THE CSTE WASHINGTON REPORT

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

July 13, 2005 Volume 9, Number 14

INSIDE THIS ISSUE

EDITOR'S NOTE:. The U.S. Preventive Services Task Force issued a new recommendation calling for all pregnant women, not just those identified as at risk for contracting HIV, to be screened for the infection. This recommendation is based on evidence that currently available tests accurately identify pregnant women who are HIV infected and that recommended treatment strategies can dramatically reduce the chances that an infected mother will transmit HIV to her infant. The Task Force also reaffirmed its earlier recommendation that all adolescents and adults at increased risk for HIV infection be screened and has broadened its definition of high-risk. In addition to patients who report high-risk behaviors, all patients receiving care in high-risk settings such as homeless shelters or clinics dedicated to the treatment of sexually transmitted diseases should be tested. The Task Force found at least fair evidence that screening adolescents and adults who are not at increased risk can improve health outcomes, but concluded that the balance of benefits and harms is too close to justify a general recommendation. The

new recommendations are published in the July 5 issue of the *Annals of Internal Medicine*. -- 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 Senate Labor-HHS-Education Subcommittee on Appropriations marked up its FY 2006 bill yesterday, July 12. Details are not yet available, but a press release issued by the Subcommittee indicates that a total of $65.410 billion was provided for health programs which is $1.640 billion more than FY 2005 and $2.892 billion more than the President's request. Most of the increase, $1.050 billion, was provided to the National Institutes of Health bringing that agency's total to $29.4 billion (+3.9 percent). Another $250 million was provided for the Health Professions Training program whose funding for 12 programs was zeroed out in the President's budget request and the corresponding House appropriations bill. Unfortunately, the Senate bill matches the House bill in providing only $100 million for the Prevention Block Grant, a cut from $131 million provided in FY 2005 before $12 million was reprogrammed later in the year, but an improvement over the President's budget which requested zero funding. The Senate bill matches the President's request for the CDC State and Local Bioterrorism grants, cutting that program by $130 million, or 14 percent; the House bill reduced the proposed cut to $67 million, or 8 percent.

The Senate Subcommittee utilized an accounting maneuver to provide the increased funds for its bill: $3.3 billion in mandatory payments under the Supplemental Security Income (SSI) program would be shifted by a few days from F 2006 to FY 2007. Another $105 million was freed up by including language prohibiting payment for impotency drugs under the Medicaid and Medicare programs. This was also adopted in the corresponding House appropriations bill. Last year, Senate efforts to forward fund the SSI payments was rejected in conference making that approach unlikely to succeed. The Administration has endorsed the House Labor-HHS-Education Appropriations bill.

The full Senate Appropriations Committee marks up the bill tomorrow, July 14. It is unclear when it may be taken up on the Senate floor.

COMMITTEE UPDATE – The Senate Subcommittee on Bioterrorism and Public Health Preparedness will hold a roundtable discussion tomorrow, July 14 on the topic: "When Terror Strikes – Preparing an Effective and Immediate Public Health Response." Included among the 12 experts called to discuss the topic is Leah M. Devlin, the chief Health Officer, North Carolina Department of Health. The Subcommittee is chaired by Sen. Richard Burr (R-NC).

FEDERAL AGENCIES FACE CHALLENGES IN IMPLEMENTING INITIATIVES TO IMPROVE PUBLIC HEALTH INFRASTRUCTURE – The U.S. Government Accountability Office (GAO) July 11 released a comprehensive assessment of information technology on public health www.gao.gov/cgi-bin/getrpt?GAO-05-308.

According to the report, although significant work remains, federal agencies have made progress onmajor public health IT initiatives. These initiatives include one broad initiative at the Centers for Disease Control and Prevention (CDC)—known as the Public Health Information Network (PHIN)—which is intended to provide the nation with integrated information systems, and two initiatives at the Department of Homeland Security (DHS), which are focused on biosurveillance (see table). CDC's PHIN initiative has made progress by establishing communications systems and promoting standards, but more work remains on associated surveillance systems. For example, public health officials told GAO that they did not find PHIN's BioSense application useful because of limitations in the data currently collected. DHS also has major initiatives related to public health, both of which are in development.

In addition, a system associated with one of the DHS initiatives—BioWatch—has been deployed. BioWatch, an early-warning environmental monitoring system that collects air samples in order to detect trace amounts of biological materials, recently underwent modification to solve an interoperability problem: its three IT components required redundant data entry in order to communicate with each other. According to DHS, it has developed a solution to this interoperability problem and implemented it at two locations; DHS plans to install that solution in the remaining BioWatch locations.

According to the GAO, CDC and DHS face challenges in planning and implementing their major public health IT initiatives. These challenges include (1) integrating current initiatives into a national health IT strategy and federal architecture to reduce the risk of duplicative efforts, (2) developing and adopting consistent standards to encourage interoperability, (3) coordinating initiatives with states and local agencies to improve the public health infrastructure, and (4) overcoming federal IT management weaknesses to improve progress on IT initiatives. Until these challenges are addressed, progress toward building a stronger public health infrastructure will be impeded, as will the ability to share essential information concerning public health emergencies and bioterrorism.

The anthrax scare of October 2001 exposed serious weaknesses in the U.S. public health infrastructure. Since then, the appearance of new infectious diseases has made preparation and readiness even more critical. Information technology (IT) can be a major factor in detecting and responding to public health emergencies, including bioterrorism.

GAO was asked to review the progress of major federal IT initiatives aimed at strengthening the ability of government at all levels to respond to public health emergencies, as well as to describe key challenges facing agencies pursuing these initiatives.

To improve the development of major public health IT initiatives, GAO recommends, among other actions, that the Secretary of Health and Human Services (1) establish clear linkage between the initiatives and the national health care strategy and federal health architecture and (2) encourage interoperability through the adoption of standards for health care data and communications.

In response to a draft of this report, HHS generally concurred with the recommendations, while DHS did not comment specifically on them. Both agencies provided additional contextual information and technical comments, which were incorporated as appropriate.

HHS APPOINTS MEMBERS TO NATIONAL SCIENCE ADVISORY BOARD FOR BIOSECURITY -- HHS Secretary Mike Leavitt June 29 announced the appointment of 24 members to the National Science Advisory Board for Biosecurity (NSABB). The board will provide advice and recommend specific strategies for efficient and effective oversight of federally conducted or supported dual-use biological research taking into consideration both national security concerns and the needs of the research community.

"We all realize some research that results in new medical treatments, agricultural advances, and biodefense countermeasures could end up in the hands of terrorists who could twist it for their own purposes," Secretary Leavitt said. "The NSABB will provide a forum to help educate scientists on biosecurity and a means for the federal government to receive advice on how to advance scientific knowledge without compromising security."

Dennis L. Kasper, M.D., director of the Channing Laboratory at the Department of Medicine, Brigham and Women's Hospital/Harvard Medical School will chair the NSABB. The NSABB members are:

Arturo Casadevall, M.D., Ph.D., chair of biomedical research, chief of infectious disease, and professor of medicine, microbiology, and immunology at the Albert Einstein College of Medicine.

Murray L. Cohen, Ph.D., M.P.H., C.I.H., the president of Consultants in Disease and Injury Control, Inc., a consulting firm specializing in emerging infections and hospital safety.

Lynn W. Enquist, Ph.D., a professor and chair in the Department of Molecular Biology at Princeton University, and editor-in-chief of the Journal of Virology.

Barry J. Erlick, Ph.D., the founder and president of BJE Associates, Inc., a scientific and technical consulting firm advising government, industry and academia.

David R. Franz, D.V.M., Ph.D., the vice president and chief biological scientist with the Midwest Research Institute and director of the National Agricultural Biosecurity Center at Kansas State University.

Claire M. Fraser, Ph.D., the president, director and co-founder of the Institute for Genomic Research, and professor of microbiology, tropical medicine, and pharmacology at George Washington University School of Medicine.

General John A. Gordon (Ret.), a four-star general retired from the U.S. Air Force; also a former Homeland Security Advisor and former deputy National Security Advisor for Counter-Terrorism to the White House.

Michael J. Imperiale, Ph.D., a professor of microbiology and immunology at the University of Michigan Medical School, where he is also chair of the Institutional Biosafety Committee.

Paul S. Keim, Ph.D., the director of pathogen genomics at the Translational Genomics Research Institute, holding an endowed chair of microbiology at Northern Arizona University.

Stanley M. Lemon, M.D., dean of medicine, as well as chair and director of the Institute for Human Infections and Immunity at the University of Texas Medical Branch at Galveston.

Stuart B. Levy, M.D., a professor of molecular biology and microbiology and professor of medicine, as well as the director of the Center for Adaptation Genetics and Drug Resistance at Tufts University School of Medicine.

John R. Lumpkin, M.D., M.P.H., a senior vice president and director of the Health Care Group at the Robert Wood Johnson Foundation, and former director of the Illinois Department of Public Health.

Adel A. F. Mahmoud, M.D., Ph.D., the president of Merck Vaccines at Merck & Co., Inc. and adjunct professor of medicine at Case Western Reserve University and University Hospitals of Cleveland.

Mark E. Nance, J.D., an attorney in private practice focused on matters of biotechnology law and business.

Michael T. Osterholm, Ph.D., M.P.H., the director of the Center for Infectious Disease Research and Policy, associate director of the National Center for Food Production and Defense, and professor in the School of Public Health at the University of Minnesota.

David A. Relman, M.D., associate professor of medicine and of microbiology and infectious diseases at Stanford University School of Medicine, and chief of the Infectious Diseases Section at the Veterans Affairs Palo Alto Health Care System.

James A. Roth, D.V.M., Ph.D., a distinguished professor in the Department of Veterinary Microbiology and Preventive Medicine in the College of Veterinary Medicine and director of the Center for Food Security and Public Health at Iowa State University.

Harvey Rubin, M.D., Ph.D., the director of the Institute for Strategic Threat Analysis and a professor of medicine specializing in infectious diseases at the University of Pennsylvania.

Thomas F. Shenk, Ph.D., a virologist and professor in the Department of Molecular Biology at Princeton University.

Andrew A. Sorensen, Ph.D., the president of the University of South Carolina with a research background in public health, epidemiology, and health policy.

Admiral William O. Studeman (Ret.), a private consultant who is currently a member of the Defense Science Board, the Presidential Commission on Weapons of Mass Destruction, the Council on Foreign Relations, and other key advisory bodies.

Anne K. Vidaver, Ph.D., a professor and head of the Department of Plant Pathology at the University of Nebraska, Lincoln, and former chief scientist at the USDA.

Diane W. Wara, M.D., professor of pediatrics and program director of the Pediatric Clinical Research Center at the University of California, San Francisco, as well as chair of the NIH Recombinant DNA Advisory Committee.

CDC DIRECTOR ANNOUNCES NEW CENTER DIRECTORS -- Centers for Disease Control and Prevention (CDC) Director Dr. Julie Louise Gerberding announced July 7 new directors for four of the agency's national centers, including the newly created National Center for Health Marketing.

"I am excited about the leadership team we are assembling at CDC. These individuals are leading scientists in their fields and will strengthen our scientific foundation on all fronts. With their unique skills and abilities, the agency is certainly in good hands and in terrific position to meet the daily challenges to protect the nation's health," Dr. Gerberding said.

The announcement of these key positions marks another important step forward in the transformation to a "new CDC" that began two years ago. Since that time, CDC has worked with hundreds of employees, other agencies and organizations to strengthen the agency and prepare for the public health challenges ranging from SARS and pandemic flu to obesity and traumatic brain injury. Two months ago, Congress accepted CDC's new strategic orientation, which includes the creation of four new coordinating centers and two national offices.

The new directors announced include Jay Bernhardt, PhD, as director of the National Center for Health Marketing (NCHM), one of two new national centers created during the reorganization. Dr. Bernhardt is the Founding Director of the Center for Public Health Communication and an Assistant Professor of Behavioral Sciences and Health Education in the Rollins School of Public Health at Emory University. Before coming to Emory, he was an Assistant Professor of Health Promotion and Behavior at the University of Georgia in Athens.

Building CDC's capacity for health marketing is a key strategic imperative. A health marketer well respected in the marketing field and a leader in web-based health

communication, Dr. Bernhardt will help expand CDC's influence in shaping the way its vital health protection information reaches the public.

"Dr. Bernhardt's outstanding knowledge and experience in health communications, e-health, consumer research, and mentoring of health professionals will make him an invaluable addition to CDC," Dr. Gerberding said.

In a second announcement, Howard Frumkin, M.D., Dr.P.H., was named director of the National Center for Environmental Health. Dr. Frumkin is Professor and Chair of the Department of Environmental and Occupational Health at the Rollins School of Public Health of Emory University, and Professor of Medicine at Emory Medical School, in Atlanta. He is an internist, environmental and occupational medicine specialist, and epidemiologist. He founded the Environmental and Occupational Medicine Consultation Clinic at The Emory Clinic and directed it from 1991 to 2000.

"We're privileged to have Dr. Frumkin move down the street from Emory to CDC. We have a long and rich history of successful collaborations with Dr. Frumkin, who as a world renowned leader in environmental health, will serve our country well," Dr. Gerberding said.

In addition, Janet Collins, PhD, was named director of the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). Dr. Collins previously served as the Acting Director for the National Center for HIV, STD, and TB Prevention where she worked closely on the integration of that center into the Coordinating Center for Infectious Diseases. She is a behavioral scientist with a Ph.D. in educational psychology from Stanford University and a Master's degree in Clinical Psychology from San Diego State University.

"Dr. Collin's wealth of knowledge and experience at CDC are invaluable for this key position charged with battling some of our nation's biggest health challenges including obesity, diabetes, and other chronic conditions," Dr. Gerberding noted.

Filling the position of the director of the National Center for Injury Prevention and Control is Ileana Arias, PhD, who has been acting director at the center since June 2004. Before being named as the acting center director in June 2004, Dr. Arias was the Chief of the Etiology and Surveillance Branch in the Division of Violence Prevention in CDC's Injury Center. A clinical psychologist by training, Dr. Arias had been on the faculty of the Psychology Department at the University of Georgia since 1985 before coming to CDC.

"Dr. Arias has brought vision and strength to the center at a time when it confronts the increasingly important issues of family violence, child maltreatment, quality of life for seniors, and acute care injury and disability," Dr Gerberding said.

More announcements about the appointments of additional center directors are expected soon.

HEALTH INSURANCE COVERAGE FOR CHILDREN UP IN 2004; NUMBER OF UNINSURED ADULTS STABLE -- Health insurance coverage for children showed continued improvement in 2004, and the percentage of working-age adults without insurance coverage, which had been climbing in recent years, did not increase last year, according to a new report from the Centers for Disease Control and Prevention (CDC).

The data, based on CDC's National Health Interview Survey, provides estimates of insurance coverage for the United States in 2004. For the first time, the latest survey also includes statistics on insurance coverage for the nation's 10 largest states.

The report, which tracks insurance coverage since 1997, finds that the improvement in coverage for children reflects an increase in public coverage—including the State Children's Health Insurance Program--for poor and near-poor children.

Highlights of the report include:

* In 2004, over 90 percent of America's children had health insurance at the time of the interview – a steady rise from the first report in 1997. In 2004, 9.4 percent of children – 7 million children under 18 years of age – were without health insurance. In contrast, in 1997, about 14 percent – 10 million children – lacked coverage.

* Among poor and near-poor children, lack of coverage dropped by about a third from 1997. For near-poor children, public coverage almost doubled from 24 percent to 43 percent between 1997 and 2004. Nearly 70 percent of poor children under 18 years of age rely on public coverage.

* Overall, 14.6 percent of the population – 42.1 million Americans of all ages – was without current health insurance coverage in 2004, about the same level as in 1997. One in five working-age adults (age 18 to 64) were without insurance in 2004. This number had been steadily rising in recent years but appears to have leveled off in 2004.

* One in five working-age adults (age 18-64) were without insurance in 2004. This number had been steadily rising in recent years but appears to have leveled off in 2004.

* The survey produced health insurance coverage estimates for the 10 largest states. For the population under age 65, Michigan, New York, Ohio and Pennsylvania had considerably lower rates of uninsured than the national average of 16 percent. In California and Florida, just over 20 percent were without health coverage, and in Texas, about 27 percent lacked coverage.

These findings appear in "Health Insurance Coverage: Estimates from the National Health Interview Survey, 2004," gathered from the annual household survey with a sample of the nation's civilian non-institutionalized population. In 2004, the survey,

conducted by CDC's National Center for Health Statistics, added questions to improve the accuracy of the estimates on insurance coverage.

In addition to insurance coverage, the survey collects data on a wide range of health indicators, including measures of health care utilization, health habits and health status. The findings are on the CDC website at www.cdc.gov/nchs.

TASK FORCE RECOMMENDS HIV SCREENING FOR ALL PREGNANT WOMEN -- The U.S. Preventive Services Task Force issued a new recommendation calling for all pregnant women, not just those identified as at risk for contracting HIV, to be screened for the infection. This recommendation is based on evidence that currently available tests accurately identify pregnant women who are HIV infected and that recommended treatment strategies can dramatically reduce the chances that an infected mother will transmit HIV to her infant.

The Task Force also reaffirmed its earlier recommendation that all adolescents and adults at increased risk for HIV infection be screened and has broadened its definition of high-risk. In addition to patients who report high-risk behaviors, all patients receiving care in high-risk settings such as homeless shelters or clinics dedicated to the treatment of sexually transmitted diseases should be tested. The Task Force found at least fair evidence that screening adolescents and adults who are not at increased risk can improve health outcomes, but concluded that the balance of benefits and harms is too close to justify a general recommendation. The new recommendations are published in the July 5 issue of the *Annals of Internal Medicine*.

In 1996, the Task Force recommended a targeted strategy of routine counseling and screening of high-risk pregnant women and those who live in communities with a higher rate of HIV-positive newborns. However, recent evidence indicates that prenatal counseling and HIV testing has gained wider acceptance among pregnant women and that universal testing increases the number of women diagnosed and treated for HIV prior to delivery. Currently recommended treatment of HIV-infected pregnant women has been shown to significantly reduce the number of women who pass the virus to their newborns.

Treatment includes combination drug therapies taken during pregnancy that have been found safe for both mothers and infants. In addition, elective cesarean section and avoidance of breastfeeding have been shown to further reduce the chances of a woman's passing HIV infection to her infant. Infected mothers who receive treatment can reduce the chance that their infants will be infected to as low as 1 percent, as opposed to 25 percent of infants born to HIV-positive mothers who aren't treated during pregnancy.

"This recommendation is an important advancement in reducing the rates of HIV in the United States," said Task Force Vice-Chair Diana Petitti, M.D., who also is Senior Scientific Advisor for Health Policy and Medicine for Kaiser Permanente Southern California. "More accurate HIV testing during pregnancy and new treatments for HIV

have been shown to be safe and effective for mothers and infants and may reduce the number of infants born with the disease."

Since 1995, advancements in treating HIV-positive patients with Highly Active Antiretroviral Therapy (HAART), a treatment regimen that combines three or more medications, have been shown to slow the progression of the disease as well as to reduce HIV-related death rates.

There are an estimated 850,000 to 950,000 Americans infected with HIV who are unaware that they have the virus. If left untreated, almost all infected individuals will develop acquired immunodeficiency syndrome (AIDS). AIDS is the seventh-leading cause of death in Americans between the ages of 15 and 24 and the fifth-leading cause of death among those 25 to 44 years old.

People who are or have been intravenous drug users, have had sex with an HIV-infected partner and men who have had sex with men after 1975 are among the groups at high risk for contracting HIV.

In addition, data from AHRQ's Healthcare Cost and Utilization Project indicate that, of approximately 4.7 million women who were hospitalized for pregnancy or childbirth in 2002, nearly 6,300 were infected with HIV.

The Task Force, which is supported by AHRQ, is the leading independent panel of private-sector experts in prevention and primary care. Its recommendations are considered the gold standard for clinical preventive services. It conducts rigorous, impartial assessments of the scientific evidence for a broad range of preventive services.

The Task Force grades the strength of its evidence from "A" (strongly recommends), "B" (recommends), "C" (no recommendation for or against), "D" (recommends against), or "I" (insufficient evidence to recommend for or against). The Task Force strongly recommends that clinicians screen all pregnant women for HIV (an "A" recommendation). The Task Force strongly recommends that clinicians screen all adolescents and adults at increased risk for HIV infection (an "A" recommendation). The Task Force makes no recommendation for or against routinely screening for HIV among adolescents and adults who are not at increased risk for HIV infection (a "C" recommendation).

The recommendations and materials for clinicians are available on the AHRQ Web site at www.ahrq.gov/clinic/uspstf/uspshivi.htm. Previous Task Force recommendations and summaries of the evidence and related materials are available from the AHRQ Publications Clearinghouse by calling (800) 358-9295 or sending an E-mail to ahrqpubs@ahrq.gov. Clinical information also is available from AHRQ's National Guideline Clearinghouse™ at www.guideline.gov.