

THE CSTE WASHINGTON REPORT

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INSIDE THIS ISSUE

... SURVEILLANCE AND DISEASE REPORTING
BILL READY FOR INTRODUCTION

... HHS AND DHS ANNOUNCE GUIDANCE
ON PANDEMIC VACCINATION
ALLOCATION

... LATEST CDC DATA SHOW MORE AMERICANS
REPORT BEING OBESE

... COMMUNITY WATER FLUORIDATION
NOW REACHES NEARLY 70 PERCENT OF
U.S. POPULATION

EDITOR'S NOTE: The proportion of U.S. adults who self report they are obese increased nearly 2 percent between 2005 and 2007, according to a report in the July 17 *Morbidity and Mortality Weekly Report (MMWR)*. An estimated 25.6 percent of U.S. adults reported being obese in 2007 compared to 23.9 percent in 2005, an increase of 1.7 percent. The report also finds that none of the 50 states or the District of Columbia has achieved the Healthy People 2010 goal to reduce obesity prevalence to 15 percent or less -- 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.

SURVEILLANCE AND DISEASE REPORTING BILL READY FOR INTRODUCTION -
- After 18 months of drafting, vetting, and re-drafting the "National Integrated Public Health Surveillance Systems and Disease Reporting Act," a CSTE initiative, is being finalized for

introduction in both the House and Senate. The principal sponsors for the bill are Rep. Lee Terry (R-NE) and Sen. Chuck Hagel (R-NE). The lead Democrats are Rep. Tammy Baldwin (D-WI) and Sen. Jeff Bingaman (D-NM). Rep. Edolphus Towns (D-NY) will also be an original co-sponsor. The bill is thus bi-partisan and bi-cameral and has been reviewed by CDC with largely positive recommendations which have been incorporated.

The thrust of the legislation is to protect key public health infrastructure building grant programs for state and local health departments at the CDC by authorizing them and providing them with appropriate funding targets. These programs, particularly the Epidemiology-Laboratory Capacity Cooperative Grant Program (ELC), have been seriously eroding in the past four years, or have been flat funded at levels well under what is needed to ensure a seamless, rapid 21st century disease surveillance and reporting system, not only for infectious diseases, but for other conditions of public health importance and urgency.

The bill provides over \$100 million in new funding for these programs, applied epidemiology, laboratory science, and public health informatics fellowship training programs, and increased funding for the EIS. It authorizes a process for developing and improving a list of nationally notifiable diseases and conditions, modeled on the current CSTE-CDC process. And it establishes a national committee, led by CDC, to evaluate best practices in public health surveillance with a focus on improving coordination of animal and human disease surveillance.

Details are provided in the summary of the bill below:

Summary of the “National Integrated Public Health Surveillance Systems and Reportable Conditions Act”

The Problem: The bill is designed to strengthen epidemiology and laboratory capacity in state and local health departments and, correspondingly, national surveillance and reporting of infectious diseases and other conditions of public health importance. Many parts of the local-state-federal disease surveillance system remain fragmented and paper-based, and have not fully benefited from new technologies that could improve the completeness and timeliness of reporting. A 2007 survey¹ of barriers state report in achieving electronic laboratory reporting (ELR) shows that 20 states are still using web-based manual reporting and 16 are completely paper-based. Only two state public health laboratories have bidirectional data flow and can both send and receive laboratory messages². The potential for new pathogen discovery, rapid electronic exchange of public health information, national bacterial and viral databases for DNA “fingerprinting” of infectious disease organisms has not been fully realized. The U.S. is facing serious public health challenges now and in the coming years: increased food poisoning outbreaks, emerging infections like West Nile Virus, growing antimicrobial resistance, pandemic

¹ National Electronic Disease Surveillance System: A Status Report on Implementation. Council of State and Territorial Epidemiologists. Atlanta, GA. 2008. 23 July 2008.
<<http://www.cste.org/dnn/LinkClick.aspx?fileticket=BJJMGWMITb8%3d&tabid=36&mid=390>>.

²Barriers to achieving electronic laboratory reporting, from the "2007 National ELR Snapshot Survey", conducted for the National ELR Teleconference Group by J.A. Magnuson, Oregon ELR. National ELR Teleconference Group is sponsored by CSTE.

flu, environmental health threats, particularly to clean air and water. We need a robust, complete, 21st century public health infrastructure that is strengthened at all levels of government to meet these challenges. Achieving this requires, comparatively, a very modest expansion of resources with renewed focus, and new areas of emphasis.

How this bill addresses the problem:

- Authorizes, for the first time, for FY 2009-FY 2012, the CDC Epidemiology-Laboratory Capacity Grant Program for state and local health departments. This is the existing core, public health grant mechanism for supporting the infrastructure for public health disease surveillance and reporting at the state and local levels and essential to an efficient, timely, coordinated national surveillance disease reporting system. The program has lost \$22 million in funding (28%) since FY 2004 largely due to a shift in emphasis to specific bioterrorism agents and systems and other under-resourcing of state grant mechanisms within the CDC. The bill authorizes modest increases in funding to restore lost funding, expands the program mission to include other conditions of public health importance, and provides for potential expansion of new grantees to more local health departments and tribal health authorities, as determined by the CDC Director.
- Requires the CDC Director to issue guidelines, within 180 days of enactment, for public health disease surveillance and reporting consistent with standards and recommendations issued by the National Coordinator for Health Information Technology and the American Health Information Community.
- Sets out requirements and appropriate funding target for grantees designed to enhance electronic disease reporting and gives priority to resource-poor states to help complete the national electronic disease reporting system.
- Sets out requirements and appropriate funding targets to ensure public health laboratory grantees are utilizing web-based, secure systems.
- Authorizes, for the first time, and provides appropriate funding targets, for three existing public health fellowship programs within the CDC to address serious, documented shortages³ in the core public health science professionals at the state and local levels: applied epidemiology, laboratory science, as well as public health informatics specialists.
- Provides a modest, \$5 million funding increase for the Epidemic Intelligence Service at CDC.
- Amends the Public Health and All Hazards Preparedness law (P.L. 109-417) to permit the CDC/Council of State and Territorial Epidemiologists Applied Epidemiology Fellows and the CDC/Association of Public Health Laboratories' Science Fellows to satisfy their work

³ 2006 National Assessment of Epidemiologic Capacity: Findings and Recommendations; 2004 National Assessment of Epidemiologic Capacity: Findings and Recommendations. www.cste.org

obligation, if they qualify and receive loan assistance under the law's public health workforce provisions, as full-time fellows working in state and local health departments.

- Authorizes a process for establishing a list of nationally notifiable diseases and conditions modeled on the current State-CDC collaboration process.
- Requires the CDC Director, within one year, to finalize and adopt negotiated guidelines for “U.S.-Mexico Coordination on Epidemiological Events of Mutual Interest.”
- Creates a national committee to evaluate best practices in public health surveillance with a focus on improving coordination of human and animal disease surveillance, as well as environmental health monitoring.

HHS AND DHS ANNOUNCE GUIDANCE ON PANDEMIC VACCINATION

ALLOCATION -- The U.S. Departments of Health and Human Services (HHS) and Homeland Security (DHS) released July 23 guidance on allocating and targeting pandemic influenza vaccine. The guidance provides a planning framework to help state, tribal, local and community leaders ensure that vaccine allocation and use will reduce the impact of a pandemic on public health and minimize disruption to society and the economy.

“This guidance is the result of a deliberative democratic process,” HHS Secretary Mike Leavitt said. “All interested parties took part in the dialogue; we are confident that this document represents the best of shared responsibility and decision-making.”

“A severe pandemic has the potential to disrupt our everyday way of life,” said DHS Assistant for Health Affairs and Chief Medical Officer Dr. Jeffrey Runge. “This guidance was developed to ensure that our nation’s critical infrastructure remains up and running and we address the needs of all of our citizens, enabling the country to recover from a pandemic more quickly.”

As part of developing the guidance, HHS held day-long public engagement and stakeholder meetings throughout the country and received more than 200 written public comments on the goals and objectives of pandemic vaccination. In all the meetings, stakeholders and the public identified the same four vaccination program objectives as the most important:

- Protect persons critical to the pandemic response and who provide care for persons with pandemic illness
- Protect persons who provide essential community services
- Protect persons who are at high risk of infection because of their occupation and
- Protect children

The guidance is also firmly rooted in the most up-to-date scientific information available and directly considers the values of our society and the ethical issues involved in planning a phased approach to pandemic vaccination.

The ultimate goal of the pandemic vaccination program is to vaccinate every person in the United States who wants to be vaccinated. Because pandemic vaccine cannot be made fast enough for everyone to be vaccinated at once, federal, state, local and tribal governments, communities, and the private sector can use the guidance to decide who should be vaccinated during this early stage to best protect people and communities.

The guidance's vaccination structure defines four broad target groups: people who 1) maintain homeland and national security, 2) provide health care and community support services, 3) maintain critical infrastructure and 4) are in the general population.

Everyone in the United States is included in at least one vaccination target group. People who are not included in any occupational group would be vaccinated as part of the general population based on their age and health status.

While vaccines are an important resource in a pandemic, vaccination will only be one of several tools to fight the spread of influenza if and when a pandemic emerges. Other tools include community public health measures, antiviral medications, facemasks and respirators, washing hands and covering coughs and sneezes.

For further information, please see
<http://www.pandemicflu.gov/vaccine/allocationguidance.pdf>.

LATEST CDC DATA SHOW MORE AMERICANS REPORT BEING OBESE --

The proportion of U.S. adults who self report they are obese increased nearly 2 percent between 2005 and 2007, according to a report in the July 17 *Morbidity and Mortality Weekly Report (MMWR)*. An estimated 25.6 percent of U.S. adults reported being obese in 2007 compared to 23.9 percent in 2005, an increase of 1.7 percent. The report also finds that none of the 50 states or the District of Columbia has achieved the Healthy People 2010 goal to reduce obesity prevalence to 15 percent or less.

In three states – Alabama, Mississippi, and Tennessee – the prevalence of self-reported obesity among adults age 18 or older was above 30 percent. Colorado had the lowest obesity prevalence at 18.7 percent. Obesity is defined as a body mass index (BMI) of 30 or above. BMI is calculated using height and weight. For example, a 5-foot, 9-inch adult who weighs 203 pounds would have a BMI of 30, thus putting this person into the obese category.

The data were derived from CDC's Behavioral Risk Factor Surveillance System, a state-based telephone survey that collects information from adults aged 18 years and older. For this survey more than 350,000 adults are interviewed each year, making BRFSS the largest telephone health survey in the world. BMI was calculated based on this self-reported information.

“The epidemic of adult obesity continues to rise in the United States indicating that we need to step up our efforts at the national, state and local levels,” said Dr. William Dietz, director of CDC's Division of Nutrition, Physical Activity, and Obesity. “We need to encourage people to eat more fruits and vegetables, engage in more physical activity and reduce the consumption of high calorie foods and sugar sweetened beverages in order to maintain a healthy weight.”

The study found that obesity is more prominent in the South, where 27 percent of respondents were classified as obese. The percentage of obese adults was 25.3 in the Midwest, 23.3 percent in the Northeast, and 22.1 percent in the West.

By age, the prevalence of obesity ranged from 19.1 percent for men and women aged 19-29 years to 31.7 and 30.2 percent, respectively, for men and women aged 50-59 years.

“Obesity is a major risk factor for a number of chronic diseases such as type 2 diabetes, heart disease and stroke. These diseases can be very costly for states and the country as a whole,” said Deb Galuska, associate director for science for CDC's Division of Nutrition, Physical Activity and Obesity.

For more information on obesity trends, including an animated map, visit <http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps>

To learn more about CDC's efforts in the fight against obesity or for more information about nutrition, physical activity, and maintaining a healthy weight, visit <http://www.cdc.gov/nccdphp/dnpa>.

COMMUNITY WATER FLUORIDATION NOW REACHES NEARLY 70 PERCENT OF U.S. POPULATION -- Nearly 70 percent of U.S. residents who get water from community water systems now receive fluoridated water, according to a study by the Centers for Disease Control and Prevention.

The proportion of the U.S. population receiving fluoridated water, about 184 million people, increased from 62.1 percent in 1992 to 69.2 percent in 2006, said the study in this week's Morbidity and Mortality Weekly Reports.

“Community water fluoridation is an equitable, cost-effective, and cost-saving method of delivering fluoride to most people,” said Dr. William Maas, director of CDC's Division of Oral Health. “We've seen some marked improvements; however, there are still too many states that have not met the national goal. The national goal is that 75 percent of U.S. residents who are on community water systems be receiving fluoridated water by 2010.”

Fluoride, a naturally occurring compound in the environment, can reduce or prevent tooth decay. Adding or maintaining tiny levels of fluoride in drinking water is a safe and effective public health measure to prevent and control tooth decay (dental caries). The second half of the 20th century saw a major decline in the prevalence and severity of dental caries, attributed in part to the increasing use of fluoride. Based upon studies and a

systematic review, the U.S. Task Force on Community Preventive Services reported that fluoridation resulted in a median 29.1 percent relative decrease in tooth decay.

The report, “Populations Receiving Optimally Fluoridated Public Drinking Water-United States 1992-2006,” provides the most recent information on the status of fluoridated water by state. The report says the percentage of people served by community water systems with optimal levels (which are defined by the state and vary based on such things as the climate) of fluoridated water ranged from 8.4 percent in Hawaii to 100 percent in the District of Columbia. Twenty-five states and the District of Columbia have met or exceeded national objectives, while 25 states need improvements. Three states (Colorado, Delaware and Nebraska) that previously reached the national objective dropped below the target by 2006.

During 1998-2006, CDC developed the Water Fluoridation Reporting System (WFRS), a Web-based method to support management of state fluoridation programs and to collect these data. The state has administrative oversight on water fluoridation and CDC relies on state dental or drinking water programs to provide fluoridation data, including populations served, fluoridation status, fluoride concentration, and fluoride source for individual community water systems.

For more information on fluoridation and oral health, please visit www.cdc.gov/oralhealth.