

Physician's Update

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2015-16 Influenza Vaccine recommendations

The Advisory Committee on Immunization Practices (ACIP) recommendations for the 2015-2016 Influenza Vaccine includes the following updates:

1. Routine Influenza vaccination is recommended for everyone over 6 months of age every year.
2. 2015-16 U.S. influenza vaccine composition includes both a new A strain and a new B strain compared to the previous year's vaccine. The trivalent contains an A/California/7/2009 (H1N1)-like virus, an A/Switzerland/9715293/2013 (H3N2)-like virus, and a B/Phuket/3073/2013-like (Yamagata lineage) virus. Quadrivalent vaccines will include an additional vaccine virus, a B/Brisbane/60/2008-like virus.
3. As in previous recommendations, all children aged 6 months–8 years who receive a seasonal influenza vaccine for the first time should receive 2 doses at least 4 weeks apart. Children in this age group need only one dose if they have a history of receiving 2 or more doses of trivalent or quadrivalent flu vaccine before July 1, 2015
4. For healthy children 2-8 years either Live Attenuated (nasal) or Inactivated Injectable flu vaccine is appropriate. No preference is expressed this year as new data did not support preference for one or the other in this age group.

Highly pathogenic avian influenza (HPAI) H5N1 infections have been reported in U.S. domestic poultry (backyard and commercial flocks), captive wild birds, and wild birds by the U.S. Department of Agriculture (USDA). HPAI H5 detections began in December 2014 and continued into mid-June 2015. During that time H5 bird flu virus detections were reported in 21 U.S. states (15 states with outbreaks in domestic poultry or captive birds and 6 states with H5 detections in wild birds only). In Michigan H5 infections were found in free ranging Canada geese in Macomb County. It is possible that H5 outbreaks in birds in the United States may recur in the fall and winter. Surveillance for H5 in U.S. birds is ongoing. At this time, no human infections with these viruses have been detected, however similar viruses have infected people in other countries and caused serious illness and death in some cases. Human infections with other avian influenza viruses have occurred after close and prolonged contact with infected birds or the excretions/secretions of infected birds (e.g., droppings, oral fluids).

CHAP

The Children's Healthcare Access Program, known as CHAP, is a collaborative community-based medical home program with the goal of improving the health of children on Medicaid while better utilizing existing resources and decreasing costs. Through partnerships with local pediatric providers and Medicaid Health Plans, CHAP seeks to accomplish these goals through decreasing the inappropriate use of emergency departments and hospitalizations, increasing the appropriate use of the medical home, and advocating for system-level improvements in the delivery of health care to children. CHAP provides resource coordination of community services with an emphasis on behavioral and oral health care via telephone consultation and/or home visit. CHAP also works with families to obtain transportation assistance in partnership with their health plan. CHAP will serve children ages 0-17 who are assigned to one of the participating CHAP primary care providers. For additional information contact Natalie Kasiborski at 231-347-5144.



School Building Waiver Rates Available

Vaccination requirements for school entry are implemented to maintain high vaccination coverage and protect schoolchildren from vaccine-preventable diseases. Before a child can attend kindergarten, seventh grade, childcare or enroll in a new school district in Michigan, parents or guardians are required to produce documentation that confirms their child has either received the school-required immunizations or has received at least one dose of each of the required immunizations and is awaiting receipt of subsequent doses to be administered at appropriate intervals. Parents can also provide documentation that an immunization requirement has been waived for religious, medical, or other (sometimes referred to as philosophical) reasons.

High waiver rates and low vaccination coverage leave children vulnerable to vaccine-preventable diseases. Only the student's provider can document a medical waiver. Families must contact the local health department to receive education on the risks of vaccine preventable diseases and the protection vaccines provide before obtaining a nonmedical waiver. The State is now posting waiver rates by school building as well as by county and local health department. For more information on waivers go to www.michigan.gov/immunize, click on Local Health Department then click on Immunization Waiver Information. Information on specific waiver rates can be found under School Immunization Data.

Expedited Partner Therapy

Chlamydia and Gonorrhea are a significant public health problem in the area and statewide are the most commonly reported communicable disease with over 55,000 cases reported annually. Infection rates are highest in men and women under the age of 24 and untreated can lead to infertility. A recent amendment to the Public Health Code authorized the use of Expedited Partner Therapy (EPT), which enables clinicians to provide patients with medication or a prescription to deliver to their sex partner(s) without a medical evaluation or clinical assessment of those partners. Furthermore, health professionals who provide EPT in accordance with the law are not subject to liability, except in the case of gross negligence. Due to the high risk of repeat infection from exposure to untreated partners, patients diagnosed with CT or GC cannot be considered adequately treated until all of their partners have been treated. This is particularly important given the asymptomatic nature of these infections. Although referral of partners for treatment and use of health department referral for partner notification and treatment remains the "gold standard", EPT is a useful alternative when a partner is unable or unlikely to seek care. Medication for EPT may be dispensed or prescribed, and if the partner's name is unknown the prescription is made out to "Expedited Partner Therapy".

The MDHHS STD Section has issued guidance for providers on use of EPT, medication recommendations, and contraindications along with information sheets for patients and partners. http://www.michigan.gov/documents/mdch/EPT_for_Chlamydia_and_Gonorrhea_-_Guidance_for_Health_Care_Providers_494241_7.pdf



Pneumococcal Vaccines in Persons 65 and Older

Gleanings from the latest edition of the Epidemiology and Prevention of Vaccine Preventable Diseases (the Pink Book):

Pneumococcal Polysaccharide Vaccine (PPSV23) was first licensed in 1983 and provides protection against 23 strains of pneumococcal bacteria that account for 60-76% of invasive disease. PPSV23 efficacy studies have resulted in various estimates of clinical effectiveness. Overall the vaccine is 60-70% effective in preventing invasive disease caused by the serotypes in the vaccine. It is less (or not) effective at preventing non-bacteremic pneumococcal pneumonia.

Pneumococcal Conjugate Vaccine (PCV13) was licensed in 2011 and provides protection against 13 serotypes that together cause about 25% of Invasive Pneumococcal Disease in adults over 65 years (In 2008 when first licensed these 13 strains accounted for over 60% of invasive disease in children under 5 years). A study done in the Netherlands among 85000 adults over age 65 years from 2008-2013 demonstrated 45.6% efficacy of PCV13 against vaccine type pneumonia and 75% efficacy against vaccine type invasive disease.

These are some of the reasons that led to the recommendation that healthy adults receive both PCV13 and PPSV23 after turning 65 years old. Ideally they would receive PCV13 first then PPSV23 12 months afterwards. If PPSV23 is given first then providers should give PCV13 12 months later. Adults that received PCV13 previously for a medical condition do not need another dose and at age 65 should be given their last dose of PPSV23 once they turn 65.

MIHP Return on Investment

The Maternal Infant Health Plan (MIHP) is a benefit of Medicaid eligible mothers to supplement medical care both prenatally and for infants. MIHP provides care coordination and intervention services focusing on both mother and infant with visits provided prenatally and for the infant after birth. Staff assist mothers in obtaining care and making changes that will promote a healthy pregnancy and that her infant will be healthy at birth.

A recent study comparing MIHP enrolled mothers who gave birth in 2010 to a matched sample found that the excess in preterm births of non MIHP mothers was 2.9 per hundred births. A cost analysis comparing the costs of MIHP program to the cost saving by reductions in preterm births showed that MIHP participation creates a net savings of over 1.2 million dollars for Medicaid in the State. For every \$1.00 spent on prenatal services for MIHP mothers, Medicaid saves \$1.38 in the costs associated with pre-term births in the first month of life.

Peters C, McKane, P. Meghea, C.. Michigan Department of Community Health. "Return on Investment: Cost Savings to Medicaid from Maternal Infant Health Program due to reduction in Preterm Birth Rate." ROI Fact Sheet Series Volume 1, Issue 1 (2015).

Tobacco 21

On June 19, 2015, Hawaii became the first state to raise the tobacco sale age to 21. At least 80 localities in eight states, including New York City, have also raised the tobacco sale age to 21. Statewide legislation is also being considered in several other states including California. Raising the legal sale age is popular with the public, including smokers. A July 2015 CDC report found that three quarters of adults favor raising the tobacco age to 21, including seven in 10 smokers. The Institute of Medicine issued a report on raising the minimum age of legal access to tobacco products in March 2015 (www.iom.edu/TobaccoMinimumAge). Based on a review of the literature and predictive modelling, it found that raising the tobacco sale age will significantly reduce the number of adolescents and young adults who start smoking; reduce smoking-caused deaths; and immediately improve the health of adolescents, young adults and young mothers who would be deterred from smoking, as well as their children.

Delaying the age when young people first experiment or begin using tobacco can reduce the risk that they transition to regular or daily tobacco use and increase their chances of successfully quitting, if they do become regular users. The IOM report notes that the age of initiation is critical and predicts that "Increasing the minimum age of legal access to tobacco products will likely prevent or delay initiation of tobacco use by adolescents and young adults." The IOM report found that "The parts of the brain most responsible for decision making, impulse control, sensation seeking, and susceptibility to peer pressure continue to develop and change through young adulthood, and adolescent brains are uniquely vulnerable to the effects of nicotine and nicotine addiction." In 1982 a researcher for RJ Reynolds was quoted saying "if a man has never smoked by age 18, the odds are three-to-one he never will. By age 24, the odds are twenty-to-one."

The Boards of Health for both District Health Department #4 and Health Department of NW Michigan passed resolutions this summer supporting raising the minimum legal age for tobacco access to 21, along with many other health departments and agencies. The Michigan State Medical Society at the 2015 annual House of Delegates also passed a resolution in support. A workgroup involving public health physicians and others is working on promoting tobacco 21 statewide. If you are interested in supporting tobacco control efforts or want more information please contact me anytime.



Ebola Update

Although Ebola has faded from media attention the outbreak continues in West Africa. Transmission appears controlled in Liberia, but cases continue in Guinea and Sierra Leone with a recent slowing in the number of new cases. There have been over 28,000 cases and over 11,000 deaths from the outbreak since it began a little over a year ago. Although modified, screening of arrivals from affected countries with monitoring for symptoms by local health departments continues including over 125 in Michigan. Hospitals and health care providers should be prepared to institute personal protection and precautions appropriate for the level of care they provide. For more updates and information visit www.michigan.gov/ebola or www.cdc.gov/ebola.

Communicable Disease Totals 2015 Y-T-D

Disease	Antrim	Charlevoix	Emmet	Otsego	Total
Campylobacter	3	4	3	11	21
Cryptosporidiosis	0	0	0	4	4
Giardiasis	1	0	0	2	3
Salmonellosis	3	0	2	1	6
Shiga toxin-producing Escherichia coli --(STEC)	0	0	0	1	1
Shigellosis	0	0	1	0	1
Yersinia enteritis	0	0	1	0	1
Flu Like Disease*	168	512	2205	2496	5381
Influenza	5	3	2	9	19
Influenza, 2009 Novel*	0	0	0	0	0
Influenza, Novel	0	0	0	0	0
Meningitis - Aseptic	1	0	0	0	1
Meningitis - Bacterial Other	1	0	0	0	1
Meningococcal Disease	1	0	0	0	1
Streptococcus pneumoniae, Inv	1	0	3	0	4
Head Lice	56	64	45	37	202
Histoplasmosis	0	0	0	1	1
Strep Throat	66	90	246	158	560
Streptococcal Dis, Inv, Grp A	1	1	2	0	4
Animal Bite	0	0	1	0	1
Chlamydia (Genital)	27	25	41	30	123
Gonorrhea	0	0	0	6	6
Syphilis - Early Latent	0	1	0	0	1
Syphilis - Latent of Unknown Duration	0	0	0	1	1
Mycobacterium - Other	1	0	0	1	2
Chickenpox (Varicella)	1	0	2	0	3
H. influenzae Disease - Inv.	0	0	3	0	3
VZ Infection, Unspecified	0	0	7	2	9
Lyme Disease	0	1	1	0	2
Hepatitis B, Acute	0	1	1	0	2
Hepatitis B, Chronic	0	1	0	3	4
Hepatitis C, Acute	5	1	2	0	8
Hepatitis C, Chronic	12	11	24	13	60
Total	353	715	2592	2776	6436

Michigan Zoonotic and Vector-Borne Disease Surveillance Summary 2014

The summary is available at www.michigan.gov/emergingdiseases. Highlights include:

- West Nile virus activity was mild last year with only 3 cases total reported in MI, all in the SW part of the state. WNV remains endemic to our region and actions can be taken to reduce the risk of mosquito bites especially in adults over 50 who are more susceptible to serious illness from WNV.
- There were 128 cases of Lyme disease reported in MI, mostly from the Western UP and western Lower Michigan where infected ticks are most endemic. New detections of blacklegged ticks, the vector for *Borrelia burgdorferi*, occurred in Clinton and Ingham Counties in 2014. In May of 2015 the tick was identified on Beaver Island (Charlevoix County), marking the first evidence of its presence north of Grand Traverse County. The [Lyme Disease Healthcare Provider Toolkit](#) is an excellent resource for providers and is available at www.michigan.gov/lyme.
- Rabies continues to be identified in area wildlife with peak submissions for testing in August. Bats are the most frequently tested animal and 3.4% of those tested at the state lab were positive for rabies infection. Last year 38 bats and 3 skunks were positive across the state. Animal bites and other potential exposures from wild animals should be reported to the health department. For exposures to bats and other potentially rabid animals such as cats, dogs, raccoons, foxes, and skunks, animal capture and testing is preferred but if not possible then rabies post exposure prophylaxis should be considered.

To report a Communicable Disease/STD to the Health Department:

Antrim County:
Rhonda Decker, RN
231-533-1005

Charlevoix County:
Marley Niewendorp, RN
231-547-7631

Emmet County:
Melissa Mundy, RN (*Chlamydia only)
231-347-5636

Emmet/Otsego Counties:
Sandy Tarbutton, RN
989-732-6869

OR

**Send a secure fax 24 hours / day:
231-547-6238**

