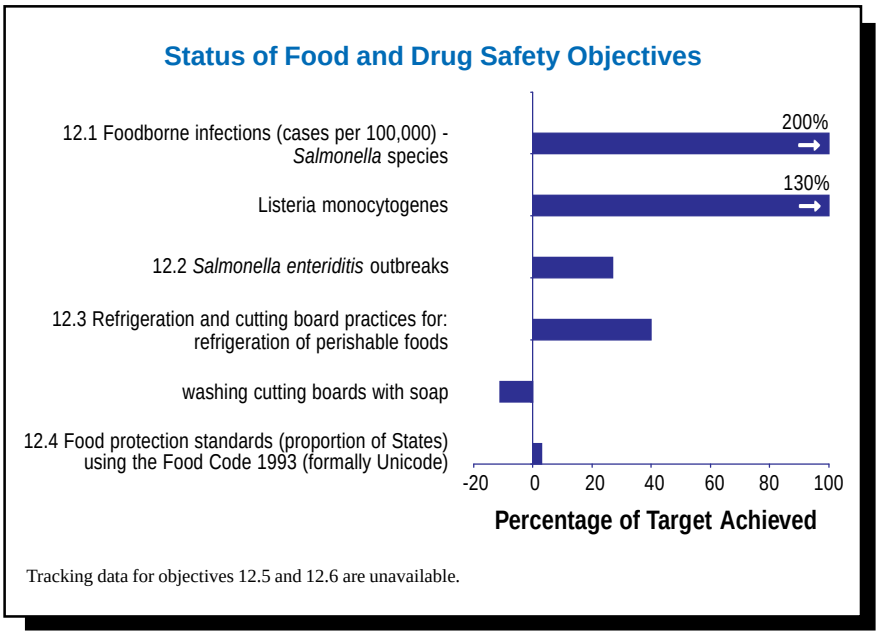
# 12 Food and Drug Safety




**Lead Agency:** ***Food and Drug Administration***

# FOOD AND DRUG SAFETY

Food and Drug Safety was designated as a priority area for the year 2000 in recognition of the importance that food and drug safety plays in reducing the risks to public health associated with contaminated foods, foodborne pathogens, drug interactions, and noncompliance with drug regimens established by primary care providers for patients. Food and drug safety was not included as a separate priority area in the 1990 objectives.

Food and Drug Safety focuses on two specific health concerns. One is to ensure the safety of the food supply by reducing and eliminating the health risks posed by contaminated foods, foodborne infections, and improper handling of foods both by commercial food handlers and consumers. The other is to ensure that the public and in particular older adults, who are taking a number of medications, are better educated and understand the proper use of the medications and to reduce the incidence of serious adverse drug reactions they are likely to experience by effective documentation and reporting of observed adverse events.

During the June 1991 Food and Drug Safety Progress Review with the Assistant Secretary for Health, strategies for the implementation of these objectives were presented. Augmenting both professional and public educational efforts, appropriate changes to Federal, State, and local regulatory and enforcement initiatives, and improved surveillance techniques were suggested. The 1993 multi-State outbreak of *Escherichia coli* O157:H7 and the periodic *Salmonella* outbreaks illustrate the difficulties of controlling foodborne illness.

## Review of Progress

Data demonstrate that progress has been made in the reduction of *Salmonella enteritidis* outbreaks from 77 during 1989 to 63 documented in 1993. Some of this progress may be attributed to recently implemented 1990 regulations that are focused on the reduction of salmonellosis from infected chickens and eggs together with focused consumer and education programs. In 1992, the majority of States reported the rate of *Salmonella* infections was below the 16 per 100,000 people targeted in HEALTHY PEOPLE 2000 Objective 12.1. Despite that fact, 12 States and the District of Columbia still exceeded the target. (See State map.)

National data that are specific for tracking infections caused by *Campylobacter jejuni* and *Escherichia coli* O157:H7 are not currently available. This is in part because the reporting systems for these foodborne pathogens are not uniform among the States, not available in a timely manner, and may be underreported.

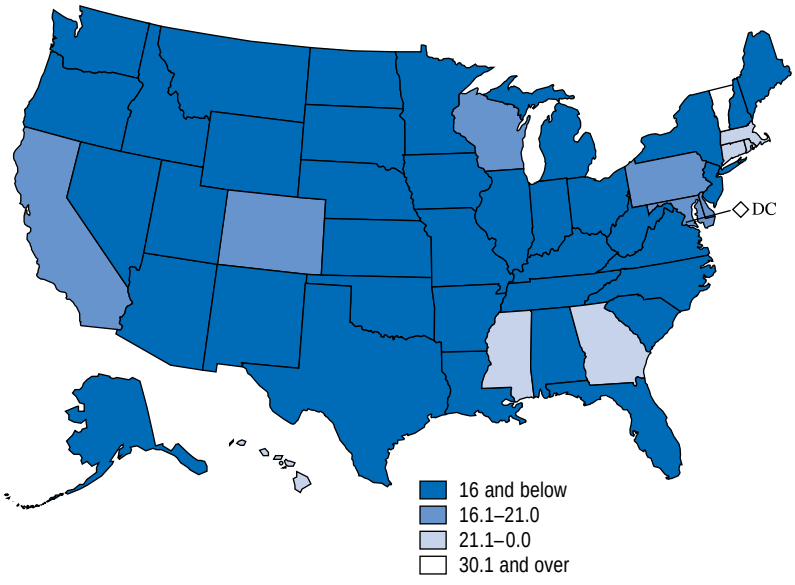
The 1992–1993 Food and Drug Administration Food Safety Survey found increased sanitation in household food handling practices. The practice of refrigerating perishable foods increased in use from 70 percent of households in 1988 to 72 percent in 1992–1993. The practice of washing cutting boards with soap showed little change, going from 66 percent in 1988 to 65 percent in 1992–1993. The 1988 data for

washing cutting boards with soap do not include other sanitation practices such as washing with bleach or the use of a different cutting board. The 1988 figure that includes these options is 70 percent and the 1992–1993 data showed 68 percent. Data were not collected in 1992–1993 on household utensil washing practices. The 1988 baseline figure of 55 percent represents the percentage of households found to be washing utensils with soap. When data for another safe method, switching to another knife, are included, the 1988 baseline figure is adjusted upward to 74 percent.

Food protection standards, as measured by the adoption of model food codes, are tracked in Objective 12.4. Three model food codes were updated and combined into one code during 1990 to 1993. The Food Code 1993 was announced in January 1994 and became available in March 1994. FDA estimates that more than 80 percent of the States are now in the process of actively reviewing the Food Code 1993 for possible adoption. Once a State makes a decision to seek adoption, it is not uncommon for the adoption process to span approximately 2 years. The national Conference for Food Protection is reviewing the Food Code 1993 to identify needed improvements for future editions. Although FDA expects to see the widespread adoption of the code during the 1995–2000 period, at least two Federal agencies, one State, and two local jurisdictions have already adopted the new recommendations.

Data on the use of the Food Code 1993 and previous model codes by food operations serving institutions are not yet available. However, use of the Food Code 1993 is being encouraged through active promotion by FDA and other agencies. FDA has produced food safety videos for nursing homes jointly with the Health Care Financing Administration (HCFA) and the Centers for Disease Control and Prevention (CDC). FDA and HCFA are cooperating in training health surveyors (nursing home inspectors) and providing information concerning foodborne illness and the Food Code 1993. FDA also participated with USDA in three video teleconferences to State and local officials to promote the Food Code 1993.

**Objective 12.1: *Reduce infections caused by key foodborne pathogens (*Salmonella *species) to an incidence of no more than 16 per 100,000 people***




Source: CDC/Center for Infectious Diseases, 1992

Available data indicate that computer utilization in the practice of pharmacy has steadily increased. In 1992, approximately 95 percent of pharmacies incorporated the use of computers in their pharmacy practice. During September 1994, HCFA published a rule implementing the Omnibus Budget Reconciliation Act of 1990 requirements with regard to drug utilization reviews (DUR). The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring that prescriptions are appropriate and medically necessary and that they are not likely to result in adverse medical effects. The regulations require a review of drug therapy before each prescription is filled or delivered to a recipient. The review is done at the point of sale and carried out in part to detect drug-disease contraindications and drug- or allergy-related interactions. Counseling and maintenance of patient profiles by the pharmacist are also required. Although these regulations apply only to the Medicaid program, most States are in the process of expanding the requirements to all prescriptions filled by pharmacists. For many patients covered by third party insurers, the pharmacist effects linkage by obtaining preauthorization to fill the prescription. When he or she does this, the insurer checks the patient's record of prescriptions received from all sources. Pharmacists are accomplishing this public health service by the use of a variety of available computer software packages and the use of computerized patient profiles. In addition, many chain pharmacies are implementing linked computer systems that enable the patient to have a prescription filled at any store in that specific chain with the pharmacist having the capability of retrieving that patient's profile for purposes of efficient patient counseling and review.

Baseline data have been determined for Objective 12.6 to extrapolate the percentage of primary care providers that routinely review medications with older adults. Separate data for specific primary care provider groups were derived from a 1992 survey, showing that 70 percent of family physicians routinely reviewed current medications and 63 percent reviewed medications when prescribing. Among internists, 84 percent routinely counseled elderly patients on their current regimen of medications and 77 percent reviewed new prescriptions as they were prescribed.

## 1995 Revisions

Two new objectives have been added to the Food and Drug Safety priority area. One tracks the proportion of serious adverse event reports that are voluntarily forwarded to FDA. The other facilitates an increase in the proportion of people who receive useful information about their drug regimens when being counseled by both prescribers and dispensers of medications by measuring patient assessment of counseling efforts. This objective complements objective 12.6, which tracks the extent to which primary care providers are counseling older adults. Additionally, the language of objective 12.6 has been modified to expand the tracking of patient counseling to include both primary care providers and dispensers of medication. This change will facilitate tracking pharmacist counseling at the point of patient contact when prescriptions are dispensed. Another revision has been made to objective 12.4 to address the adoption of the new Food Code 1993 by the States. The goal of the objective is to have at least 70 percent of the States adopt this uniform code for food storage, preparation, and sanitation by restaurants, food vendors, and institutional food service providers by the year 2000.