THE CSTE WASHINGTON REPORT

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INSIDE THIS ISSUE

EDITOR'S NOTE: The Centers for Disease Control and Prevention April 22 released the first data from the National Violent Death Reporting System (NVDRS). Data reported by the first six participating states, (Maryland, Massachusetts, New Jersey, Oregon, South Carolina and Virginia) show increases in suicide and homicide rates for the years 2000 through 2003. This data is in contrast to decreases in violent deaths reported in these states and nationwide from 1993 through 2000. Because this system only contains the first year of data in a small number of states, it's too early to determine how risk factors and trends might have changed in recent years. In 2003, homicide increased four percent and suicide increased five percent above 2002 rates in the six reporting states. Homicide rates among males under age 25 increased 18 percent in those states--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

BUDGET UPDATE -- Last night, Congress passed a Budget Resolution that includes $10 billion in Medicaid cuts over a five year period (until FY 2010), caps discretionary spending at $843 billion for FY 2006 as targeted in the President's budget request, and provides $100 billion in tax cuts over five years. The measure provides reconciliation instructions to key Committees for mandatory program savings of $35 billion. None of these savings affects discretionary health spending, but the overall capped discretionary spending amount means the most likely allocation that the House and Senate Labor-HHS-Education Subcommittees will receive will be approximately $1.2 billion less than FY 2005 levels. Health programs, such as those at CDC, will need to compete with education and labor programs for a smaller allocation.

OBESITY BATTLES – As reported in this edition of CSTE Washington Report, earlier this month CDC released new NHANES data on the mortality risk of being overweight, obese, or severely obese. The new estimate downgrades, considerably, the estimated number of premature deaths caused by obesity from a March 2004 CDC report (112,000 versus 400,000 deaths). In addition, the new report posits that overweight may be a protective factor for the elderly since excess deaths were found to be associated with very lean older Americans. The significant difference in the mortality estimates of the two reports is providing the restaurant industry with an opening to criticize CDC and other organizations such as the Center for Science in the Public Interest as misleading the public about the health consequences of overweight and obesity. A focal point for the industry has been the Center for Consumer Freedom, non-profit entity, which the *Washington Post* reports this week was founded 10 years ago by the big tobacco company Phillip Morris and restaurant money to fight smoking curbs in restaurants. After the tobacco wars, funding and focus has shifted to the restaurant industry to fight obesity lawsuits. Earlier this week, the Center for Consumer Freedom ran full page ads in the Washington Post, New York Times, LA Times, Chicago Tribune, and other major national publications accusing the CDC of "hype" and of force-feeding the public a set of obesity myths. The Center also plans to run a series of ads on Washington's metro system to influence "public opinion leaders," Congressional staff and other key government employees.

LEGISLATIVE UPDATE -- Yesterday, Sens. Lieberman (D-CT) Hatch (R-UT) and Brownback (R-KS) introduced their 360 page BioShield II bill. While much of the bill is focused on bolstering production of bioterrorism countermeasures, attention is also given to bolstering countermeasures for naturally occurring diseases, particularly pandemic flu. There are also some aspects of the bill that address preparedness. Below is the press release on the bill issued by Sen. Lieberman's office. A copy of the complete bill will not be available on government web sites for several more days. The authors' vision for the bill is to complement, and replace, provisions in the Gregg (R-NH) bill introduced

earlier this year as S. 3. That bill includes provisions creating a National Notifiable Disease Surveillance System that is opposed by CSTE.

FOR IMMEDIATE RELEASE
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Lieberman, Hatch, Brownback Call for Next Step in Bioterrorism Preparedness
Unveil bipartisan BioShield II legislation

WASHINGTON – Senators Joe Lieberman (D-CT), Orrin Hatch (R-UT) and Sam Brownback (R-KS) today unveiled legislation to energize a biodefense sector that will provide the medicines the nation needs to combat the threat of bioterrorism. The Project BioShield II Act of 2005 will take the next step in developing crucial new bioterror antidotes and encourage companies to develop countermeasures by reducing their financial risk while also ensuring quality control.

Lieberman first introduced a bill to provide incentives for research on bioterrorism countermeasures in December 2001, just two months after the anthrax attacks in New York, Connecticut, Washington and Florida. He and Hatch have introduced subsequent versions of the bill and in July 2004 President Bush signed BioShield, a bill that contained many provisions of the Lieberman-Hatch bill.

The BioShield law passed last year and modeled on provisions in the earlier Lieberman-Hatch legislation authorizes $5.6 billion over 10 years for the government to procure drugs, biological products, and devices as countermeasures against biological, chemical, radiological and nuclear agents that could cause a public health threat. However, there are still many obstacles to the development of bioterrorism antidotes by private companies, including tax, intellectual property and liabilities risks that inhibit development. The incentives to promote the development of new countermeasures are required because there is no market for these remedies unless there is a national disaster, so there is no normal market to encourage drug development in this biothreat area. Lieberman, Hatch and Brownback, a leader in research and public health issues regarding infectious diseases, are introducing the Project BioShield II Act of 2005 to address these remaining concerns.

“The best way to combat the very real and serious threat of bioterrorism is to utilize our greatest strength – the entrepreneurial talent of our nation – in our national defense. The BioShield law enacted last year takes the first step, but without additional reforms, companies are not likely to risk their own capital to fund this research, leaving us with a government-funding model that will be exceedingly expensive and not likely to produce the results we need,” Lieberman said. “The concepts in our legislation– including tax,

intellectual property and liability reforms –will give us important additional tools to enlist the entire industry in this vital research."

"This bipartisan bill shows that we consider bioterrorism to be a deadly threat to America and the world," Hatch said. "We need to do more to combat natural threats such as AIDS, SARS, Avian Flu, malaria, antibiotic resistant organisms, and other agents, including genetically manipulated materials, which, in the hands of terrorists, could create a public health catastrophe. Comprehensive legislation is needed today to thwart tomorrow's biological threats, including bioterrorism attacks."

"It is critical that the federal government find ways to engage the vibrant private sector in the essential work of saving lives in the developing world," Brownback said. "This bill not only serves our own national security, but could leave a lasting legacy of cures for diseases that kill millions of the world's most vulnerable people."

Specifically, the Project BioShield II Act of 2005 authorizes:

- Tax incentives to spur capital investment in this research;
- Intellectual property protections, including patent incentives that could help spur crucial countermeasures or a cure for AIDS or a new class of antibiotics;
- Liability protections to companies who produce vaccines that cannot be fully tested in clinical trials because of the nature of the deadly diseases they are designed to combat.

The legislation does not allocate a specific funding amount for these provisions but promises government funding only for final products that meet the government specifications. Thus the risk is shifted to the industry and its investors to produce the products.

In crafting the legislation, Lieberman, Hatch and Brownback consulted with more than five hundred national and international infectious disease and biodefense experts and many of them, including the International AIDS Vaccine Initiative (IAVI), the Infectious Disease Society of America (IDSA) and the American Society of Tropical Medicine and Hygiene (ASTMH), have expressed their support for the bill.

Earlier this year, the Senate Republican leadership introduced S. 3, a less comprehensive bill also designed to combat bioterrorism and infectious diseases. Lieberman, Hatch and Brownback said they hoped to work with their colleagues to include the more comprehensive bioterror provisions of their legislation into S. 3.

A more detailed discussion of the bill is contained in testimony that Lieberman gave before a joint hearing of the Senate Judiciary and Health, Education, Labor and Pensions Committees last October. Read the testimony at:
http://lieberman.senate.gov/newsroom/reports/bioshieldtestimony0604.pdf

IAVI's endorsement press release is available at:
http://www.iavi.org/viewfile.cfm?fid=10864

For more information on the IAVI, IDSA and ASTMH contact Peg Willingham at 703-553-5569, Bob Guidos at 703-299-0200, and Katie Weyforth at 202-544-1880, respectively.

FOODBORNE ILLNESSES CONTINUE DOWNWARD TREND: 2010 HEALTH GOALS FOR E. COLI 0157 REACHED -- A report released by the Centers for Disease Control and Prevention (CDC) in collaboration with the Food and Drug Administration (FDA) and U.S. Department of Agriculture (USDA) showed important declines in foodborne infections due to common bacterial pathogens in 2004.

For the first time, cases of E. coli O157 infections, one of the most severe foodborne diseases, are below the national Healthy People 2010 health goal. From 1996-2004, the incidence of E. coli O157 infections decreased 42 percent. Campylobacter infections decreased 31 percent, Cryptosporidium dropped 40 percent, and Yersinia decreased 45 percent.

Overall, Salmonella infections dropped 8 percent, but only one of the five most common strains declined significantly. Different Salmonella strains are found in a variety of animal hosts and in different geographic locations. Further efforts are needed to better understand why some Salmonella strains tend to contaminate produce during production and harvest. FDA has recently developed a plan to decrease foodborne illnesses associated with fresh produce. To better control foodborne pathogens in animals and plants, prevention efforts should be implemented across the farm to table continuum.

"This report is good news for Americans and underscores the importance of investments in food safety. Our efforts are working and we're making progress in reducing foodborne illnesses," said CDC Director Dr. Julie Gerberding. "However, foodborne disease is still a significant cause of illness in the United States and further efforts are needed to sustain and extend these important declines and to improve prevention of foodborne illnesses."

"The continued reduction in illnesses from E. coli O157 is a tremendous success story and we are committed to continuing this positive trend in the future," said USDA Secretary Mike Johanns. "These results demonstrate that through innovative policies and strong and consistent enforcement of inspection laws, we are protecting the public's health through a safer food supply."

Several factors have contributed to the decline in foodborne illnesses. USDA's Food Safety and Inspection Service implemented a series of new recommendations beginning in 2002 to combat E. coli O157 in ground beef and Listeria in ready-to-eat products. In response, most establishments have significantly enhanced their food safety systems. Many have applied new technologies to reduce or eliminate pathogens and have increased their testing to ensure the effectiveness of control measures. Furthermore, these improvements likely reflect industry efforts to reduce E. coli O157 in live cattle and during slaughter.

The reduction in Campylobacter infections may be due to greater consumer awareness of safe poultry handling and cooking methods. Food safety education efforts targeted to specific foodborne hazards as well as general consumer tips, such as the public-private Fight Bac campaign, have helped consumers become more aware and knowledgeable of food safety hazards and how to prevent them.

The incidence of Shigella, which is found in a wide variety of foods, did not change significantly from 1996 through 2004. Vibrio infections increased 47 percent. Vibrio infections, which are primarily associated with consumption of certain types of raw shellfish, can be prevented by thoroughly cooking seafood, especially oysters.

In 1996, the FoodNet surveillance system began collecting valuable information to quantify, monitor, and track the incidence of laboratory confirmed cases of foodborne illnesses caused by Campylobacter, Cryptosporidium, Cyclospora, E. coli O157, Listeria, Shigella, Yersinia and Vibrio. Since its inception, FoodNet has grown to include ten states and 44 million people, about 15 percent of the American population.

The full report, "Preliminary FoodNet Data on the Incidence of Infections with Pathogens Transmitted Commonly Through Food - Selected Sites, United States, 2004" appears in this week's Morbidity and Mortality Weekly Report (April 15, 2005) and is available online at www.cdc.gov/mmwr.

CDC RELEASES FIRST NATIONAL VIOLENT DEATH REPORTING SYSTEM (NVDRS) DATA -- The Centers for Disease Control and Prevention April 22 released the first data from the National Violent Death Reporting System (NVDRS). Data reported by the first six participating states, (Maryland, Massachusetts, New Jersey, Oregon, South Carolina and Virginia) show increases in suicide and homicide rates for the years 2000 through 2003. This data is in contrast to decreases in violent deaths reported in these states and nationwide from 1993 through 2000. Because this system only contains the first year of data in a small number of states, it’s too early to determine how risk factors and trends might have changed in recent years.

In 2003, homicide increased four percent and suicide increased five percent above 2002 rates in the six reporting states. Homicide rates among males under age 25 increased 18 percent in those states.

“NVDRS puts us on the front line to collect rapid, reliable data to better inform our prevention strategies,” said CDC’s Director, Dr. Julie L. Gerberding. ”With NVDRS, we can spot early warning trends for violent deaths and modify our prevention efforts. Among those warning signs are the role of alcohol and drugs in violent deaths, and how often a homicide is followed by a suicide.”

CDC established NVDRS in 2003 to address a crucial gap in understanding national and regional trends in violent deaths by combining relevant records into one repository state-specific data.

“This system provides states and communities valuable information that can be used to develop and implement tailored violence prevention efforts,” said Dr. Ileana Arias, acting director of CDC’s National Center for Injury Prevention and Control. “The data help to identify potential strategies and also allow us to evaluate our current violence prevention efforts and determine if they are saving lives.”

The NVDRS will document the circumstances of suicides and homicides to help identify and evaluate prevention opportunities. Each state collects detailed information about a violent death directly from the records of state health departments, medical examiners and coroners, and law enforcement, providing a clearer picture of the circumstances surrounding violent deaths at the national, regional, and state levels. Information such as a history of depression or a family dispute, gang activity, drugs and other circumstances surrounding the violent death are recorded.

Currently, 17 states participate in this state-based surveillance system. The next report expected later this year will include the data from the initial six states as well as seven additional states (Alaska, Colorado, Georgia, Oklahoma, North Carolina, Rhode Island and Wisconsin) which began collecting data in 2004. The final four states (California, Connecticut, Utah and New Mexico) which began data collection in 2005, will not release any data until 2006.

CDC hopes to expand NVDRS to all 50 states so data can be compared across states and regions of the country, and to establish national violence related data. For more information about NVDRS, visit www.cdc.gov/ncipc/profiles/nvdrs/facts.htm or www.cdc.gov/injury.

HHS SECRETARY APPOINTS ADVISORY COMMITTEE ON MINORITY HEALTH -- HHS Secretary Mike Leavitt April 22 announced the appointment of eight members to serve on the Advisory Committee on Minority Health. The committee will advise the U.S. Department of Health and Human Services on improving the health of racial and ethnic minority groups and on the development of goals and specific program activities for the department's Office of Minority Health.

"Our goal is to eliminate health disparities and improve health outcomes for all Americans," Secretary Leavitt said. "The expertise this group brings will go a long way toward helping us meet that goal."

The next meeting of the committee, on April 25-26, will include presentations on the status of racial and ethnic health disparities, research challenges and opportunities, improving service delivery to better address racial and ethnic disparities, and the role of prevention in improving health outcomes for racial and ethnic minorities. The committee met at the Marriott Bethesda North Hotel and Conference Center, 5701 Marinelli Road, North Bethesda, Md., on April 25th from 1:00 p.m. until 5:00 p.m. and on April 26th from 9:00 a.m. until 5:00 p.m.

Leo MacKay, Ph.D., Chief Operating Officer, ACS State Healthcare, Atlanta, Ga., has been appointed as Committee Chairperson.

Dr. MacKay is the chief operating officer (COO) of ACS State Healthcare in Atlanta. Prior to becoming COO for ACS State Healthcare, Dr. MacKay served as deputy secretary of the Department of Veterans Affairs' health care system. As deputy secretary, he served as the COO of the nation's second largest cabinet department, responsible for a $60 billion dollar budget and 219,000 employees. Prior to joining the Department of Veterans Affairs, Dr. MacKay was vice president of Bell Helicopter Textron, Inc. in Ft. Worth, Texas. He is a 1983 graduate of the United States Naval Academy where he was awarded the Secretary of the Navy's Distinguished Midshipman Graduate Award. Dr. MacKay's military career included serving as military assistant to the Assistant Secretary of Defense from 1993-1995.

The other new Committee members are:

Joseph Kevin Villagomez, M.A., Counseling Psychologist, Department of Public Health, Saipan, Commonwealth of the Northern Mariana Islands

Dr. Villagomez is a distinguished psychologist, serving over a decade in the Department of Public Health for the Commonwealth of the Northern Mariana Islands. He established the Substance Abuse Treatment Program and the Substance Abuse Prevention Program and was subsequently appointed in 1995 by the Governor to be the first director for the newly created Division of Mental Health and Social Services. As the director, he was responsible for developing the Transitional Living Center, which serves as a housing unit for long-term psychiatric patients.

Cheryl Killion, B.S., M.S., M.A., Ph.D., Research Associate Professor, Center for Minority Family Health, Hampton, Virginia

Dr. Killion's career spans 30 years in nursing and research. She is currently a research associate professor and director of Minority Family Health in the School of Nursing Program at Hampton University. Previously, Dr. Killion served as research assistant at Charles Drew Postgraduate Medical School.

Edna M. Berastain, M.B.A., Executive Director of Latinos/as, Contra SIDA, Hartford, Conn.

Ms. Berastain serves as executive director of Latinos/as Contra SIDA (LCS). LCS provides comprehensive services for at-risk individuals, particularly those disproportionately impacted within the Hispanic, African-American, and Caribbean populations. Prior to becoming executive director of LCS she served as assistant commissioner for the Connecticut Department of Public Health. She also served as the director of the Connecticut Regional Office of the Puerto Rico Federal Affairs Administration and the executive assistant to the Mayor of the City of Hartford.

Inam Ur Rahman, M.D., President and Founder of the Diabetic Clinic, Honolulu, Hawaii

Dr. Ur Rahman is the president and founder of the Diabetic Clinic, a unique diabetic clinic dedicated to prevention, early diagnosis, education and treatment of diabetes. In addition to his clinical responsibilities, Dr. Rahman is the host of the radio program "Healers of the New Millennium" which is broadcast in Hawaii. He also hosts and produces the "Healers of the New Millennium" medical television series in Hawaii.

RADM Kermit C. Smith, D.O., M.P.H. (Ret), Former Chief Medical Officer, Indian Health Service (IHS), Tucson, Ariz.

Dr. Smith dedicated his career to improving the health of American Indians. Prior to his retirement from the Commissioned Corps of the U.S. Public Health Service, Rear Admiral Smith served in various positions within IHS. He has the distinguished honor of being selected as the first chief medical officer for IHS. Dr. Smith has also served as director of the Sacaton Diabetes Program, acting director for the Office of Health Programs/deputy chief medical officer, acting chief medical officer for IHS Headquarters East, and director and primary care physician at the Phoenix Indian Medical Center in Phoenix, Ariz. Dr. Smith is a member of the Assisniboine Tribe.

Adrienne Laverdure, M.D., Medical Director of Family Health, Peter Christensen Health Center, Lac Du Flambeau, Wis.

Dr. Laverdure has worked to improve the health of families in Wisconsin. She has vast experience in family health, occupational health, adult and pediatrics care and in managing extended care providers of physician assistants and nurse practitioners. During her career she has received a number of awards including, the Minority Health Leadership Award, Wisconsin 2003.

Valerie Romero-Leggott, M.D., Assistant Professor/Director of Cultural & Ethnic Programs, University of New Mexico, Albuquerque, N.M.

Dr. Romero-Leggott has dedicated her career to advancing cultural competency within the health care profession. She takes pride in her responsibilities for mentoring underrepresented faculty, spearheading the development of a culturally competent curriculum in the School of Medicine, and serving as chair of the Diversity/Cultural Competence Task Force, Undergraduate Medical Education Curriculum.

CDC REVEWS EFFORTS TO REDUCE OR PREVENT OBESITY -- The prevalence of overweight and obesity has increased substantially over the past several decades. The latest National Health and Nutrition Examination Survey (NHANES) data indicate 65 percent of U.S. adults aged 20 years and older are overweight with a body mass index (BMI) of 25 or higher, or obese with a BMI of 30 or higher. In addition, 16 percent of children and adolescents ages 6-19 in the United States are overweight.

Body mass index (BMI) is a measure of weight adjusted for height. Although it does not differentiate between body fat and muscle mass, BMI is a useful tool for indicating whether a person is underweight, at a healthy weight, overweight or obese.

According to *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*, the medical and related costs of obesity in the United States in 2000 was more than $117 billion. Overweight and obesity have been associated with a number of conditions. Among these are heart disease, stroke, diabetes, cancer (such as colon cancer, endometrial cancer, and postmenopausal breast cancer) and osteoarthritis.

Two studies in the April 20, 2005 issue of *Journal of the American Medical Association (JAMA)* provide more information on issues related to obesity and mortality.

"Excess Deaths Associated with Underweight, Overweight and Obesity"

Using data collected from the most recent NHANES, Katherine Flegal, Ph.D., CDC's National Center for Health Statistics, and her co-authors from CDC and the National Cancer Institute, part of the National Institutes of Health, found that both obesity and being underweight are associated with excess deaths when compared with the normal weight population.

The study found:

* There were 112,000 more deaths than expected in 2000 among obese individuals (BMI of 30 or higher).

* Underweight individuals (BMI of less than 18.5) had a higher risk of death with nearly 34,000 more deaths than expected.

* Most of the excess deaths among the underweight occurred in people age 70 or older. Among the obese, the increased risk of death was most pronounced among people younger than 70.

* Being overweight (BMI of 25-29.9) was not associated with excess mortality. The study found that 87,000 fewer deaths than expected were associated with being overweight.

"Secular Trends in Cardiovascular Disease Risk Factors According to Body Mass Index in US Adults"

Edward Gregg, Ph.D., of CDC's diabetes program and his CDC co-authors, analyzed NHANES data and found large decreases in many of the cardiovascular disease risk factors known to be associated with early deaths in all U.S. adults ages 20-74, regardless of their BMI. The exception was diabetes. The prevalence of total (diagnosed and undiagnosed) diabetes increased by 55 percent over the past 40 years, likely the result of the dramatic increase in obesity during this time period.

Other key findings:

* Prevalence of elevated cholesterol and blood pressure dropped by almost half in all U.S. adults ages 20-74, while smoking prevalence dropped by about a third.

* Reductions in the prevalence of high cholesterol levels were most substantial among obese people compared to lean individuals.

* Reductions in blood pressure and smoking prevalence were similar among lean and obese persons.

CDC Efforts to Reduce or Prevent Obesity

Because the current generation of children, adolescents and young adults is the most overweight in our nation's history, reducing obesity is one of CDC's top health priorities. CDC is undertaking an agency-wide effort to conduct research activities and programs to improve our understanding of all the ways that obesity can affect health, as well as identify strategies to prevent obesity-related health problems. CDC's efforts include surveillance, prevention research, and state, community and school-based programs in nutrition and physical activity.