Vaccinate Vermont

Vermont Department of Health

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Inside this issue:

New HPV Vaccine Data Brief For Vermont 2014 Is here In IMR Spotlight

Immunization Rates for Vermont Children: 2013 National Immunization Survey

Since April 1994, the CDC has been conducting a National Immunization Survey (NIS) to estimate immunization coverage rates for children 19-35 months of age. This survey is administered in all 50 states and 28 urban areas in the United States, and is conducted by random digit dialed telephone methodology. Parents respond to NIS survey questions. Their answers are then validated by the child's health care provider.

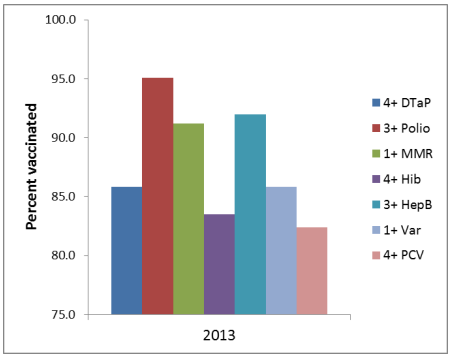
In 2013, 66.9% of Vermont children received the complete series of all ACIP recommended vaccines. The percentage of Vermont children 19-35 months immunized against polio, measles, mumps, rubella (MMR) and hepatitis B exceeded the Healthy People 2020 goal of 90%. There were statistically significant increases in the percentage of children who received the hepatitis B birth dose (38%), hepatitis A (48.5%) and rotavirus (73.4%) vaccines. Despite the 2013 increase in the hepatitis B birth dose, Vermont had the lowest rate in the U.S. (national rate 71.8%). The percentage of children who were fully immunized against pneumococcal disease with all four doses of PCV13 vaccine dropped from 84.2% to 82.4%.

Despite comparable vaccine access, Vermont's immunization rates are lower than all other New England states. Vermonters have excellent access to children's vaccines through the universal vaccine program. The Immunization Program provides vaccines at no cost to providers for use in ALL children. Funding for the universal program is provided through the federal Vaccines for Children program and Vermont health insurers.

The Immunization Program is working to improve rates with several complementary initiatives that include:

- The It's OK to Ask campaign.
- Primary care provider/staff quality improvement efforts.
- Automated use of recall-reminder letters for children ages eight and 20 months whose immunizations are not up-to-date in the Immunization Registry.
- Child care immunization requirements.

Vaccination coverage among children 19-35 months,



Vermont, 2013 NIS

Vaccine Storage and Handling Update

Practices participating in the Vaccines for Children (VFC) and Vaccines for Adults (VFA) programs are expected to manage publicly purchased vaccine for their patients.

One of the more complex aspects of vaccine management is following proper storage and handling procedures that ensure the cold chain is maintained while vaccines are stored at the provider office. Sound management practices will minimize vaccine loss and waste, and the potential need to revaccinate patients as a result of administering compromised vaccine.

Vaccine coordinators are required to check and document refrigerator/freezer temperatures two times per day when a practice is open for business. Starting on January 1, 2015, VFC/VFA enrolled practices are required to document the time and the name/initials of the staff person who completed each reading on a paper temperature log. In addition, the vaccine coordinator must document all actions that are taken if the temperatures readings are out of acceptable range.

Also beginning January 1, 2015, VFC providers will be required to have at least one back up thermometer with a current certificate of calibration on hand (not stored in the unit alongside current thermometer). In order to satisfy this requirement, the Vermont Immunization Program will provide all VFC/VFA enrolled practices with one Fisher Scientific thermometer with a current certificate of calibration. This backup thermometer is to be used when:

- Transporting vaccine to another practice.
- If the data logger stops working (must contact the Immunization Program before using the backup thermometer).

Vaccine coordinators please note that the backup thermometer and certificate of calibration must be available for visual inspection and verification during the VFC/VFA compliance site visit.

Site Visit Summary

All practices enrolled in Vaccines For Children (VFC) and Vaccines For Adults (VFA) must have a periodic site visit to ensure the quality of vaccines, and to maintain the integrity of the VFC/VFA program. VFC/VFA visits assess a practice's compliance with VFC and VFA program requirements. The site visit will help to identify potential issues with vaccine accountability and determine whether vaccines are being handled, stored, and administered in accordance with the policies governing the VFC and VFA programs.

The goals of these visits are to:
• Identify areas where providers are doing well and areas that need additional follow-up.
• Identify the educational needs of VFC/VFA providers to support them with meeting program requirements.
• Ensure that Vermonters receive properly managed and viable vaccine.

The total number of participating practices in Vermont is 227. In 2014, 162 VFC and 26 VFA-only compliance site visits have been conducted. Areas of the program needing the most attention are VFC screening and documentation, and required annual training for key staff. Future efforts will be focused on collaboration with practices to meet and comply with the program requirements.

Flu Update December 29, 2014

Flu activity is increasing in the US, and the Centers for Disease Control and Prevention (CDC) is getting reports of flu illnesses, flu hospitalizations and flu-related deaths. Fifteen pediatric deaths have been reported so far this season. The most common strain is Influenza A (H3N2). CDC has found that H3N2-predominant seasons are associated with more severe illness and mortality, especially in older people and young children, than during H1N1 or B-predominant seasons.

More than two-thirds of the influenza A (H3N2) viruses analyzed since October 1 are antigenically or genetically different from the H3N2 vaccine virus component for the 2014-2015 season. As a result of this antigenic drift, the vaccine may not work as well.

The Vermont Department of Health and CDC still urge flu vaccination because it can still reduce flu illnesses, doctor's visits and missed work and school due to flu, as well as prevent flu-related hospitalizations and deaths. Antiviral drugs are not a substitute for vaccination, but when used as an adjunct within two days of the onset of symptoms, they are an important second line of defense to treat flu illness. The December 12, 2014 MMWR contains a report estimating that the 2013-2014 flu vaccine prevented 7.2 million influenza-associated illnesses, 3.1 million medically attended illnesses and 90,000 hospitalizations. CDC has also reported early 2014-2015 vaccination coverage estimates are about 40% (all people 6 months and older).

The Future of Vaccine Inventory and Ordering

The Vermont Immunization Program recently received a grant from the Centers for Disease Control and Prevention providing $489,169 over two years to integrate the CDC Vaccine Tracking System (VTrckS) with the Vermont Immunization Registry (IMR). Currently, state supplied vaccine ordering and distribution is managed through the web-based VTrckS program. Providers are also required to report immunizations to the Immunization Registry (IMR).

This grant will allow the Immunization Program to research, select and implement an inventory management system that will tie these two systems together. Upon implementation of the proposed IT integration, the system will be tested, piloted and a plan will be developed to transition all VFC and/or VFA enrolled health care providers to this new system for all aspects of vaccine management. The project meets a need expressed by providers, and moves us closer to the national standard of using the Immunization Information System for all vaccine management processes. The project period runs from October 2014 – September 2016. More information about project progress will be provided.

A successful solution would:

- Address the need to track vaccines when ordered, received, stored and disbursed at VDH, VFC/VFA enrolled health care practices, or any point of vaccine administration.
- Track Vaccine Inventory from the point of order through the point of immunization administration or disposal at the provider and state level.
- Tie all doses administered to a specific patient in the IMR.
- Incorporate a streamlined system for vaccine recalls.
- Improve the process of purchase and distribution of vaccines by integration with VTrckS.
- Maintain strict confidentiality of all immunization records.

Allow for functionality needed during a future Pandemic Flu epidemic.

PCV13 Update

This article was adapted from a story published on Medscape by Dr. Sandra Fryhofer. www.medscape.com/viewarticle/833475

The Advisory Committee on Immunization Practices (ACIP) issued a new recommendation for seniors, just in time for this year's flu vaccination clinics.

Pneumococcal infection (Streptococcus pneumonia) is a major cause of morbidity and mortality.[1] It kills as many as 4000 people in the United States each year, mostly adults. It's a leading cause of serious illness including: bacteremia, meningitis, and pneumonia. The risk for invasive pneumococcal disease (IPD) is increased in adults who are immunocompromised. In fact, disease rates for immunocompromised adults are 20 times higher than that for adults without high-risk medical conditions. Therefore, in June 2012, the ACIP recommended routine use of pneumococcal conjugate vaccine (PCV13) for immunocompromised adults in addition to the pneumococcal polysaccharide vaccine (PPSV23).

Older adults are also at increased risk for invasive disease. Incidence of invasive disease in adults aged 18-34 years is 3.8 per 100,000. Incidence of invasive disease in older adults, those aged 65 years or older, is nearly 10 times higher: 36.4 per 100,000. Because ACIP recommendations are now evidence-based, the decision was made to defer further expansion of the recommendation for routine use until results of the Community-Acquired Pneumonia Immunization Trial in Adults (CAPITA), a randomized controlled trial of efficacy of PCV13 against pneumococcal pneumonia, were released.[2] CAPITA was conducted in The Netherlands and was designed to look at the efficacy of PCV13 at preventing vaccine-type community-acquired pneumonia in adults aged 65 years or older.

In the trial, nearly 85,000 seniors were randomized to receive either PCV13 or placebo. The results?

PCV13 was effective: 75% effective at preventing vaccine-type IPD, and 45% effective in preventing vaccine-type nonbacteremic pneumonia (NBP). These data were presented to ACIP at the June 2014 meeting. The findings were so impressive that ACIP called an emergency meeting on August 13, 2014, to vote on routine PCV13 vaccine procedures. The vote was 13 to 2 in favor of routine PCV13 vaccination for adults aged 65 years or older.[3]

Both the timing and the order of the two pneumococcal vaccines, one conjugate and the other polysaccharide, is important because it can affect vaccine effectiveness.

• Adults aged 65 years or older who have never received any type of pneumococcal vaccine should receive PCV13 first, followed by PPSV23 6-12 months later.

• Adults aged 65 years or older who have already received PPSV23 should also be given one dose of PCV13, but timing is important. Wait at least a year after receiving PPSV23 before giving PCV13.

• For those who need PPSV23 revaccination, wait at least 5 years after the last dose of PPSV23 and 6-12 months after receiving PCV13 to revaccinate.

References

1. Cox CM, Link-Gelles R. http://www.cdc.gov/vaccines/pubs/surv-manual/chpt11-pneumo.html Accessed October 16, 2014.

2. Bonten M, Bolkenbaas M, Huijts S, et al. http://isppd.meetingxpert.net/ISPPD_433/poster_90453/program.aspx/anchor90453 Accessed October 16, 2014.

3. Tomczyk S, Bennett NM, Stoecker C, et al. Wkly http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6337a4.htm Accessed October 16, 2014.

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