THE CSTE WASHINGTON REPORT

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EDITOR'S NOTE: Less than a third of the nation's hospital emergency and outpatient departments use electronic medical records, and even fewer doctors' offices do, according to a report released March 15 by the Centers for Disease Control and Prevention (CDC). About 31 percent of hospital emergency departments, 29 percent of outpatient departments, and 17 percent of doctors' offices have electronic medical records to support patient care, as reported in CDC's ambulatory medical care surveys, conducted from 2001 to 2003. The use of electronic records in health care lags far behind the computerization of information in other sectors of the economy. In health care, billing applications were the first to be computerized. Electronic billing systems are used in three-quarters of physician office practices, but computerization of clinical records has been much slower. – 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

GAO RELEASES REPORT SAYING STATES ARE SPENDING BT FUNDS – The Government Accountability Office released a new report on March 30th that found at least 80 percent of the bioterrorism grants awarded in 2002 and 2003 were spent or allocated by cities and states, and more than half of the money awarded in the 12-month period ending August 30, 2004 was allocated. The report contradicts an earlier federal study that was the impetus for the Department of Health and Human Services to shift millions of dollars elsewhere. That study said that communities had not spent large portions of their FY 2002 and 2003 grants and HHS reallocated $55 million in funds to other local and national bioterrorism activities. Senators Lieberman (D-CT) and Kennedy (D-MA), who requested the report, said in a press statement: "Instead of working with jurisdictions to figure out what was going on, HHS reprogrammed the funds and undermined the ability of states and local governments to improve the very bioterrorism capabilities the grants were intended to create." The report can be read at: http://www.gao.gov/cgi-bin/getrpt?GAO-05-239

OBESITY THREATENS TO CUT U.S. LIFE EXPECTANCY, NEW ANALYSIS SUGGESTS -- Over the next few decades, life expectancy for the average American could decline by as much as 5 years unless aggressive efforts are made to slow rising rates of obesity, according to a team of scientists supported in part by the National Institute on Aging (NIA), a component of the National Institutes of Health (NIH) of the Department of Health and Human Services (DHHS).

The U.S. could be facing its first sustained drop in life expectancy in the modern era, the researchers say, but this decline is not inevitable if Americans — particularly younger ones — trim their waistlines or if other improvements outweigh the impact of obesity. The new report in the March 17, 2005 issue of *The New England Journal of Medicine* appears little more than a year after the DHHS unveiled a new national education campaign and research strategy to combat obesity and excessive weight.

The new analysis, by S. Jay Olshansky, PhD, of the University of Illinois at Chicago, Leonard Hayflick, Ph.D., of the University of California, San Francisco, Robert N. Butler, M.D., of the International Longevity Center in New York, and others* suggests that the methods used to establish life expectancy projections, which have long been based on historic trends, need to be reassessed. This reevaluation is particularly important, they say, as obesity rates surge in today's children and young adults.

"Forecasting life expectancy by extrapolating from the past is like forecasting the weather on the basis of its history," Olshansky and his colleagues write. "Looking out the window, we see a threatening storm — obesity —that will, if unchecked, have a negative effect on life expectancy."

Unlike historic life expectancy forecasts, which rely on past mortality trends, the Olshansky group bases their projection on an analysis of body mass indexes and other factors that could potentially affect the health and well-being of the current generation of children and young adults, some of whom began having weight problems very early in life. The authors say that unless steps are taken to curb excessive weight gain, younger

Americans will likely face a greater risk of mortality throughout life than previous generations.

“This work paints a disturbing portrait of the potential effect that life styles of baby boomers and the next generation could have on life expectancy,” says Richard M. Suzman, Ph.D., Associate Director of the NIA for Behavioral and Social Research. Indeed, Suzman notes, obesity may already have had an effect. The sharp increase of obesity among people now in their 60s, he suggests, may be one explanation why the gains in U.S. life expectancy at older ages have been less than those of other developed countries in recent years.

“But it is critical to note that the reduced life expectancy forecast by the study is not inevitable, and there is room for optimism,” Suzman says. “Government and private sector efforts are mobilizing against obesity, and increased education, improved medical treatments, and reduced smoking can tip the balance in favor of reduced mortality and continued improvements in life expectancy.”

For instance, smoking significantly reduces the life expectancy of the average smoker, Suzman says, so obesity is just one of many factors that will need to be accounted for, together or separately, in projecting how Americans will age. The NIA supports several projects on population demography that forecast life and health expectancy, research which is critically important to policy makers looking at the implications of an aging population.

According to the NEJM report, studies suggest that two-thirds of American adults are overweight (having a body mass index — BMI — of 25 or more) or obese (having a BMI of 30 or more). One study cited by the authors indicates that the prevalence of obesity in U.S. adults has increased about 50 percent per decade since 1980. Additional research has shown that people who are severely obese — with a BMI greater than 45 — live up to 20 years less than people who are not overweight. Some researchers have estimated that obesity causes about 300,000 deaths in the U.S. annually. In addition, obesity is fueling an epidemic of type 2 diabetes, which also reduces lifespan.

To estimate the overall effect of obesity on life expectancy in the U.S., Olshansky and his colleagues calculated the reduction in death rates that would occur if everyone who is currently obese were to achieve the difficult goal of losing enough weight to reach an “optimal” BMI of 24. The calculation was based, in part, on age, race, and sex-specific prevalence of obesity in the United States from the Third National Health and Nutrition Examination Survey. Based on these calculations, the researchers estimated that life expectancy at birth would be higher by 0.33 to 0.93 year for white men, 0.30 to 0.81 year for white women, 0.30 to 1.08 year for black men, and 0.21 to 0.73 year for black women if obesity did not exist.

The overall reduction in life expectancy of one-third to three-fourths of a year attributed to obesity in this analysis exceeds the negative effect of all accidental deaths combined, and could deteriorate over time, the researchers said.

"These trends suggest that the relative influence of obesity on the life expectancy of future generations could be markedly worse than it is for current generations," Olshansky and the authors conclude in their report. "In other words, the life-shortening effect of obesity could rise …to two to five years, or more, in the coming decades, as the obese who are now at younger ages carry their elevated risk of death into middle and older ages."

The projected decline contrasts with estimates by other leading researchers, which predict a continuation of the historic trend of increasing life expectancy in America and Europe dating back to the 1850s, according to Dr. Suzman. In fact, he points out that the experience of other developed nations is instructive as a barometer of how much room might exist to increase U.S. life expectancy. More than 20 other developed nations, including France, Japan, Germany, Sweden, and the United Kingdom have a higher average life expectancy than the U.S. Women in Japan, for example, live about 5 years longer than women in the U.S. There is little evidence that life expectancy in these countries is approaching any kind of limit, Suzman says.

In March 2004, the DHHS launched public awareness campaign, entitled *Healthy Lifestyles and Disease Prevention*, to encourage American families to take small, manageable steps within their current lifestyle, such as using the stairs instead of the elevator, to ensure effective, long-term weight control. The campaign includes multi-media public service announcements (PSAs) and a new interactive website, www.smallstep.gov**.**

NEW STUDY SHOWS LIMITED USE OF ELECTRONIC MEDICAL RECORDS
--Less than a third of the nation's hospital emergency and outpatient departments use electronic medical records, and even fewer doctors' offices do, according to a report released March 15 by the Centers for Disease Control and Prevention (CDC).

About 31 percent of hospital emergency departments, 29 percent of outpatient departments, and 17 percent of doctors' offices have electronic medical records to support patient care, as reported in CDC's ambulatory medical care surveys, conducted from 2001 to 2003.

The use of electronic records in health care lags far behind the computerization of information in other sectors of the economy. In health care, billing applications were the first to be computerized. Electronic billing systems are used in three-quarters of physician office practices, but computerization of clinical records has been much slower.

To help bring health care into the information age, President Bush called for the majority of Americans to have electronic health records within 10 years and established the role of a National Coordinator for Health Information Technology in order to realize this goal.

"Electronic medical records and computerized systems offer opportunities to improve the quality of medical care in all settings as health care providers learn the potential of these

systems and how to use them," said Catharine W. Burt, Ed.D., lead author of the study. "The majority of ambulatory care in this country is provided in physicians' offices but less than one in five doctors is using electronic medical records."

The survey measured the use of systems to improve the accuracy and safety of prescription drug use. About 8 percent of physicians use a computerized physician order entry system (CPOE), in which orders for drugs and diagnostic tests are entered electronically rather than on prescription pads. In these electronic systems, the computer compares the order against standards for dosing, checks for allergies or drug interactions, and warns of potential patient problems.

The study found younger physicians, those under 50 years of age, were twice as likely as physicians age 50 or over to use this computerized system for ordering prescriptions.

About 40 percent of hospital emergency departments use automated drug dispensing systems (ADD), compared to about 18 percent of outpatient departments. Other studies have shown that automated drug dispensing systems, that operate like vending machines where the order is written and the machine dispenses the correct drug and dosage for patients, can reduce medical errors. These automated systems were more likely to be in use in emergency departments located in metropolitan areas and those with the highest volume of patients. For outpatient departments, medical school affiliation was associated with use of automated drug systems.

"While national adoption rates for health information technology are slowly climbing, we are seeing a widening gap between larger hospitals and physician groups and their smaller counterparts," said Dr. David Brailer, National Coordinator for Health Information Technology. "Physicians and providers face many barriers to adopting health information tools. We need to create incentives for providers to adopt electronic medical records and ensure the products they buy will do the job."

The National Ambulatory Medical Care Survey of the care provided by office-based physicians and the National Hospital Ambulatory Medical Care Survey, covering hospital emergency and outpatient departments regularly report on the characteristics of patients, including diagnosis and symptoms, as well as the diagnostic and therapeutic care provided to track trends in the patterns and quality of medical care. Items on the use of electronic medical records were added to these comprehensive surveys of medical care providers to track important changes in their use of information technology.

"Use of Computerized Clinical Support Systems in Medical Settings: United States, 2001-2003" is available at www.cdc.gov/nchs.

TB AT ALL-TIME LOW, BUT DECLINE IS SLOWING AND RACIAL DISPARITIES PERSIST -- More than one-third of the global population is infected with the tuberculosis (TB) bacterium, and TB disease remains one of the world's leading causes of disease and death. Each year, 8 million people become ill with TB, and 2 million people die from the disease. World TB Day on March 24 – the date in 1882 that

scientist Robert Koch announced his discovery of the TB bacterium – is an international call to action against the disease.

In the United States, the latest national surveillance data show a significant, but slowing, decline in the case rate of TB. In 2004, a total of 14,511 TB cases were reported in the U.S. The overall TB case rate – 4.9 per 100,000 persons – was the lowest rate ever recorded since reporting began in 1953. However, the decline in the case rate from 2003 to 2004 was one of the smallest in more than a decade (3.3 percent compared with an average of 6.8 percent per year). And despite the nationwide downward trend, TB continues to exact a severe toll on many U.S. communities. Seven states now bear more than half the total burden of TB disease in the U.S. California, Florida, Georgia, Illinois, New Jersey, New York, and Texas account for 59.9% of the national case total. The toll continues to be greatest among minority and foreign-born individuals, who consistently have higher rates of TB disease.

TB's Racial and Ethnic Disparities

In 2004, minority populations had rates of TB significantly higher than the overall U.S. average. The 2004 TB case rate among Asians was 20 times higher than that among whites (26.9/100,000 and 1.3/100,000, respectively), while blacks (11.1/100,000) and Hispanics (10.1/100,000) each had rates eight times higher than whites.

In 2004, for the first time, there were more cases of TB among Hispanics than any other ethnic group. However, the TB rate among Hispanics decreased slightly from 10.3 in 2003 to 10.1 in 2004. This divergent trend was the result of a 3.6 percent increase in the U.S. Hispanic population between 2003 and 2004.

Impact on Foreign-Born Persons

The TB rate among foreign-born individuals (22.5/100,000) was nearly nine times the rate among persons born in the United States (2.6/100,000). Individuals born outside the United States accounted for more than half (7,701 cases, or 53.7 percent) of all new TB cases in 2004.

While the TB rate among U.S-born persons has declined 64.6 percent over the past 12 years, the rate among foreign-born persons has declined only 33.9 percent.

Ninety-five percent of Asians reported to have TB in the U.S. in 2004 were foreign-born. Foreign-born individuals also accounted for the majority – 74 percent – of cases among Hispanics in the U.S. Globally, Asia accounts for the largest number of TB cases. The impact of TB on Mexico is also worrisome because many Hispanics diagnosed with TB in the U.S. were born in that country.

Accessing and Completing TB Therapy

The proportion of patients completing treatment in a timely manner is an important measure of the effectiveness of TB control efforts. Treatment is recommended for 6 to 9 months, and patients who do not complete therapy are at increased risk of developing multidrug-resistant TB (MDR TB). The most recent treatment-completion data (2001) show that 81.4 percent of U.S.-born and 80.4 percent of foreign-born TB patients completed therapy within one year. There was no significant variation in treatment completion by race. Health officials hope to increase treatment completion rates in the U.S. to 90% by 2010.

Significant Decline Seen in Multidrug Resistant TB

Cases of MDR TB have declined sharply in the U.S. over the past decade. In 2003, the most recent year for which there is resistance rate reporting, 114 individuals were reported with MDR TB – a 76.5 percent decline since 1993. Of these individuals, 28 were born in the U.S. and 86 were born in other nations. Because previous data suggest little variation in rates of treatment completion by country of origin, the greater proportion of cases of MDR TB among foreign-born individuals is likely the result of TB infection in the person's country of origin, where MDR TB rates are higher than in the U.S.

Stepping Up TB Elimination Efforts

Even though preventable and treatable, TB remains a serious airborne disease – one with the ability to adapt, grow stronger, and travel from one country to another as easily as people do. The health threat must continue to be taken seriously, both here in the U.S. and abroad.

CDC is working to strengthen global partnerships to address TB among populations hardest-hit by the disease. These efforts include improving overseas screening for immigrants and refugees, and testing recent arrivals from high-incidence countries for latent TB infection. CDC is also improving the notification system that alerts local health departments about the arrival of immigrants who are known or believed to have TB, and collaborating with public health teams in Mexico to improve TB control among those who frequently cross the U.S.-Mexico border.

Along with state and local health departments, CDC is working to ensure that adequate local resources are in place in communities with the greatest burden of TB. These efforts include funding demonstration projects to help address TB among African Americans and building the capacity of front-line health care providers to ensure complete TB treatment is available to those who need it.

RUBELLA NO LONGER MAJOR PUBLIC HEALTH THREAT IN THE UNITED STATES -- A major public health milestone has been achieved in the United States - the rubella virus, a major cause of serious birth defects such as deafness and blindness, also known as congenital rubella syndrome (CRS), is no longer considered to be a major public health threat in the United States, Dr. Julie Gerberding, director, Centers for

Disease Control and Prevention announced at the National Immunization Conference March 21 in Washington, DC.

“The elimination of rubella in the United States is a tremendous step in protecting the health and well being of pregnant women and infants,” said Dr. Gerberding. “A disease that once seriously harmed tens of thousands of infants is no longer a major health threat, thanks to a safe and effective vaccine and successful immunization programs across the country. We should take pride in this accomplishment, and also recognize that we must maintain our vigilance or we can see a resurgence of disease.”

Currently about 93 percent of the nation’s children under age two are vaccinated against measles, mumps and rubella, according to the CDC’s National Immunization Survey. More than 95 percent of the nation’s children are vaccinated against rubella by the time they enter school. “The importance of continuing vaccination cannot be emphasized enough, “said Dr. Steve Cochi, Acting Director, CDC’s National Immunization Program. “Cases of rubella continue to be brought into the country by worldwide travelers and because of bordering countries where the disease is active.”

During 1964 and 1965 a rubella epidemic in the United States caused an estimated 12.5 million cases of rubella and 20,000 cases of congenital rubella syndrome (CRS) which led to more than 11,600 babies born deaf, 11,250 fetal deaths, 2,100 neonatal deaths, 3,580 babies born blind and 1,800 babies born mentally retarded.

Since reporting of rubella began in 1966, the largest number of rubella cases reported was in 1969 with 57,686 cases. Following vaccine licensure in 1969 and development of a rubella vaccination program to prevent rubella infection during pregnancy, rubella incidence fell rapidly. By 1983, fewer than 1,000 cases were reported per year.

In 1989, CDC established a rubella elimination goal despite a resurgence in rubella and measles cases during the measles epidemic from 1989-1991, reported rubella cases in the 1990s declined to all-time low numbers. From 1990 through 1999, only 117 cases of CRS were reported, 66 of these babies were born in 1990 and 1991. In 2001, for the first time in history, less than 100 cases were reported in the United States. In 2003, there were only eight rubella cases and one CRS case reported in the United States. In 2004, there were only nine rubella cases reported in the United States.

Since the mid-1990s, the United States has worked closely with the Pan American Health Organization (PAHO) and Mexico to improve rubella control in the Americas. Those efforts have resulted in dramatic reductions of rubella in many nations of the Americas. In September 2003, ministers of health of all countries in the Americas resolved to eliminate rubella and CRS by 2010.

Last fall, an independent panel including internationally recognized immunization experts from academia, the Council for State and Territorial Epidemiologists (CSTE), the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the Pan

American Health Organization (PAHO), Mexico and the CDC concluded that rubella virus in no longer endemic in the United States.

Rubella is prevented through vaccination. Rubella vaccine is recommended for all children and for adolescents and adults without documented evidence of immunity. It is especially important to verify that all women of child-bearing age are immune to rubella before they get pregnant.

Although it is available as a single preparation, it is recommended that rubella vaccine be given as MMR vaccine (protecting against measles, mumps and rubella). The first dose of MMR should be given on or after the first birthday; the recommended range is from 12-15 months. The second dose is usually given when the child is 4-6 years old, or before he or she enters kindergarten or first grade. Maintaining high coverage and rubella population immunity in the United States among children and adults will be important to maintain the benefits of achieving rubella elimination.