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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EDITOR'S NOTE: HHS Secretary Tommy G. Thompson August 26 unveiled the department's draft Pandemic Influenza Response and Preparedness Plan, which outlines a coordinated national strategy to prepare for and respond to an influenza pandemic. The draft plan can be found online at http://www.hhs.gov/nvpo/pandemicplan and is available for public comment for 60 days."This plan will serve as our roadmap on how we as a nation, and as a member of the global health community, respond to the next pandemic influenza outbreak, whenever that may be," Secretary Thompson said. "Our proposed strategy draws upon the wealth of experience and knowledge we have gained in responding to a number of recent public health threats, including SARS and avian influenza." -- additional 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

APPROPRIATIONS UPDATE – The full House of Representatives will take up the FY 2005 Labor-HHS-Education Appropriations bill on the floor this afternoon (9/8). The Senate Labor-HHS-Education Subcommittee on Appropriations is planning to mark up its FY 2005 bill tomorrow (9/9). However, it is not expected that the full Senate will consider the Labor-HHS-Ed bill before the end of the federal fiscal year on October 1st and there is strong likelihood that the bill will be rolled into an omnibus bill, along with at least 10 other unfinished appropriations bills, and dealt with after the November 2nd elections in a Lame Duck session. Non-appropriated federal agencies will be kept operating through a series of continuing resolutions until Congress conferences the omnibus bill.

FIRST NATIONAL SUMMARY REPORT SHOWS MAGNITUDE OF INJURIES -- Eighteen people die every hour from injuries in America (or 157,000 people in 2001) spanning all age groups, both sexes and all races, according to the first national report for both fatal and nonfatal injuries released September 2 by the Centers for Disease Control and Preventions (CDC).

Unintentional injury is the fifth leading cause of death in the U.S. and about one in every three people treated in an emergency department is treated for an injury. CDC researchers also noted that in 2001, an estimated 29.7 million persons, or one in 10 U.S. residents, were treated for nonfatal injuries in hospital emergency departments and 1.6 million were hospitalized or transferred for specialized medical care. Traumatic brain injuries are a leading cause of injury deaths, accounting for about 50,000 deaths each year. More than 1.2 million cases of traumatic brain injuries were treated in 2001.

All of this brings a substantial price tag to U.S. residents – costing an estimated $117 billion in medical care costs annually.

Whether driving or riding in a car, participating in sports and recreation activities, working, or merely doing chores around the house, people can find ways to reduce their risk of injury. Efforts such as wearing a safety belt, not drinking and driving, using safety gear during sports activities, removing hazards in the home that might cause a fall, and learning peaceful ways to resolve conflicts can help reduce the risk of injury.

Key findings in this report for 2001 are:

<u>All Ages</u>

* Overall, fatal and nonfatal injuries were higher for males than females and disproportionately affect younger and older persons. Overall, the leading cause of injury death was motor-vehicle traffic crashes and the leading cause of nonfatal injuries treated in hospital emergency departments was unintentional falls.

* Motor-vehicle traffic crashes accounted for more than 2.9 million nonfatal occupant injuries treated in hospital emergency departments and almost 33,400 occupant

deaths. The motor-vehicle traffic occupant death rate for males was almost twice that of females and the rate was highest for those ages 15 to 24 years.

* In 2001, unintentional falls accounted for more than 7.8 million nonfatal injuries treated in hospital emergency departments and more than 15,000 deaths. The unintentional fall nonfatal injury rate for females was higher than that for males and the rate was highest for those ages 75 years and older.

* Violence-related injuries also take a toll on Americans. In 2001, almost 21,000 homicides and 31,000 suicides occurred; and almost 1.8 million people were assaulted, while about 323,000 harmed themselves and were treated in hospital emergency departments.

Children 14 years or younger

* For children ages one to four years, drowning ranked first above motor-vehicle occupants killed in traffic crashes, accounting for over one out of four unintentional injury deaths.

* Children ages 14 years and younger suffered almost 450,000 traumatic brain injuries, representing 36% of more than 1.2 million traumatic brain injuries treated among injured persons of all ages.

Teenagers and Young Adults ages 15 to 24 years

* The motor vehicle traffic occupant death rate was highest for those ages 15 to 24 year.

* Males ages 20 to 24 years had the highest homicide rate and the highest nonfatal assault rate compared to all other ages and more than 80% of homicides were firearm-related.

* For persons ages 15 to 24 years, poisoning accounted for 63% of nonfatal self-harm injuries treated in hospital emergency departments.

Adults ages 65 years or older

* For adults 65 years or older, fall-related injuries accounted for 62% of unintentional injuries treated in U.S. hospital emergency departments. The fall death rate for persons ages 75 years and older is over five times higher than that of any other age group.

* Persons ages 75 years and older had the highest suicide rate compared to all other age groups.

This summary uses 2001 national data to examine injury deaths and nonfatal injuries by cause and intent of injury, age, and sex; nonfatal injuries also are presented by primary body part affected and type of injury. The ten leading causes of injury death and nonfatal injury are ranked by age groups for males and females. It does not provide data on injuries and injury deaths by state.

PUBLIC COMMENT PERIOD BEGINS ON REPORT OF DIETARY GUIDELINES ADVISORY COMMITTEE -- The U.S. Departments of Health and Human Services (HHS) and Agriculture (USDA) August 27 announced that public comments are now being accepted on the Report of the Dietary Guidelines Advisory Committee on the Dietary Guidelines for Americans, 2005 to the Secretaries of Health and Human Services and Agriculture. Individuals and organizations are encouraged to provide written comments by Monday, Sept. 27, or provide oral comments at a public meeting on Sept. 21.

"We thank the committee members for their guidance, expertise and hard work to ensure their report reflects the most current and comprehensive nutritional science. This document provides a strong foundation for the 2005 *Dietary Guidelines*, which will be released by our Departments early next year. We encourage the public to submit comments that will help HHS and USDA translate these recommendations into meaningful policies and messages for Americans," HHS Secretary Tommy G. Thompson and Agriculture Secretary Ann M. Veneman said.

The 13 professionals on the current advisory committee have held five public meetings over the last year. The next step, after a 31-day comment period, will be an internal scientific review of the document. Later this fall, HHS and USDA will consider public comments as they translate the advisory committee's report into the 2005 *Dietary Guidelines for Americans*. Secretary Thompson and Secretary Veneman will release the 2005 Dietary Guidelines jointly early next year.

First published in 1980, the *Dietary Guidelines* are reviewed, updated and released by HHS and USDA every five years, and contain the latest nutritional and dietary guidance for the general public.

The report is available in the Aug. 27 edition of the Federal Register. An electronic copy of the advisory committee document is available at http://www.health.gov/dietaryguidelines or in hard copy for viewing at Suite LL100, 1101 Wootton Parkway, Rockville, Md. 20852. Written comments can be submitted at http://www.health.gov/dietaryguidelines or mailed to Kathryn McMurry, HHS Office of Disease Prevention and Health Promotion, Office of Public Health and Science, Suite LL100, 1101 Wootton Parkway, Rockville, Md. 20852.

HHS ISSUES NATIONAL PANDEMIC INFLUENZA PREPAREDNESS PLAN -- HHS Secretary Tommy G. Thompson August 26 unveiled the department's draft Pandemic Influenza Response and Preparedness Plan, which outlines a coordinated

national strategy to prepare for and respond to an influenza pandemic. The draft plan can be found online at http://www.hhs.gov/nvpo/pandemicplan and is available for public comment for 60 days.

"This plan will serve as our roadmap on how we as a nation, and as a member of the global health community, respond to the next pandemic influenza outbreak, whenever that may be," Secretary Thompson said. "Our proposed strategy draws upon the wealth of experience and knowledge we have gained in responding to a number of recent public health threats, including SARS and avian influenza."

In particular, the plan provides guidance to national, state, and local policy makers and health departments for public health preparation and response in the event of pandemic influenza outbreak.

Influenza pandemics are explosive global events in which most, if not all, persons worldwide are at risk for infection and illness. While rare, the appearance of such a pandemic virus will likely be unaffected by currently available flu vaccines that are modified each year to match the strains of the virus that are known to be in circulation among humans around the world. Unlike the gradual changes that occur in the influenza viruses that appear each year during "flu season," a pandemic influenza virus is one that represents a major, sudden shift in the virus' structure that increases its ability to cause illness in a large proportion of the population. During previous influenza pandemics large numbers of people were ill, sought medical care, were hospitalized and died.

Three influenza pandemics occurred during the 20th century. The most recent influenza pandemic occurred in 1968 with the Hong Kong Flu outbreak, which resulted in nearly 34,000 deaths in the United States. In 1957, the Asian flu pandemic resulted in about 70,000 deaths. The most deadly influenza pandemic outbreak was the 1918 Spanish flu pandemic, which caused illness in roughly 20 to 40 percent of the world's population and more than 50 million deaths worldwide. Between September 1918 and April 1919, approximately 675,000 deaths from the Spanish flu occurred in the United States alone.

Planning and implementing preparedness activities are critical to improving the effectiveness of a response and decreasing the impacts of a pandemic. HHS has increased support for pandemic influenza activities and is engaged in several efforts to enhance the nation's preparedness for such an outbreak. HHS supports pandemic influenza activities in five key areas: surveillance, vaccine development and production, antiviral stockpiling, research, and public health preparedness.

This draft plan includes a core section and twelve annexes. The core plan describes coordination and decision making at the national level; provides an overview of key issues; and outlines action steps that should be taken at the national, state, and local levels before and during a pandemic. Annexes provide additional information to health departments and private sector organizations for use in developing local preparedness plans as well as additional technical information to support the core document.

NEARLY ALL ELIGIBLE HOSPITALS ARE REPORTING QUALITY OF CARE DATA -- Nearly all of the nation's eligible hospitals have begun reporting data on the quality of care they deliver, a vital first step in improving patient care, the Centers for Medicare & Medicaid Services (CMS) announced September 2.

"Improving the quality of health care in America is one of our primary goals at HHS," said Health and Human Services Secretary Tommy G. Thompson. "Making information available on care delivered provides people with the tools necessary to make decisions on where to go for their health care. That's why we're asking hospitals, nursing homes and home health care agencies to provide information on the care they deliver and making it publicly available."

"People on Medicare and other hospital patients will benefit from this new information, and will get further benefits as the quality of care in the nation's hospitals improves," said CMS Administrator Mark B. McClellan, M.D., Ph.D.
The Medicare Modernization Act of 2003 (MMA) provided a financial incentive for hospitals to report quality of care data by linking it to the payments they will receive for treating Medicare beneficiaries. Almost 100 percent of covered hospitals reported data by the August 15 deadline.

"When it comes to quality reporting, payment incentives are nearly 100 percent effective - and in turn, quality information will provide further incentives to improve the quality of care available to millions of Americans," McClellan said. "As patients and doctors start using this quality information to help them make decisions about hospital care, hospitals will start using it to improve their performance."

Under the MMA, hospitals that submit quality information to CMS will be eligible to receive the full Medicare payment for health care services in 2005. Although reporting is voluntary, those inpatient acute care hospitals that do not report will get a 0.4 percentage point reduction in their annual Medicare fee schedule update.
Among the nation's 3,906 inpatient acute care hospitals eligible to report quality data under MMA, 3,839 (98.3 percent) met all of CMS's requirements and will receive the full annual payment update from Medicare in 2005.

Beginning early in 2005, the hospital quality data will be available to consumers at www.medicare.gov, the CMS website for consumers, or by calling 1-800-MEDICARE (800-633-4227). Currently, CMS publishes this information on www.cms.hhs.gov. Already CMS publishes quality information on www.medicare.gov for Medicare and Medicaid-certified nursing homes and Medicare-certified home health agencies.
Reporting of quality data began in 2003 under the National Voluntary Hospital Reporting Initiative, a public-private effort on quality reporting that supported the development of Medicare's Hospital Quality Initiative. Reported hospital data is currently posted on www.cms.hhs.gov. As of the last update, more than 3,000 hospitals were reporting data voluntarily for this website.

The Hospital Quality Initiative is designed to improve the quality of hospital care across the nation. The program is part of the U.S. Department of Health and Human Services' (HHS) national Quality Initiative that also focuses on improving the quality of care in home health agencies and nursing homes using hands-on training and resources from Medicare's Quality Improvement Organizations (QIOs).

"The American Hospital Association, the Federation of American Hospitals, and the American Association of Medical Colleges have been strong partners in their efforts to support getting better information to consumers," McClellan said. "We intend to continue to work with our partners to build on this quality information next year."
The data on quality of care that participating hospitals report will give consumers information about performance in three medical conditions - heart attack, heart failure and pneumonia. These conditions can result in hospital stays and are common among people with Medicare.

The quality data is reported as ten quality measures (standards of care) for these three conditions and have gone through years of extensive testing for validity and reliability by CMS and QIOs, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and researchers. The National Quality Forum (NQF), a voluntary standard-setting, consensus-building organization representing providers, consumers, purchasers, and researchers, has endorsed these measures as valid, reliable indicators of health care quality.

The measures in each condition address key aspects of appropriate care:

* Heart attack (Acute Myocardial Infarction)

Was aspirin given to the patient upon arrival at the hospital?
Was aspirin prescribed when the patient was discharged?
Was a beta-blocker given to the patient upon arrival at the hospital?
Was a beta-blocker prescribed when the patient was discharged?
Was an ACE Inhibitor given to the patient with heart failure?

* Heart failure

Did the patient get an assessment of his or her heart function?
Was an ACE Inhibitor given to the patient?

* Pneumonia

Was an antibiotic given to the patient in a timely way?
Had a patient received a Pneumococcal vaccination?
Was the patient's oxygen level assessed?

The current reports provide ten measures involving common, serious conditions for Medicare beneficiaries. CMS is working with hospitals and other groups to build on this information to provide a more comprehensive view of the quality of health care services provided at hospitals. Next year, CMS anticipates gathering and displaying additional measures of clinical quality as well as measures related to patient satisfaction with the care they received. There are no payment incentives currently associated with these additional measures.

Most of the nation's hospitals are subject to the annual payment update provision under MMA. The provision does not impact some specialty, rural, and certain other hospitals.

SYNDROMIC SURVEILLANCE CONFERENCE ANNOUNCEMENT -- The third annual Syndromic Surveillance Conference, to be held Nov. 3-4, 2004, in Boston, provides health care professionals an opportunity to learn the most current trends in syndromic surveillance. Key issues to be addressed include: Innovative uses of syndromic surveillance data; Aberration Detection Methods; Evaluation Methods and Metrics; Public Health Practice; Standards and Privacy Issues. Last year's conference attracted nearly 500 public and private health officials throughout the country. The conference program committee is co-chaired by senior staff of the New York Dept. of Health and Mental Hygiene and the U.S. Dept. of Defense Walter Reed Army Institute of Research. More information is available at www.syndromic.org.