THE CSTE WASHINGTON REPORT

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

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INSIDE THIS ISSUE

… SENATE BILLS RAISE CONCERNS

… DRAFT RYAN WHITE REAUTHORIZATION LEGISLATION MISSES MARK: FURTHER FRACTURES SYSTEMS OF CARE AND FAILS TO ADDRESS ADAP FUNDING CRISIS

… AMERICAN HEALTH INFORMATION COMMUNITY APPROVES FIRST SET OF RECOMMENDATIONS

… NEW CHECKLIST HELPS LONG-TERM CARE AND OTHER RESIDENTIAL FACILITIES PREPARE FOR AN INFLUENZA PANDEMIC

… CDC MAKES PREPAREDNESS A PRIORITY

EDITOR'S NOTE:. HHS Secretary Mike Leavitt May 17 announced the release of the "Long-Term Care and Other Residential Facilities Pandemic Influenza Checklist." This tool provides guidance for these facilities to assess and improve their preparedness for responding to pandemic influenza. "The collaboration of long-term care and other residential facilities with public health agencies will be important in protecting the people living in those facilities if and when a pandemic occurs," Secretary Leavitt said. "These facilities provide vital services for their residents. By working together now, we'll be better equipped to serve these residents and their caregivers in the future."
-- additional information is included 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

SENATE BILLS RAISE CONCERNS -- Two recently introduced bills are causing concern among State Epidemiologists and those directing state Ryan White CARE Act programs. Sen. Judd Gregg (R-NH) introduced S. 2792 on May 11th which includes provisions that federalize the current National Notifiable Disease Surveillance System. The provisions are exactly the same as provisions included in S. 3 introduced last year which CSTE has diligently sought to alter in a direction that would eliminate penalties for non-reporters, remove states from assuming a regulatory and punitive role in dealing with disease reporters, tailor disease reporting to appropriate areas of federal interest, and ensure states are simultaneously notified in electronic disease reporting systems. CSTE is working successfully with the Senate Subcommittee on Bioterrorism and Public Health Preparedness on their efforts to reauthorize the 2002 Public Health Security and Bioterrorism Response Act and continues to try and reach out to Sen. Gregg who is a senior Member of the Senate Health, Education, Labor and Pensions Committee (HELP).

The Senate HELP Committee is also moving ahead on reauthorization of the Ryan White CARE Act. Committee Chairman, Sen. Michael Enzi (R-WY) introduced S. 2823 on May 17th. The bill is cosponsored by Sen. Kennedy (D-MA), the ranking Democratic Member on the Committee, and Sens. Hatch (R-UT), DeWine (R-OH), Burr (R-NC), and Frist (R-TN). The National Association of State AIDS Directors issued a press release criticizing the bill. Below is the NASTAD press release:

DRAFT RYAN WHITE REAUTHORIZATION LEGISLATION MISSES MARK: FURTHER FRACTURES SYSTEMS OF CARE AND FAILS TO ADDRESS ADAP FUNDING CRISIS -- – Members of Congress are currently drafting legislation to reauthorize the Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act) with the Senate Health, Education, Labor and Pensions Committee scheduled to mark up a bill on May 17th. The National Alliance of State and Territorial AIDS Directors (NASTAD) is concerned with the direction of the draft legislation and is calling on Congress to slow down until it can be thoroughly analyzed and significantly altered.

The Ryan White CARE Act was enacted in 1990 to provide primary health care, pharmaceutical treatments, and support services for low-income people with HIV/AIDS. The authorization for the CARE Act expired in September of 2005. The CARE Act is funded at $2 billion in FY2006. “We appreciate the hard work of Congressional staff in drafting reauthorization legislation. This is a complex law with fifteen years of history providing care and treatment to Americans living with HIV/AIDS,” said Julie Scofield, Executive Director of NASTAD. “Unfortunately, state AIDS directors believe the current draft bill is a major setback to the efforts of states to provide comprehensive, streamlined systems of care and treatment across the country. This bill, if enacted in its current form, would fragment state care systems, provide countless opportunities for administrative waste and duplication, and do nothing to assure access to HIV treatments,” continued Scofield.

“It was our hope that this legislation would address the urgent needs of states particularly in the South without large population centers,” said Evelyn Foust, North Carolina AIDS Director and Co-Chair of the Southern AIDS Coalition (SAC). “I concur fully with NASTAD’s concerns and believe this bill adds bureaucratic complexity and undermines the statewide approach to

HIV/AIDS care delivery we've worked so hard to establish," Foust added. "We are extremely troubled by the multiple formula changes that are proposed throughout this legislation," said Felipe Roche, Texas AIDS Director. "States have not received sufficient information to adequately analyze the impact of the multiple, simultaneous proposed changes," added Rocha. The draft legislation not only fails to address the crisis in AIDS Drug Assistance Programs (ADAPs), it actually makes it worse by significantly cutting funding to certain areas of the country (New York -$24 million, Florida -$12 million, and Texas -$9.5 million.) These cuts will expand the current ADAP crisis and lead to further access restrictions. ADAPs provide HIVrelated medications to 134,000 HIV-positive Americans. ADAPs have been seriously under funded for the last four years and addressing the ongoing fiscal challenges of ADAPs was expected to be a major focus in the reauthorization process. Nine states currently have ADAP waiting lists, with nearly 800 Americans unable to access HIV medications through this critical safety net program. "The draft legislation ignores the ADAP crisis and proposes no solutions," commented Scofield.

"Congress must slow down and allow these major flaws to be corrected before moving forward. The draft legislation has holes where provisions are still being negotiated on items that will have a significant impact on systems of CARE. A revised draft must be shared prior to moving forward with the bill so that the entire impact can be assessed. As it stands, this bill looks like an election year game of winners and losers rather than a conversation about how best to support the
solid, streamlined systems of care and treatment for people living with HIV/AIDS established by state health departments across the country," Scofield concluded.

AMERICAN HEALTH INFORMATION COMMUNITY APPROVES FIRST SET OF RECOMMENDATIONS -- The American Health Information Community (the Community) unanimously approved and delivered 28 recommendations yesterday to HHS Secretary Mike Leavitt for his consideration. The Community made recommendations on how to make health records digital and interoperable while protecting patient privacy and the security of those records.

"I have identified nine priorities at HHS to focus my effort around, and health IT is at the heart of every one of them. The work we do in this group is vital, its need is urgent, and I am pleased by the steps taken by the Community to further these goals," Secretary Leavitt said.

Secretary Leavitt led discussion of the recommendations, stressing the importance of the work being done by the Community, and emphasizing urgency in making progress on health IT. Among the recommendations, the Community advised that:

* The Health Information Technology Standards Panel (HITSP) identify and define standards that will enable:
* secure messaging between patients and clinicians, such as secure e-mail to allow a patient to receive a doctor's advice outside a traditional office visit;
* reporting results from laboratory testing, so lab results will travel with patients; and

* availability of electronic registration information to replace the medical clipboard.
* The Certification Commission for Health Information Technology (CCHIT) incorporates HITSP standards as criteria for product certification on an ongoing basis, to ensure interoperability.
* A subgroup be formed to frame privacy and security issues relevant to the work of the breakthroughs.

The Community also unanimously adopted all CCHIT criteria for certification of ambulatory electronic health records (EHRs). The Office of the National Coordinator for Health Information Technology (ONC) entered into a $2.7 million contract with the CCHIT last year to develop and test criteria for certification of health IT, which began in April of 2006. The CCHIT will expand certification to inpatient EHRs in 2007.

Secretary Leavitt also welcomed Robert Cresanti, Under Secretary of Technology at the Department of Commerce, to the Community. Mr. Cresanti replaces Michelle O'Neill, who was the Acting Under Secretary.

For more information about the Community and its Workgroups, and to read their recommendation letters containing the complete recommendations, visit http://www.hhs.gov/healthit/ahic.html.

NEW CHECKLIST HELPS LONG-TERM CARE AND OTHER RESIDENTIAL FACILITIES PREPARE FOR AN INFLUENZA PANDEMIC -- HHS Secretary Mike Leavitt May 17 announced the release of the "Long-Term Care and Other Residential Facilities Pandemic Influenza Checklist." This tool provides guidance for these facilities to assess and improve their preparedness for responding to pandemic influenza.

"The collaboration of long-term care and other residential facilities with public health agencies will be important in protecting the people living in those facilities if and when a pandemic occurs," Secretary Leavitt said. "These facilities provide vital services for their residents. By working together now, we'll be better equipped to serve these residents and their caregivers in the future."

The new checklist identifies steps that long-term care and other residential facilities can take to prepare for a pandemic, and could be helpful in other types of emergencies. The checklist was developed by the Centers for Disease Control and Prevention (CDC).

Preparedness suggestions include:

* Have a structure for planning and decision-making, with a multidisciplinary group created to specifically pandemic influenza preparedness planning.
* Develop a written pandemic influenza plan that identifies the person or persons authorized to implement the plan and the organizational structure to be used.

* Develop a facility communication plan that includes key points of contact such as local and state health department officials, and a person responsible for communicating with staff, residents and families.
* Have a plan to provide education and training to ensure that all personnel, residents and family members of residents understand basic prevention and control measures for pandemic influenza.
* Have an infection control plan in place for managing residents and visitors with pandemic influenza.
* Have a plan to get and use vaccines and antiviral drugs.
* Address issues related to sudden increased needs, such as prioritizing services, staffing and supply shortages, and alternative care for residents who need acute care when hospital beds are unavailable.

The release of this new tool builds on the Administration's overall planning to increase pandemic preparedness. President Bush has outlined a coordinated government strategy that includes the establishment of the new International Partnership on Avian and Pandemic Influenza, stockpiling of vaccines and antiviral medications, expansion of early-warning systems domestically and abroad and new funding and initiatives for local and state level preparedness.

Secretary Leavitt has met with senior officials from all 50 states and has been holding summits with the goal of enhancing state and local preparedness. In addition to today's checklist, Secretary Leavitt has issued preparedness checklists for individuals and families, businesses, state and local health departments, and faith-based and community organizations to aid their pandemic preparedness efforts.

A copy of the "Long-Term Care and Other Residential Facilities Pandemic Influenza Preparedness Checklist" is available at http://www.pandemicflu.gov/plan/LongTermCareChecklist.html. Additional pandemic planning information is available online at www.pandemicflu.gov.

CDC MAKES PREPAREDNESS A PRIORITY -- Preparedness from disasters, both natural and man-made, is a major priority for the CDC. Since the inception of CDC's Public Health Emergency Preparedness program, closely monitoring programmatic progress at the state and local levels has been at the heart of our efforts. As the program has matured, so too has CDC's sophistication in developing performance measures. Our knowledge base is growing and we are getting better at knowing what to measure and how to measure it. Greater program maturity has also allowed CDC to transition from focusing on basic building blocks, such as preparedness plans, to measuring actual performance capability that is demonstrable. CDC now has sufficient building blocks in place to facilitate an integrated, comprehensive approach when evaluating response capability.

We Have Data

* Since the establishment of critical benchmarks in 2002, we have collected performance data from funding recipients every six months.
* In 2002, critical benchmarks were established using the best expert opinion available at the time. Critical benchmarks have been refined over time as the program has matured.
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* In 2005, the Coordinating Office of Terrorism Preparedness and Emergency Response (COTPER) Division of State and Local Readiness (DSLR) moved to a more sophisticated evaluation structure using CDC's 9 agency-wide preparedness goals and 34 performance measures with quantitative metrics and performance targets.
* The new structure moves CDC from a focus area approach of independent activities to an integrated format that reflects the necessity of an integrated comprehensive emergency response capability.

1. The 34 performance measures within this new structure were introduced in the 2005 cooperative agreement guidance.
2. Baseline data were obtained on the 34 measures as part of the application process.
3. Additional measure refinement is continuing to ensure data collection is feasible and that each measure is a reliable, stable indicator of the performance area being measured. This included field testing in February 2006.

Progress Has Been Made

Lab Capacity

* Prior to 1999, state and local public health laboratory capacity in the United States was on the decline. Most labs were not capable of rapid molecular testing for biological threat agents, which is crucial for early threat containment. Today, the picture is very different.
* Rapid molecular testing as well as Category A and B threat agent testing capability has increased significantly as public health labs have updated their equipment and methods. For example, the ability to test for anthrax, ricin and plague has notably increased in just one year, from 2004 to 2005:

Agent	**2004**	**2005**	**Increase**
Anthrax	84 labs	95 labs	9 labs
Ricin	51 labs	71 labs	10 labs
Plague	83 labs	93 labs	10 labs

* The number of Bio-Safety Level 3 Labs has increased to over 139 in 2005 – up from only 69 in 2001.
* There has been significant growth in the number of labs participating in the Laboratory Response Network (LRN). There are now 150 biological LRN reference labs with at least one in every state. In 2001, there were only 91 participating labs.

* Chemical lab capacity has increased as well. Today, there are 62 state, territorial, and metropolitan public health laboratories that are members of the chemical component of the LRN.

Progress of States and Funded Cities

* 100% report they have detailed public health response plans. This type of planning didn't exist before 2001.
* 94% report they have exercised their response plan in the last 12 months.
* 98% report they develop after-action reports on real outbreaks to determine lessons learned to improve future responses.
* 100% of states report they have plans in place for receiving and distributing SNS assets.
* 100% report they have protocols to activate their emergency response systems 24/7/365.
* 98% report they have established Incident Command Structures as recommended in the National Incident Management System.
* 100% report having 24/7/365 capacity to investigate urgent disease reports.
* 98% report having designated facilities to receive, store, and distribute contents of the Strategic National Stockpile.
* 98% report having crisis and risk communication plans in place.

Advances in Evaluation and Accountability

* Previously CDC relied on self-reported data and project officer site visits to monitor and assess progress. Today, CDC is moving to a third-party evaluation program that will include extensive on-site assessments to verify self-reported data.
* Exercise guidance and evaluation tools are being developed to test performance measure achievement and to ensure exercise standardization and consistency across all projects.