THE CSTE WASHINGTON REPORT

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INSIDE THIS ISSUE

EDITOR'S NOTE: Two studies issued by the Centers for Disease Control and Prevention (CDC) in the Morbidity and Mortality Weekly Report show that racial and regional disparities in stroke prevalence and stroke-related deaths still continue to exist in the United States, particularly among African Americans. In the first study, researchers found that the years of potential life lost due to stroke by African Americans before age 75 was more than double that of all other races. The second report provides further evidence that the prevalence of stroke is higher in the Southeast, also known as the "Stroke Belt," and is most significant among African Americans -- 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

CONGRESSIONAL COMMITTEE UPDATE – The Senate Subcommittee on Bioterrorism and Public Health Preparedness held a hearing on May 11th on, "21st Century Biological Threats." Testimony from three witnesses: John Deutch, Massachusetts Institute of Technology, Cambridge, former Director of Central Intelligence, and former Deputy Secretary of Defense, Harvey Fineberg, President of the Institute of Medicine, and Shelley Hearne, Executive Director, Trust for America's Health stressed the importance of dual use of bioterrorism grants for state and local health departments and the underlying importance of a strong public health infrastructure for both bioterrorism and other infectious disease threats. Other witnesses were: J. Craig Venter, J. Craig Venter Institute, Rockville, Maryland; Guenael R. Rodier, World Health Organization, United Nations, New York, New York. CSTE's leadership is in active communication with the principal staff of the Subcommittee which is working on legislation to reauthorize the 2002 Public Health Security and Bioterrorism Response Act.

The House Energy and Commerce Committee is holding a hearing today (5/26) on the "Threat of and Planning for Pandemic Flu." This is the third hearing by a major Congressional Committee this year on the topic of pandemic flu preparation. Principal witnesses at the hearing today are: Bruce Gellin, Director, National Vaccine Program Office; U.S. DHHS, Julie Gerberding, Director, CDC; Anthony Fauci, Director, National Institute for Allergy and Infectious Dieseases, NIH; Marcia Crosse, Director, Health Issues, GAO. A second witness panel is made up of academic and pharmaceutical company representatives.

LEGISLATIVE UPDATE – Recently introduced bills of interest are as follows:

S. 1074, the "Healthy Lifestyles and Prevention America Act or the HeLP America Act" was introduced by Sen. Harkin (D-IA) on May 18th. Known as the wellness bill, the bill is a comprehensive set of provisions to improve the health of Americans and reduce health care costs by reorienting the Nation's health care system toward prevention, wellness, and self care. Much of the bill focuses on smoking and obesity prevention. The bill has been referred to the Committee on Finance. CSTE has endorsed the bill which is designed to spur Congressional discussion and debate on reorienting the entire health care system toward prevention.

H.R. 2526, the "Tick-Borne Disorders Advisory Committee Act of 2005," was introduced by Rep. Kelly (R-NY) on May 23. The bill would establish a national tick-borne disorders advisory committee to advise the HHS Secretary on interagency coordination and communication, coordinate with private organizations and develop informed responses to constituency groups on the Department's efforts and progress. Committee representatives would include representatives from state and local health departments and their respective national organizations. The bill also authorizes $10 million for a research and public awareness effort, and urges the Secretary to consider adoption of a five year plan to develop a diagnostic test, surveillance to determine the

prevalence of the tick-borne disorders, and prevention capabilities. This bill has bipartisan support and is similar to bills introduced in the past by Rep. Chris Smith (R-NJ).

H.R. 2562, the "Preservation of Antibiotics for Medical Treatment Act of 2005," was introduced by Rep. Brown (D-OH) on May 24. A Senate companion bill was introduced by Sen. Snowe (R-ME) on April 7. The bill A Congressional Research Service summary of the bill is as follows: "Preservation of Antibiotics for Medical Treatment Act of 2005 - Amends the Federal Food, Drug, and Cosmetic Act to require the Secretary of Health and Human Services to deny an application for a new animal drug that is a critical antimicrobial animal drug unless the applicant demonstrates that there is a reasonably certainty of no harm to human health due to the development of antimicrobial resistance attributable to the nontherapeutic use of the drug. Defines "critical antimicrobial animal drug" as a drug intended for use in food-producing animals that contains specified antibiotics or other drugs used in humans to treat or prevent disease or infection caused by microorganisms.

Requires the Secretary of Health and Human Services to withdraw approval of a nontherapeutic use of such drugs in food-producing animals two years after the date of enactment of this Act unless certain safety requirements are met.

Authorizes the Secretary of Agriculture to make payments to livestock or poultry producers to defray the costs of reducing the use of such drugs, with priority given to family-owned or small farms and ranches.

Amends the Farm Security and Rural Investment Act of 2002 to direct the Secretary of Agriculture to award grants to colleges and universities to establish programs to phase out the nontherapeutic use of such drugs in livestock or poultry.

Requires the manufacturer of such a drug or an animal feed for food-producing animals containing such a drug to report sales information to the Secretary of Health and Human Services."

H.R. 2391, the "Safe Communities and Safe Schools Mercury Reduction Act of 2005," was introduced by Rep. Baldwin (D-WI) on May 17. The bill creates a grant program within the Environmental Protection Agency to reduce mercury in the environment and educate communities about the harmful effects of mercury; creates controls over the sale and supply of mercury fever thermometers and building thermostats; focuses on mercury removal in schools; calls for guidelines for the capture and waste management of dental mercury-laden amalgams; requires annual reporting by the EPA Administrator on the agencies activities and progress in mercury removal efforts. The bill has 15 co-sponsors with one Republican; does not yet have a Senate companion bill. It has been referred to the House Energy and Commerce Committee.

H.R. 2553, the "Responsible Education About Life Act," was introduced by Rep. Lee (D-CA) on May 23. The bill seeks to provide for the reduction of adolescent pregnancy, HIV rates, and other sexually transmitted diseases, and for other purposes. It has been

referred to the Committee on Energy and Commerce. It has 84 co-sponsors, all Democrats, and there is not currently a Senate companion bill.

H.R. 2206, the "Veterinary Workforce Expansion Act of 2005," introduced by Rep. Pickering (R-MS) on May 8. This is a companion bill to S. 914 introduced by Sen. Allard (R-CO) in April. The bill amends the Public Health Service Act to establish a competitive grant program to build capacity in veterinary medical education and expand the workforce of veterinarians engaged in public health practice and biomedical research. The bill has been referred the House Energy and Commerce Committee and the Committee on Health, Education, Labor, and Pensions.

HHS SECRETARY AND LEADING U.S. COMPANIES SAY HEALTH INFORMATION TECHNOLOGY SHOULD BE URGENT PRIORITY -- HHS Secretary Mike Leavitt issued a new report May 11 citing investment in information technology (IT) as an essential, high priority for the American health care system and the U.S. economy.

"Information technology is a pivotal part of transforming our health care system," Secretary Leavitt said. "We are at a critical juncture. Working in close collaboration, the federal government and private sector can drive changes that will lead to fewer medical errors, lower costs, less hassle and better care."

The report, "Health Information Technology Leadership Panel: Final Report," was released at the Business Rountable's Chief Executive Officer (CEO) Health Care Summit where Secretary Leavitt and Treasury Secretary John Snow discussed the burden of rising health care costs on the U.S. economy and global competitiveness and the role of health IT in managing these costs. The meeting was chaired by Michael B. McCallister, CEO of Humana, Chairman of the Roundtable's Health and Retirement Task Force, and leader of the Roundtable's efforts to improve the health care system.

In April 2004, President Bush called for personal electronic health records for most Americans within 10 years and nationwide adoption of health IT. Answering this call, HHS issued the Framework for Strategic Action in July 2004. The Lewin Group, a health care policy consulting firm, which was the HHS contractor, convened the Health Information Technology Leadership Panel. Membership was drawn from corporate executives in large companies that purchase a substantial amount of health care for their employees. The report issued today was prepared by the Lewin Group.

The Leadership Panel identified three **key imperatives** for health IT:

1. Widespread adoption of interoperable health IT should be a top priority for the U.S. health care system.
2. The federal government should use its leverage as the nation's largest health care payer and provider to drive adoption of health IT.
3. Private sector purchasers and health care organizations can and should collaborate alongside the federal government to drive adoption of health IT.

The panel also reached six **conclusions** to guide health IT adoption by the federal government and private sector.

1. Potential benefits of health IT far outweigh manageable costs.
2. Health IT needs a clear, broadly motivating vision and practical adoption strategy.
3. The federal government should provide leadership, and industry will engage and follow.
4. Lessons of adoption and success of IT in other industries should inform and enhance adoption of health IT.
5. Stakeholder incentives must be aligned to foster health IT adoption.
6. Among its multiple stakeholders, the consumer – including individual beneficiaries, patients, family members and the public-at-large – is key to adoption of health IT and realizing its benefits.

Finally, the Leadership Panel identified **themes** regarding the relative benefits and costs of health IT implementation.

* First, investment in health IT is urgent and vital to rising health care demands, business interests and the broader US economy. Despite the initial costs, health IT will become an essential means -- among others -- for managing health care costs.
* Second, the potential benefits and costs of health IT must be clearly perceived by its stakeholders.

“The Leadership Panel asked the Federal government to approach health care in a new way -- as a catalyst for change and as a collaborator,” said National Coordinator for Health Information Technology, David J. Brailer, M.D., Ph.D. “The panelists’ recommendations verify the need for shared public and private investment and ongoing collaboration to achieve the President’s vision for widespread health information technology adoption.”

Panelists specifically suggested several actions the government could take to help lead the adoption of health IT. Specific recommendations included: making changes to policies and programs that would take the form of incentives and rewards for health IT adoption in the private industry; continue to strengthen efforts to coordinate the adoption and use of interoperable health IT across the federal enterprise; take savings from streamlining investments and reinvest them back into additional health IT implementation; continue to promote the adoption of harmonized standards; and, finally, continue funding demonstrations and evaluations of interoperable health IT.

CEOs who participated on the HIT Leadership Panel included: CEO of the FedEx Corporation, Frederick Smith; CEO of General Motors, Rick Wagoner; CEO of International Paper, John Faraci; CEO of Johnson Controls, John Barth; CEO of Target Corporation, Robert J. Ulrich; CEO of Pepsico, Steve Reinemund; CEO of Procter & Gamble, Alan G. Lafley; CEO of Wells Fargo, Richard Kovacevich; and David Glass (former CEO) of Wal-Mart Stores, Inc.

A copy of the “Health Information Technology Leadership Panel: Final Report” is available at http://www.hhs.gov/healthit/HITFinalReport.pdf.

AFRICAN AMERICANS AND PEOPLE LIVING IN SOUTHEAST U.S. MORE LIKELY TO HAVE A STROKE -- Two studies issued by the Centers for Disease Control and Prevention (CDC) in the Morbidity and Mortality Weekly Report show that racial and regional disparities in stroke prevalence and stroke-related deaths still continue to exist in the United States, particularly among African Americans.

In the first study, researchers found that the years of potential life lost due to stroke by African Americans before age 75 was more than double that of all other races. The second report provides further evidence that the prevalence of stroke is higher in the Southeast, also known as the "Stroke Belt," and is most significant among African Americans.

"As we observe National Stroke Awareness Month, these two studies serve as sobering reminders that it is crucial that we do everything within our power to educate people about the steps they can take to reduce their risk for stroke. We especially need to reach African Americans and people living in the Southeastern United States," said Donna Stroup, Ph.D., director of CDC's Coordinating Center for Health Promotion. "We must improve access to health care and look at creative ways to increase public awareness of the early signs of stroke, particularly among those most at risk."

The first study titled, "Disparities in Deaths from Stroke Among Persons Aged <75 Years — United States, 2002," used national and state mortality data based on death certificate information reported to CDC for 2002. The study found that approximately 3,400 more stroke deaths than would be expected occurred among African Americans before age 65. Age adjusted stroke death rates before age 65 ranged from 37.4 (per 100,000 population) in New York to 74.3 (per 100,000 population) in Arkansas. Age-adjusted estimates of years of potential life lost before age 75 ranged from 132.7 (per 100,000 population) in Vermont to 361.0 (per 100,000 population) in Mississippi.

The second study, "Regional and Racial Differences in Prevalence of Stroke – 23 States and the District of Columbia, 2003," used data from the 2003 Behavioral Risk Factor Surveillance System collected from 23 states and the District of Columbia. The states were divided in two categories — Southeast states (Alabama, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, and Virginia) and non-Southeast states (Alaska, Colorado, Connecticut, Hawaii, Maine, Maryland, Minnesota, Montana, Nebraska, New York, North Dakota, Ohio, West Virginia, and the District of Columbia). The study found that the prevalence of stroke was higher in the Southeast than non-Southeast states. Stroke prevalence was highest among African Americans residing in the Southeastern region (3.4 percent) compared to African Americans in non-Southeastern states (2.8 percent), white residents of Southeastern states (2.5 percent), and white residents of non-Southeastern states (1.8 percent). Differences in demographics, education, uninsured medical care and risk factors

for stroke accounted for a substantial proportion of the higher stroke prevalence in the Southeast.

"It is critical that we properly address the risk factors for stroke, such as diabetes, high blood pressure, smoking, and overweight and obesity," said Dr. George A. Mensah, acting director for CDC's National Center for Chronic Disease Prevention and Health Promotion. "We must continue efforts to help people make the kind of lifestyle choices that can help prevent stroke, like eating a healthy diet, getting regular physical activity and not smoking. We must also continue to raise awareness of the signs and symptoms of stroke, stress the importance of calling 9-1-1 and improve emergency response and quality of care for stroke victims."

An estimated 700,000 people in the United States will have a stroke in 2005. Approximately 160,000 people will die from stroke, and 15 percent to 30 percent of stroke survivors will be disabled permanently. Recognizing the warning signs for stroke and immediately seeking emergency medical care are critical first steps toward obtaining appropriate treatment that might prevent death and disability. In observance of National Stroke Awareness Month, the public is encouraged to become familiar with the warning signs of stroke: 1) sudden numbness or weakness of the face, arm, or leg, especially on one side of the body; 2) sudden confusion, including trouble speaking or understanding; 3) sudden trouble seeing in one or both eyes; 4) sudden trouble walking, dizziness, or loss of balance or coordination; and 5) sudden, severe headache with no known cause.

PARENT, PREGNANCY, AND BIRTH FACTORS FOUND POSSIBLE ASSOCIATIONS WITH THE RISK OF AUTISM -- Pregnancy factors, parental psychiatric history, and preterm delivery may be associated with the risk of autism, according to a recent study supported in part by the Centers for Disease Control and Prevention (CDC). The study, “Risk Factors for Autism: Perinatal Factors, Parental Psychiatric History, and Socioeconomic Status,” appears in the most recent issue of the American Journal of Epidemiology.

The research, which involved national study of all 698 Danish children with autism born after 1972 and diagnosed before 2000, focused on perinatal risk factors (i.e., delivery and newborn characteristics, pregnancy characteristics, and parental characteristics), parental psychiatric history (i.e., did a parent have a diagnosed psychiatric illness before the date that autism was diagnosed in the child) and socioeconomic status (i.e., the mom’s formal education and parental wealth at the child’s birth). Previous research had suggested each category may represent or include risk factors for autism.

“This study is a helpful step forward in identifying possible risk factors for autism,” said Dr. José Cordero, director of CDC’s National Center on Birth Defects and Developmental Disabilities. “It also indicates there may be some children for whom we need extra vigilance in watching for signs of developmental delay. In recent years, many programs and studies have found that early recognition of autism and other developmental disabilities is important because early treatment can significantly improve a child’s development.”

Some of the specific factors that the study found to be associated with the risk of autism included: breech presentation at birth, delivery before 35 weeks, a parent who had a diagnosis of schizophrenia-like psychosis before the date that autism was diagnosed in the child, and low birth weight at delivery. The study also found many of these factors were independently associated with autism. For example, there was an association between adverse pregnancy events and autism, regardless of whether one of the parents had a diagnosed psychiatric illness.

“We need to further investigate the role of events during pregnancy, including their possible interaction with genetic factors, to learn more about potential causes of autism,” said Diana Schendel, CDC epidemiologist and one of the authors. “We also need additional research to determine if the factors identified here really play a role in causing autism. Right now, we have only identified possible associations. But if we can find a cause-and-effect relationship, it may help our efforts to prevent autism.”

Autism spectrum disorders (ASDs) are a group of developmental disabilities that are caused by unusual brain development. People with ASDs tend to have problems with social and communication skills. Many people with ASDs also have unusual ways of learning, paying attention, or reacting to different sensations. ASDs begin during childhood and last throughout a person's life. CDC funds projects on autism spectrum disorders (ASDs) in several states. These projects track the number of children who have an ASD, conduct studies to find out what factors make it more likely that a child will have an ASD, and offer education and outreach programs for researchers, families, and other people affected by ASD. Large representative studies are needed to answer questions necessary to determine the potential causes of autism and develop prevention strategies for this disorder.

NEW EXPERT PANEL REPORT EXAMINES STANDARDS OF CARE DURING MASS CASUALTY EVENTS -- Guidelines for officials on how to plan for delivering health and medical care in a mass casualty event are outlined in a new report from an expert panel convened by HHS' Agency for Healthcare Research and Quality and Office of Public Health Emergency Preparedness.

The report, *Altered Standards of Care in Mass Casualty Events*, offers a framework for how to provide optimal care during a potential bioterrorism or other public health emergency involving thousands, or even tens of thousands, of victims. For example, planners at the Federal, State, regional, community, and health systems levels should develop or revise triage guidelines for specific types of events and allocation guidelines for the use of scarce resources such as ventilators, burn beds, or surgical suites, according to the report.

Altered Standards of Care in Mass Casualty Events includes the recommendations of a 39-member panel of experts in bioethics, emergency medicine, emergency management, health administration, health law and policy, and public health that was convened in August 2004 to examine this challenge.

"Providing optimal care in a mass casualty event requires that we identify, plan, and prepare for the circumstances of available providers, facilities, equipment, and transportation of casualties," said AHRQ Director Carolyn M. Clancy, M.D. "We're grateful to the experts who helped provide a starting point for government agencies and private organizations grappling with these critical issues."

In addition to examining the reallocation of health and medical resources among hospitals and other health facilities, the report considers a number of important non-medical issues, including:

* What circumstances would trigger a call for altered standards of care, and who is authorized to make that call?
* What existing laws and mechanisms allow for legal, regulatory, or accreditation adjustments in provider liability, licensing, facility standards, and patient privacy?
* What sources of relief are available to address concerns about financial resources and reimbursement of medical care costs?
* What public communication strategies are needed before, during, and after a mass casualty event?
* What supports are available for populations with special needs, such as children, persons with physical or cognitive disabilities, and non-English speakers?

The report suggests that a collaborative approach should be taken by government and private organizations when developing next steps in responding to public health emergencies.

Altered Standards of Care in Mass Casualty Events can be found online at http://www.ahrq.gov/research/altstand/. Printed copies may be ordered by calling (800) 358-9295 or by sending an E-mail to ahrqpubs@ahrq.gov.

AHRQ has funded more than 50 emergency preparedness-related studies, workshops, conferences, and other activities to help hospitals and health care systems prepare for medical emergencies. Information about these projects can be found at www.ahrq.gov/browse/bioterbr.htm.