholera toxins
- * Developing new vaccines against anthrax, plague, tularemia, smallpox and Ebola
- * Developing new antibiotics and other therapeutic strategies
- * Studying bacterial and viral disease processes
- * Designing new advanced diagnostic approaches for biodefense and for emerging diseases
- * Conducting immunological studies of diseases caused by potential agents of bioterrorism
- * Developing computational and genomic approaches to combating disease agents
- * Creating new immunization strategies and delivery systems

In addition to the eight RCEs, NIAID is funding two Planning Grants for Regional Centers of Excellence for Biodefense and Emerging Infectious Diseases (P-RCEs). The P-RCEs will support training, planning, research development and resource acquisition

that could lead to the future establishment of a regional center. The lead institutions and principal investigators of the P-RCEs are:

- * University of Iowa, Bradley Britigan, M.D.
- * University of Minnesota, Patrick Schlievert, Ph.D.

Additional information on NIAID's biodefense program is available at <http://www.niaid.nih.gov/biodefense/>.

INFLUENZA VACCINE SUPPLY EXPECTED TO MEET DEMAND --Sufficient supplies of flu vaccine should be available during the coming influenza season. The Centers for Disease Control and Prevention (CDC) predicts that everyone wanting to get a flu shot to avoid influenza, regardless of age or health status, should be able to get vaccinated as soon as vaccine becomes available in October.

CDC estimates that vaccine manufacturers will produce approximately 85.5 million doses of influenza vaccine during the 2003 influenza season. This projection represents 9.5 million fewer doses than were produced last year. However, influenza vaccine production is expected to exceed the estimated 79 million doses that were actually sold to providers in 2002.

"Influenza vaccination is the best way to prevent influenza and its severe complications," said Dr. Walter Orenstein, director of the CDC National Immunization Program. "The best time to be vaccinated against influenza continues to be October and November. However, vaccination in December or later can still be beneficial."

Production and distribution of the influenza vaccine was delayed in the years 2000 and 2001. These delays prompted CDC to recommend that people 65 years of age and older and people with health conditions that put them at high risk for complications from influenza be the first to receive the vaccine. This recommendation helped to ensure that an adequate vaccine supply was available to those at the greatest risk. Individuals without risk factors were asked to wait until November to receive their vaccinations. Influenza causes approximately 36,000 deaths and 114,000 hospitalizations each year. More than 90 percent of deaths occur among people age 65 and older.

22 MILLION IN U.S. SUFFER FROM SUBSTANCE DEPENDENCE OR ABUSE -
-In 2002, an estimated 22 million Americans suffered from substance dependence or abuse due to drugs, alcohol or both, according to the newest results of the Household Survey released September 5 by the Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services (HHS). There were 19.5 million Americans, 8.3 percent of the population ages 12 or older, who currently used illicit drugs, 54 million who participated in binge drinking in the previous 30 days, and 15.9 million who were heavy drinkers.

The report highlights that 7.7 million people, 3.3 percent of the total population ages 12 and older, needed treatment for a diagnosable drug problem and 18.6 million, 7.9 percent of the population, needed treatment for a serious alcohol problem. Only 1.4 million received specialized substance abuse treatment for an illicit drug problem and 1.5 million received treatment for alcohol problems. Over 94 percent of people with substance use disorders who did not receive treatment did not believe they needed treatment.

There were 362,000 people who recognized they needed treatment for drug abuse. Of them, there were 88,000 who tried but were unable to obtain treatment for drug abuse in 2002. There were 266,000 who tried, but could not obtain treatment for alcohol abuse.

"There is no other medical condition for which we would tolerate such huge numbers unable to obtain the treatment they need," HHS Secretary Tommy G. Thompson said.

"We need to enact President Bush's Access to Recovery Program to provide treatment to those who seek to recover from addiction and move on to a better life. That is what Recovery Month is all about."

The new 2002 Household Survey has been renamed the National Survey on Drug Use and Health. The survey creates a new baseline with many improvements. The annual survey of approximately 70,000 people was released as part of the kick-off for the 14th annual National Drug and Alcohol Addiction Recovery Month (Recovery Month) observance.

John Walters, White House Director of National Drug Control Policy, pointed out that "a denial gap of over 94 percent is intolerable. People need to understand the addictive nature of drugs and not presume that they are 'all right' when everyone around them knows better. Families and friends need to urge their loved ones to seek treatment when they experience the toll that addiction takes on loved ones and communities."

The 2002 survey found that marijuana is the most commonly-used illicit drug, used by 14.6 million Americans. About one third, 4.8 million, used it on 20 or more days in the past month. There was a decline in the number of adolescents under age 18 initiating use of marijuana between 2000 and 2001, according to the 2002 survey. There were 1.7 million youthful new users in 2001, down from 2.1 million in 2000. The percentage of youth ages 12-17 who had ever used marijuana declined slightly from 2001 to 2002, from 21.9 percent to 20.6 percent. Most youngsters 12-17 reported that the last marijuana they used was obtained without paying, usually from friends.

"Prevention is the key to stopping another generation from abusing drugs and alcohol," SAMHSA Administrator Charles G. Curie said. "It is gratifying to see that fewer adolescents under age 18 are using marijuana. Now, we need to step up our prevention activities to drive the numbers down further."

The survey found that 30 percent of the population 12 and older, 71.5 million people, use tobacco. Most of them smoke cigarettes. But, the number of new daily smokers decreased from 2.1 million per year in 1998 to 1.4 million in 2001. Among youth under age 18, the decline was from 1.1 million per year in each year between 1997 and 2000 to 757,000 in 2001. This is a decrease from about 3,000 new youth smokers per day to 2,000 per day. In 2002, there were 2 million persons who currently used cocaine, 567,000 of whom used crack. Hallucinogens were used by 1.2 million people, including 676,000 who used

Ecstasy. There were 166,000 current heroin users. Among youngsters 12-17, inhalant use was higher than use of cocaine.

The second most popular category of drug use after marijuana is the non-medical use of prescription drugs. An estimated 6.2 million people, 2.6 percent of the population ages 12 or older, were current users of prescription drugs taken non-medically. Of these, an estimated 4.4 million used narcotic pain relievers, 1.8 million used anti-anxiety medications (also known as tranquilizers), 1.2 million used stimulants and 0.4 million used sedatives. The survey estimates that 1.9 million persons ages 12 or older used OxyContin non-medically at least once in their lifetime.

Current illicit drug use is highest among young adults 18 to 25 years old, with over 20 percent using drugs. Youth ages 12-17 also are significant users, with 11.6 percent currently using illicit drugs. Among adults ages 26 and older, 5.8 percent reported current drug use. There were also 9.5 million full-time workers, 8.2 percent, who used illicit drugs in 2002. Of the 16.6 million illicit drug users ages 18 or older in 2002, 12.4 million were employed either full or part time.

The 2002 survey found that 11 million people, 4.7 percent of the population ages 12 or older, reported driving under the influence of an illicit drug during the past year. Those age 21 reported the highest rate of driving while drugged, 18 percent, but the rate was 10 percent or greater for each age from 17 to 25.

About 10.7 million people ages 12 to 20 (28.8 percent of this age group) reported drinking alcohol in the month prior to the survey interview. Of these, 7.2 million were binge drinkers (19.3 percent) and 2.3 million were heavy drinkers (6.2 percent). There were 33.5 million Americans who drove under the influence of alcohol at least once in the 12 months prior to the interview.

Of those 3.5 million people ages 12 or older who received some kind of treatment related to the use of alcohol or illicit drugs in the 12 months prior to the survey interview, 974,000 received treatment for marijuana, 796,000 received treatment for cocaine, 360,000 received treatment for non medical use of narcotic pain relievers, 277,000 for heroin, and 2.2 million received treatment for alcohol.

Trends in lifetime use of substances were calculated from the 2002 survey based on reports of prior use. Use of pain relievers non-medically among those ages 12-17 increased from 9.6 percent in 2001 to 11.2 percent in 2002, continuing an increasing trend from 1989 when only 1.2 percent had ever used pain relievers non-medically in their lifetime. Among young adults, ages 18-25, the rate of ever having used pain relievers non-medically increased from 19.4 percent in 2001 to 22.1 percent in 2002. This rate was 6.8 percent in 1992.

For teens ages 12-17, the lifetime LSD rate is down from 3.3 percent of this population to 2.7 percent, the Ecstasy rate is up slightly from 3.2 percent to 3.3 percent, cocaine use is

up from 2.3 percent of this population to 2.7 percent, and inhalant use is up from 9 percent in 2001 to 10.5 percent in 2002.

In 2002, the survey found, over 83 percent of youth ages 12-17 reported having seen or heard alcohol or drug prevention messages outside of school in the past year. Youth who had seen or heard these messages indicated a slightly lower past month use of an illicit drug (11.3 percent) than teens who had not seen or heard these types of messages (13.2 percent).

There are 4 million adults who have both a substance use disorder and serious mental illness. In 2002, there were an estimated 17.5 million adults ages 18 or older with serious mental illness. This is 8.3 percent of all adults. Adults who used illicit drugs were more than twice as likely to have serious mental illness as adults who did not use an illicit drug. Among adults who used an illicit drug in the past year, 17.1 percent had serious mental illness in that year, compared to 6.9 percent of adults who did not use an illicit drug. Among adults with serious mental illness in 2002, over 23 percent, were dependent on or abused alcohol or illicit drugs. The rate among adults without serious mental illness was only 8.2 percent. Among adults with substance dependence or abuse, 20.4 percent had serious mental illness, compared with 7 percent among adults who were not dependent on or abusing alcohol or drugs.

The survey is based on interviews with 68,126 respondents who were interviewed in their homes. This includes persons residing in dormitories or homeless shelters. The interviews represent 98 percent of the population ages 12 and older. Not included in the survey are persons in the active military, in prisons or other institutionalized populations or who are homeless.

AHRQ STUDY IDENTIFIES KEY SYMPTOMS DIFFERENTIATING INHALED ANTHRAX FROM FLU --Researchers have identified key symptoms that may help distinguish inhaled anthrax from the flu and other common respiratory conditions in the event of a bioterrorist attack, according to a new study partially funded by the Agency for Healthcare Research and Quality and published in the September 2, 2003, issue of *Annals of Internal Medicine*.

Results of the study are being used to create the first evidence-based pre-hospital screening protocol designed for response to future anthrax attacks. By helping emergency management and public health authorities rapidly and accurately identify both potential cases and likely non-cases, this protocol, once fully tested, will help to preserve scarce hospital capacity while ensuring that patients receive appropriate advanced medical care. Combining data from the 11 inhaled anthrax cases from the 2001 attacks with historical case reports of 17 additional patients, researchers at Weill Medical College of Cornell University compared the features of anthrax-related illness with more than 4,000 cases of common viral respiratory tract infections such as the flu. While symptoms such as fever and cough did not reliably discriminate between anthrax and flu or flu-like illnesses, others—most notably neurologic problems like dizziness and confusion, serious

gastrointestinal symptoms like nausea and vomiting, and shortness of breath—were much more common in patients with inhaled anthrax. Although sore throat and runny nose were present in some cases of anthrax infection, these flu-like symptoms never occurred without at least one of these other symptoms.

"The ability to differentiate between patients who should be tested—and triaged—to determine whether they have anthrax or are coming down with other illnesses is particularly important in the wake of a possible bioterrorism event," said Carolyn Clancy, M.D., director of AHRQ, which funded the study as part of its bioterrorism preparedness research portfolio. "This study provides the critical foundation needed to direct further science-based research in this important area."

Lead study author Nathaniel Hupert, M.D., an assistant professor of public health and medicine at Weill Medical College of Cornell University, agreed. "This highlights the importance of considering the complete clinical presentation of inhaled anthrax, as opposed to simply its component signs and symptoms, in formulating accurate screening protocols," he said. Four of the 11 patients who developed anthrax in 2001 were originally sent home with diagnoses of a viral syndrome, bronchitis, or gastroenteritis. The study, "Accuracy of Screening for Inhaled Anthrax after a Bioterrorist Attack," is published in the September 2, 2003, issue of *Annals of Internal Medicine*.

DR. HENRY FALK TO LEAD CDC'S NATIONAL CENTER FOR ENVIRONMENTAL HEALTH/ATSDR

--The Centers for Disease Control and Prevention (CDC) August 25 announced the appointment of Dr. Henry Falk as the new director of the Center for Disease Control and Prevention's (CDC) National Center for Environmental Health (NCEH). In addition, Dr. Falk will continue as assistant administrator of the Agency for Toxic Substances and Disease Registry (ATSDR).

"Dr. Falk has over 30 years experience in protecting public health. In addition, his early disease investigations as an Epidemic Intelligence Service officer helped lead to the creation of the National Center for Environmental Health. The nation's environmental health capacity will be stronger as a result of Dr. Falk's leadership," said HHS Secretary Tommy G. Thompson.

"The appointment of Dr. Falk to lead NCEH and ATSDR is the first step in a process to consolidate administration and management activities of these two organizations, both of which have tremendous expertise in environmental public health issues," said Dr. Julie Gerberding, CDC Director. "This consolidation will help leverage this expertise and increase synergies in order for CDC to continue to be the nation's premier public health agency when it comes to environmental issues."

Falk has served as the assistant administrator for ATSDR since July 1999. Previously he served as director of the division of environmental hazards and health effects at NCEH for 14 years. Under Falk's leadership, ATSDR has expanded its cooperative agreement program, which provides technical assistance and funds for states and other partners to conduct public health assessment activities at waste sites. The agency has also

accomplished its goal of having a Pediatric Environmental Health Specialty Unit in each federal region to serve as a resource for physicians, parents and others, and initiated a series of public health activities in many key sites, including Libby, Montana, where ATSDR has assisted Libby residents who were exposed to asbestos in vermiculite mined there for many years.

Falk received his Doctor of Medicine (MD) degree from the Albert Einstein College of Medicine in New York City in 1968 and a Master of Public Health (MPH) degree from the Harvard School of Public Health in Boston in 1976. Falk began his career with CDC in 1972 as an Epidemic Intelligence Service (EIS) officer stationed at Texas Children's Hospital in Houston.