THE CSTE WASHINGTON REPORT

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September 22, 2006 Volume 10, Number 19

INSIDE THIS ISSUE

EDITOR'S NOTE: The Centers for Disease Control and Prevention September 19 announced that 2005 childhood immunization rates for vaccines routinely recommended for children between 19 and 35 months of age remain at or near record highs. For the first time in the past ten years, rates for the full series of recommended vaccines did not vary significantly by race and ethnicity. According to CDCís annual National Immunization Survey (NIS), estimated immunization coverage rates for the 4:3:1:3:3:1 series ranged from 79.5 percent for children of multiple race, 77.1 percent for Asian; 76.3 percent for black; 76 percent for white, and 75.6 percent for Hispanic children. Coverage for the previous series that excluded varicella vaccine (4:3:1:3:3) was 10 percent lower for black children in 2002, compared to 3 percent in 2005. For Hispanic children coverage for the 4:3:1:3:3 series was 7.5 percent lower in 2000, compared to 3 percent in 2005. The 4:3:1:3:3:1 series includes four doses of Diphtheria, Tetanus and Pertussis (DTaP), three doses of polio vaccine, one dose of measles-containing vaccine, three doses of Hib vaccine, three doses of hepatitis B vaccine, and one dose of varicella vaccine– 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

CONGRESS YIELDS TO WHITE HOUSE IN LIMITING SHIFT OF DEFENSE FUNDS TO DOMESTIC PROGRAMS – Yesterday, lead House and Senate negotiators on the FY 2007 Department of Defense Appropriations yielded to White House/OMB pressure to limit cuts in defense spending to no more than $4.1 billion to permit shifting of these funds to the FY 2007 Labor-HHS-Education Appropriations bills. The Senate had already assumed a shift of $5 billion and the House $4.1 billion. Negotiators were hoping to settle on a total cut for defense spending of $6 billion, which would have provided that amount for a broad array of domestic programs and secured the respective shifts to the Labor-HHS-Education bills. With the agreement to limit the cut to $4.1 billion, the Senate Labor-HHS-Education bill will need to shave its funding levels by $1 billion. Advocates are working to counter this outcome by urging the 73 Senators that voted for the Specter-Harkin budget amendment earlier this year to sign onto a Specter-Harkin letter to Senate leadership requesting that the Senate honor the vote and provide a full $7 billion increase over the President's FY 2007 budget request for the programs in the Labor-HHS-Education Appropriations bill. A similar letter authored by Rep. Mike Castle (R-DE) is circulating among Moderates in the House. Advocates are also helping to gain signers for that letter.

CONTINUING RESOLUTION UNTIL NOVEMBER 17TH ADOPTED AS PART OF THE DOD APPROPRIATIONS BILL – At the last minute, negotiators added a continuing resolution to the Department of Defense Appropriations bill to fund all federal agencies and programs at the FY 2006 level through November 17th whose appropriations bills have not been enacted by October 1st, the end of the federal fiscal year. This will include both the House and Senate Labor-HHS-Education Appropriations bills which will be taken up after the November elections in a lame duck session. The final DoD bill, with the continuing resolution attached, will be taken up on the House and Senate floors next week. Congress is scheduled to adjourn September 29th.

HOUSE PASSES RYAN WHITE REAUTHORIZATION AND LIMITED BIOTERRORISM MEASURE – On September 20th, the House Energy and Commerce Committee approved legislation reauthorizing the Ryan White CARE Act on a vote of 38-10. The measure, which reflects bi-partisan and bi-cameral agreement ("bi-bi") is very contentious for program implementers as it shifts funding from larger states and cities to more rural states and smaller communities where HIV cases have been increasing. The formula for distribution of $2 billion in total funding would be based on HIV cases instead of on full-blown AIDS cases, causing considerable concern among states and localities that do not have name-based reporting fully implemented. The "bi-bi" legislation would provide states a three-year "hold-harmless" period during which their grants would not be reduced more than 5 percent from fiscal 2006. But that does not satisfy urban lawmakers. During mark-up of the bill, an amendment by Edolphus Towns,

(D-NY), to extend the period to five years was narrowly rejected, 21-22. And Frank Pallone Jr. (D-NJ) offered an amendment that would have replaced the bill with a one-year extension of programs so that Congress could spend more time working on the funding formulas. It was rejected, 21-23. Given the contentiousness of the "bi-bi" measure, it is not clear that the Senate will be able to pass it before the September 29th scheduled Congressional adjournment. The House is likely to proceed on the measure before the session's end.

The Energy and Commerce Committee also adopted HR 5533 on September 20th, a bioterrorism bill that addresses development of bioterrorism countermeasures, including creation of a new agency called the BARDA to bring added strategic focus to the challenge. In July, the Senate Health, Education, Labor and Pensions Committee adopted a broader bill (S. 3678 – Pandemic and All-Hazards Preparedness Act) that included reauthorization of the 2002 Public Health Security and Bioterrorism Response Act and focused on public health workforce and other public health infrastructure issues. While the Senate is likely to add BARDA to its bill, the House may not correspondingly add the broader public health components of the Senate bill.

CDC RECOMMENDS ROUTINE, VOLUNTARY HIV SCREENING IN HEALTH CARE SETTINGS -- The U.S. Centers for Disease Control and Prevention (CDC) September 21 published new recommendations for health care providers that are designed to make voluntary HIV screening a routine part of medical care for all patients aged 13 to 64. The recommendations aim to simplify the HIV testing process in health care settings and increase early HIV diagnosis among the estimated more than 250,000 HIV-positive Americans who are unaware of their infection. The recommendations also include new measures to improve diagnosis among pregnant women and further reduce mother-to-child HIV transmission. The *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings* were published in CDCís Morbidity and *Mortality Weekly Report (MMWR).*

Increasing the proportion of people who know their HIV status is an essential component of comprehensive HIV treatment and prevention efforts in the United States. Early diagnosis is critical in order for people with HIV to receive life-extending therapy. However, today, nearly 40 percent of individuals diagnosed with HIV are diagnosed within one year of infection progressing to AIDS, when it may be too late for them to fully benefit from treatment. Additionally, studies show that most people who learn they are infected take steps to protect their partners, while people who are unaware of their infection are estimated to account for between 50 percent and 70 percent of new sexually transmitted HIV infections.

ìWe urgently need new approaches to reach the quarter-million Americans with HIV who do not realize they are infected,î said Dr. Julie L. Gerberding, CDC director. ìPeople with HIV have a right to know that they are infected so they can seek treatment and take steps to protect themselves and their partners.î

The new recommendations address HIV screening in health care settings only, and do not apply to non-clinical settings such as community centers or outreach programs. They

replace CDCís 1993 recommendations on testing in acute care hospitals and update the portions of CDCís 2001 recommendations on HIV counseling, testing, and referral that apply to health care settings.

The new recommendations are designed to overcome several barriers that hindered implementation of the earlier recommendations, which called for HIV testing for patients in health care settings with high HIV prevalence (above 1 percent) and for all high-risk individuals. Implementation of these recommendations was difficult because many health care facilities do not have information on HIV prevalence, and many providers report that they do not have sufficient time to conduct risk assessments. Physicians also report that the processes related to separate, written consent and pre-test counseling for HIV testing have posed significant barriers. In surveys and in consultations held by CDC, health care providers consistently reported these time-consuming processes were not feasible in emergency rooms and other busy health care settings.

ìOur goal is to ensure that everyone who receives medical care also has the opportunity to learn if they are infected with HIV,î said Dr. Kevin Fenton, Director of CDCís National Center for HIV, STD and TB Prevention. ìThese new recommendations will make routine HIV screening feasible in busy medical settings where it previously was impractical. Making the HIV test a normal part of care for all Americans is also an important step toward removing the stigma still associated with testing.î

Highlights of the new recommendations for health care settings

CDCís recommendations were developed over a three-year period with extensive input from health care providers, public health experts, community-based organizations, and advocates nationwide. Major components of the new recommendations include:

- *HIV screening for all patients, regardless of risk:* Despite prior CDC recommendations for routine testing for high-risk individuals and for all patients in settings with high HIV prevalence, many patients with unrecognized HIV infection access health care but are never tested for HIV. To normalize HIV screening as a routine part of medical care, the revised recommendations advise that all patients aged 13-64 be screened.

- *Voluntary, ìopt-outî approach:* CDCís recommendations strongly emphasize that HIV testing must be voluntary and undertaken only with the patientís knowledge. The recommendations advise that patients be specifically informed that HIV testing is part of routine care and have the opportunity to decline testing. Before making this decision, patients should be provided basic information about HIV and the meanings of positive and negative test results, and should have the opportunity to ask questions.

- *Simplified testing procedures:* To overcome the most significant barriers to testing in health care settings, the recommendations advise that pre-test counseling and separate, written consent for HIV testing should no longer be required. Consent for HIV testing can be incorporated into general consent for medical care. Regarding counseling, the recommendations underscore the need to

ensure that patients who test positive for HIV are provided prevention counseling and linked to ongoing care. Additionally, CDC continues to encourage prevention counseling for all patients where feasible, especially when the health care visit is related to substance abuse, sexual health, family planning, or comprehensive health assessments.

- *Enhanced screening for pregnant women:* Existing CDC recommendations for routine prenatal HIV screening have already contributed to remarkable success in preventing mother-to-child HIV transmission in the U.S. The estimated number of infants born with HIV declined from a peak of approximately 1,650 in 1991 to fewer than 240 each year today. The new recommendations are intended to help reduce this number even further. They state that repeat HIV testing should be provided in the third trimester not only for women at high risk for HIV, as current recommendations advise, but also for women in areas with high HIV prevalence among women of childbearing age or in facilities with at least one HIV diagnosis per 1,000 pregnant women screened. They also specify that a rapid HIV test should be used during labor for all women whose HIV status remains unknown at the time of delivery.

Next Steps in Implementing the Recommendations

These recommendations are one of many steps that CDC, in conjunction with multiple private and public sector partners, is taking to increase HIV testing in health care settings. CDC will issue additional guidance for health care providers in early 2007, which will provide examples of model approaches and practical tools for implementation in various types of health care settings. CDC is also working with other federal government agencies to ensure that people diagnosed with HIV have access to care.

CDC continues to support the full range of HIV prevention interventions needed to reduce HIV infections in the United States, including comprehensive interventions for both HIV-infected and high-risk individuals. As part of these efforts, CDC believes it is essential to reach everyone with the opportunity to learn whether they are infected with HIV. These recommendations are designed to maximize opportunities for early diagnosis in health care settings, but must be supplemented with innovative approaches to expand testing in community settings and ensure linkages to prevention and care.

RACIAL DISPARITIES IN CHILDHOOD IMMUNIZATION COVERAGE RATES CLOSING OVERALL RATES REMAIN HIGH FOR ALL CHILDREN--
The Centers for Disease Control and Prevention September 19 announced that 2005 childhood immunization rates for vaccines routinely recommended for children between 19 and 35 months of age remain at or near record highs. For the first time in the past ten years, rates for the full series of recommended vaccines did not vary significantly by race and ethnicity.

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white, and 75.6 percent for Hispanic children. Coverage for the previous series that excluded varicella vaccine (4:3:1:3:3) was 10 percent lower for black children in 2002, compared to 3 percent in 2005. For Hispanic children coverage for the 4:3:1:3:3 series was 7.5 percent lower in 2000, compared to 3 percent in 2005. The 4:3:1:3:3:1 series includes four doses of Diphtheria, Tetanus and Pertussis (DTaP), three doses of polio vaccine, one dose of measles-containing vaccine, three doses of Hib vaccine, three doses of hepatitis B vaccine, and one dose of varicella vaccine.

ìThese results are terrific news, especially since there are virtually no differences with respect to race and ethnicity for this series of vaccines,î said Anne Schuchat, M.D., director of CDCís National Center for Immunization and Respiratory Diseases (NCIRD). ìWeíve been working hard, with many partners, to ensure that all children have access to recommended vaccines, and these results show weíve made significant progress.

The federal Vaccines for Children (VFC) Program has helped to substantially reduce the immunization disparity gap and contributed to the relatively high coverage levels,î according to Schuchat. ìStrong efforts to promote childhood immunizations are being made on local, state and national levels, but we need to maintain our vigilance.î

In addition to VFC, which provides free vaccines for uninsured and underinsured children, CDC has worked with its partners to develop and provide education programs and media campaigns for Spanish-speaking and black parents. Since 1994, CDC has created an annual Spanish-language national public service campaign with advertising for radio and television broadcast and newspaper and magazine placement, as well as posters, brochures and education kits for distribution through health clinics and community based organizations.

Another source of vaccine funding is the 317 program. The Section 317 grant program works to ensure that children, adolescents, and adults receive appropriate immunizations by partnering with healthcare providers in the public and private sectors. Most children served through Section 317 are underinsured or their parents are working poor who cannot afford the deductibles required to fully vaccinate their children.

Other significant findings from the 2005 NIS indicate that substantial progress has been made in five years after the introduction of the pneumococcal conjugate vaccine (PCV) despite past shortages of the vaccine. Coverage estimates for 2005 indicate that more than 50 percent of the nationís children are fully vaccinated with PCV and more than 80 percent have received at least three of the four dose series. Estimates for four doses of PCV most likely remain low because prior shortages affected children included in the 2005 NIS.

In addition to national estimates, the 2005 National Immunization Survey (NIS) provides vaccination coverage estimates among children 19 to 35 months of age for each of the 50 states and 27 selected urban areas.

As in previous years, there was wide variation in coverage levels among states and urban areas, with coverage for the 4:3:1:3:3:1 series ranging from 90.7 percent in Massachusetts to 62.9 percent in Vermont and, in urban areas, from 84.5 percent for

Jefferson County, Alabama (Birmingham) to 58.8 percent for Clark County, Nevada (Las Vegas).

CDC uses a quarterly random-digit-dialing sample of telephone numbers for each of the 77 survey areas to collect vaccination data for all age-eligible children 19 to 35 months of age. The complete 2005 National Immunization Survey data will be released with the CDCís Morbidity and Mortality Weekly Report (MMWR) on Thursday, September 14.

PEOPLE WITH DISABILITIES ARE LESS HEALTHY THAN THOSE WITHOUT DISABILITIES -- For the first time, the Centers for Disease Control and Prevention (CDC) has published a report of state-level data on the number of people with disabilities, and the wide range of health differences that exist between people with disabilities and those without. The new report, The Disability and Health State Chartbook, 2006 ñ Profiles of Health for Adults with Disabilities, was unveiled at CDCís National Health Promotion Conference scheduled at the Hilton Atlanta Hotel, Atlanta, Georgia from September 12-14, 2006.

Disability prevalence ranges substantially among the states -- from a low of 11.4 percent to a high of 25.8 percent among people with disabilities. People with disabilities make up about 20 percent of the U.S. adult, non-institutionalized population.

ìThe findings in the Chartbook will allow states to measure their progress and will highlight the need to include people with disabilities in health promotion activities to reduce smoking, obesity, and to increase physical activity,î said Dr. JosÈ Cordero, assistant surgeon general and director of the CDC's National Center on Birth Defects and Developmental Disabilities.

The Chartbook, examines five health factors, including smoking, obesity, physical activity, immunizations, and access to health care for adults age 18 years and over in 50 U.S. states, District of Columbia, and three territories.

Generally, people with disabilities are much more likely to report fair or poor health. The median percentage was 37.3 percent of people with disabilities reporting fair or poor health compared to 8.2 percent without disabilities. In addition, the findings in the Chartbook show that people with disabilities are also more likely to smoke, to be obese, and not be physically active. However, these are health conditions and behaviors that can be improved.

ìGood health is a goal for all, but people with disabilities have some unique challenges to achieving optimum health,î said CDC Director Dr. Julie L. Gerberding. ìThese challenges include their physical access to health care facilities and the lack of easy to read health information materials. The Chartbook shows us where opportunities exist to implement health promotion activities to improve the overall health and quality of life of people with disabilities. Having these state-level data is an important first step in this process.î

Highlights of the report include ñ

- States with the highest percentages of disability among adults include West Virginia (25.8 percent), Kentucky (24.7 percent), and Oregon (23.7 percent).
- States with the lowest percentages of disability include Hawaii (11.4 percent), North Dakota (15.9 percent), and Illinois (15.9 percent).
- The Southeast region reports the poorest health for people with disabilities.
- People with disabilities report the highest prevalence of smoking in Kentucky, Tennessee, and Louisiana, which is much higher among people with disabilities than those without:

	Adults with Disabilities	Adults without Disabilities
Kentucky	39.9 percent	29.1 percent
Tennessee	38.3 percent	22.4 percent
Louisiana	36.9 percent	23.9 percent

- The highest prevalence of obesity is reported in Mississippi, Indiana, and North Carolina. As with smoking, the prevalence of obesity is much higher among people with disabilities:

	Adults with Disabilities	Adults without Disabilities
Mississippi	36.8 percent	24.4 percent
Indiana	36.1 percent	22.3 percent
North Carolina	35.9 percent	20.7 percent

ìDisability itself should not be equated with sickness,î said Dr. Cordero. ìHowever, our findings show that people with disabilities often report poorer health than those without.î

The data were collected from the 2001 and 2003 Behavioral Risk Factor Surveillance System (BRFSS), a state-based system that obtains health information through telephone health surveys, with technical assistance provided by CDC. BRFSS is the largest telephone health survey system in the world; there were more than 200,000 interviews in each of these years.

The Chartbook is composed of over 100 pages of maps and charts. The resource section has phone numbers for state health offices and national organizations that promote healthy lives for people with disabilities. The brief narrative is presented in large 14- and 16-point print with high color contrast, so it is accessible for people with vision loss. People who use a screen reader can download accessible versions from the web. Additional print copies may be ordered or downloaded from www.cdc.gov/ncbddd.

Disability is a functional limitation, i.e., loss of or decrease in mobility, cognition, hearing, vision, activities of daily living, related to a health condition that exists within the context of a personís environment.

CHEMICAL IN MANY AIR FRESHENERS MAY REDUCE LUNG FUNCTION-- New research shows that a chemical compound found in many air fresheners, toilet bowl cleaners, mothballs and other deodorizing products, may be harmful to the lungs. Human population studies at the National Institute of Environmental Health Sciences (NIEHS), a part of the National Institutes of Health, found that exposure to a volatile organic compound (VOC), called 1,4 dichlorobenzene (1,4 DCB) may cause modest reductions in lung function.

"Even a small reduction in lung function may indicate some harm to the lungs," said NIEHS researcher Stephanie London, M.D., lead investigator on the study. "The best way to protect yourself, especially children who may have asthma or other respiratory illnesses, is to reduce the use of products and materials that contain these compounds."

The researchers examined the relationship between blood concentrations of 11 common volatile organic compounds and lung function measures in a representative sample of 953 adults. VOCs are a diverse set of compounds emitted as gases from thousands of commonly used products, including tobacco smoke, pesticides, paints, and cleaning products. VOCs are also released through automotive exhaust. The researchers found that of the common VOCs analyzed, which included benzene, styrene, toluene, and acetone, only the compound 1,4 DCB was associated with reduced pulmonary function and this effect was seen even after careful adjustment for smoking, The researchers found that 96 percent of the population samples had detectable 1,4 DCB blood concentration levels. African Americans had the highest exposure levels and non-Hispanic whites the lowest.

This particular VOC, 1,4 DCB, is a white solid compound with a distinctive aroma, similar to mothballs. It is typically used primarily as a space deodorant in products such as room deodorizers, urinal and toilet bowl blocks, and as an insecticide fumigant for moth control.

"Because people spend so much time indoors where these products are used, it's important that we understand the effects that even low levels might have on the respiratory system," said Leslie Elliott, Ph.D. a researcher on the NIEHS-funded study. "There has been very little research on the health effects of this particular compound in non-occupational settings."

The researchers used data from the third National Health and Nutrition Examination Survey (NHANES) and a special component of the study specifically designed to assess the level of common pesticides and VOCs in the US population. NHANES III is a nationally representative survey conducted by the Centers for Disease Control and Prevention between 1988-1994 to determine the health and nutritional status of the U.S. population.

Data from 953 adults 20-59 years old who had both VOC blood measures and pulmonary function measures are included in the study published in the August issue of Environmental Health Perspectives. Four pulmonary function measures were used in the analyses. The researchers found modest reductions in pulmonary function with increasing blood concentrations of 1,4 DCB.

There was approximately a 4 percent decrease in the test which measures forced expiratory volume in 1(FEV1) second between the highest and lowest levels of exposure. FEV1 is a commonly used index for assessing airway function and obstruction.

The researchers assessed the influence of other factors in an individual's environment that may be related to pulmonary function and to 1,4-DCB exposure, such as type of heating, use of wood fires, age of house, presence of furred pets, occupation, socioeconomic status, environmental tobacco smoke, smoking history, and diagnosis of asthma or emphysema. The authors noted that participants might have been exposed to other agents not assessed in this study1that have been linked to both respiratory impairment and levels of 1,4-DCB.

"This research suggests that 1,4-DCB may exacerbate respiratory diseases," said David A. Schwartz, M.D., NIEHS Director. "As part of the new disease-focused approach at NIEHS, researchers will use this information to better understand the pathogenesis of respiratory diseases." The NIEHS unveiled a new strategic plan, "New Frontiers in Environmental Sciences and Human Health," in May aimed at challenging and energizing the scientific community to use environmental health sciences to understand the causes of disease and to improve human health. The plan can be accessed at http://www.niehs.nih.gov/external/plan2006/.

The National Institute of Environmental Health Sciences (NIEHS), a component of the National Institutes of Health, supports research to understand the effects of the environment on human health. For more information on environmental health topics, please visit our website at http://www.niehs.nih.gov/home.htm.

The National Institutes of Health (NIH) - The Nation's Medical Research Agency - includes 27 Institutes and Centers and is a component of the U. S. Department of Health and Human Services. It is the primary federal agency for conducting and supporting basic, clinical, and translational medical research, and it investigates the causes, treatments, and cures for both common and rare diseases. For more information about NIH and its programs, visit http://www.nih.gov/.