

## Hot Off the Press

- [Transcript of July 19 CDC telebriefing: Pertussis in the U.S. and Washington state](#)
- CDC Current Issues Netconference - Influenza Vaccine Recommendations & Other Topics (Note: see website below to pre-register; pre-registration is required)  
July 26, 2012 (12-1 pm ET)  
[www.cdc.gov/vaccines/ed/ciinc/default.htm#next](http://www.cdc.gov/vaccines/ed/ciinc/default.htm#next)

## CDC Releases Influenza VIS for 2012-13 Flu Season

On July 2, the influenza Vaccine Information Statements (VIS) were updated for the 2012-2013 flu season. Both the TIV and LAIV VIS were updated. The new editions have been converted to the updated VIS format, but the text in both VIS is identical to that in last years' influenza VISs. Note that there will be minor updates in the ACIP influenza recommendations, but these will not affect the VIS language. To avoid confusion, please switch to the 2012-13 VIS, even though the language hasn't changed.

In Michigan, it is important that vaccine recipients, their parents, or their legal representatives be given the Michigan versions of VIS because they include information about the Michigan Care Improvement Registry (MCIR). By state law in Michigan, parents must be informed about MCIR. Vaccine Information Statements that are obtained from other sources (e.g., from the CDC or IAC websites) do not contain information about MCIR.

The *Important VIS Facts* handout, which includes all the current VIS dates, has also been updated. This is posted on the same web page as the Michigan versions of the [Vaccine Information Statements](#).

## Translations of Vaccine Information Statements

Michigan versions of the Spanish translations of the 2012-13 influenza VIS have also been posted on the MDCH website. MDCH thanks the California Department of Public Health, Immunization Branch, for the translations.

The 2012-13 influenza vaccine VIS will be available in several additional languages in the weeks ahead. After the IAC Express has announced the availability of translations, we will get them posted on the MDCH website as quickly as possible. Please be sure to use the Michigan versions of the VIS. *When the foreign language VIS is not the most current version, parents should also be given the current English version.*

If you need a foreign language VIS, check first at [www.michigan.gov/immunize](http://www.michigan.gov/immunize). If not listed, call the MDCH Division of Immunization at 517-335-8159.

These documents are posted on our website at [www.michigan.gov/immunize](http://www.michigan.gov/immunize) under [Vaccine Information Statements](#).

## Pentacel Supply Delay to Last through 1st Quarter of 2013

On July 16, MDCH received the following message from CDC: "Sanofi Pasteur has informed CDC that the supply delay of Pentacel will continue longer than originally anticipated, through Q1 2013, in order to complete process improvements. In addition, although CDC does not currently have allocations in place for Daptacel, Sanofi Pasteur will continue its private order restrictions for that product during this period. Sanofi Pasteur continues to manufacture both Pentacel and Daptacel, but order restrictions and allocations are in place to allow additional time to ramp up supply. As previously, ActHIB and IPOL remain in ample supply."

MDCH will continue on a Pentacel allocation for Vaccines for Children (VFC) providers. Full ordering of Daptacel is available for VFC, as well as ActHib, IPOL and Pediarix.

No child should go unvaccinated due to this Sanofi supply issue. Ample vaccines in other presentations are available and must be used to avoid missed opportunities.

For more information:

- [Guidance for Vaccinating Children during the 2012 Pentacel® and Daptacel® Shortage](#)
- [The Quick Reference to Combination Vaccines](#)
- [CDC's Current Vaccine Shortages & Delays](#)

## CDC Updates Vaccine Storage and Handling Guidance

CDC recently issued the following new guidance for proper storage and handling of vaccines: Stand-alone freezers and stand-alone refrigerators without freezers are **strongly** recommended. Studies have demonstrated that stand-alone units maintain the required temperatures better than combination units. An alternative to stand-alone units would be to use the refrigerator compartment of a combination refrigerator/freezer unit to store refrigerated vaccines. A separate stand-alone freezer would be used to store frozen vaccines. At a minimum, a combination refrigerator/freezer unit sold for home use with separate exterior doors and thermostat controls for each compartment is acceptable, but not recommended.

The updated guidance can be found on CDC's website at the 2012 Epidemiology and Prevention of Vaccine-Preventable Diseases on-line course, session 3 at: <http://www.cdc.gov/vaccines/ed/epivac/default.htm>

The guidance is also included in the Pink Book (also called the Epidemiology and Prevention of Vaccine-Preventable Diseases), 12th ed., second printing, Chapter 5 Vaccine Storage and Handling at: <http://www.cdc.gov/vaccines/pubs/pinkbook/vac-storage.html>

MDCH has an educational piece on [Storing Vaccines Safely](#) for your office. The handout is intended to help guide providers on key points for proper storage and handling of all their vaccines.

## Are Your Adolescent Patients Up-to-Date on Needed Vaccines?

This year, beat the back-to-school rush and immunize all adolescent patients throughout the summer. Utilize sports physicals to catch-up adolescents with missing doses. Every time an adolescent patient arrives at the office – whether for a preventive or sick visit – is an opportunity to immunize that patient with needed vaccines.

Sometimes parents of adolescents may come into your office and only want the vaccines required for school entry. Please take time to talk to these parents about the importance of immunizing their adolescent child according to the recommended schedule, including flu and HPV vaccines. The American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), the Society for Adolescent Medicine (SAM), and other professional medical organizations recommend that providers vaccinate based on current Advisory Committee on Immunization Practices (ACIP) recommendations. In doing so, Michigan's school immunization requirements will be met.

A key change was made to the 2012 adolescent immunization schedule for human papillomavirus (HPV) vaccine. Providers should now routinely administer HPV4 to males and HPV4 or HPV2 to females 11-12 years of age and catch-up females 13-26 years of age and males 13-21 years of age. Males 22-26 years of age within a high risk group may be vaccinated, too. High risk groups include those who are immunocompromised due to infection (including HIV), disease or medication and men having sex with men. Consider vaccination for all other males 22-26 years of age.

It's important to remember these additional recent changes to the adolescent immunization schedule. Meningococcal conjugate vaccine (MCV4) should be routinely administered at 11-12 years of age with a booster dose at 16 years of age. For those adolescents who need to be caught up on doses, if the first dose is given at 13-15 years of age, give a booster dose at 16-18 years of age; if the first dose is given at 16 years of age or older, a booster dose is not recommended. Other individuals may need MCV4 vaccine based on age or risk factors. The rate of invasive meningococcal disease among individuals 17–20 years of age is about twice that of the general U.S. population, therefore it's critical to protect adolescents by ensuring they receive both doses of MCV4 vaccine according to the recommended schedule.

Another important vaccine for adolescents to receive is tetanus-diphtheria-pertussis (Tdap) vaccine. When pertussis protection is needed, there is no minimum interval between the last dose of a tetanus or diphtheria-containing vaccine (DTaP, Td) and a dose of Tdap. Pregnant adolescents who have not previously received Tdap should receive a dose during their third trimester or late second trimester (after 20 weeks gestation). Children aged 7-10 years of age without a complete DTaP/Td series should receive 1 dose of Tdap in place of a dose of Td. Tdap is routinely given at 11-12 years of age.

Integrating vaccine administration with other preventative and acute health care visits and following the current ACIP immunization schedule are key strategies to ensuring patients have received all needed immunizations. Back-to-school check-ups and sports physicals are an ideal time to make sure adolescent patients are fully vaccinated.

## [Completion Rates of HPV Vaccination Series Decreasing](#)

*ANA Immunize, June 28, 2012\**

New research suggests that fewer women are completing the human papillomavirus (HPV) vaccine series than they did in 2006. A study from the Center for Interdisciplinary Research in Women's Health, University of Texas Medical Branch in Galveston, found that the percentage of females with health insurance who complete the HPV vaccine series has been declining over time. The research included 271,976 females who initiated the HPV vaccine series. According to the data, among females aged nine to 12 years, the rate of completion of the vaccination series declined from 57 percent in 2006 to 21 percent in 2009. Among those aged 13 to 18, the completion rate was 55 percent in 2006 and 21 percent in 2009. In addition, the rate of completion declined among 19- to 26-year-olds from 44 percent in 2006 to 23 percent in 2009. Among females aged at least 27 years, the rate of completion rose from 15 percent in 2006 to 26 percent in 2007 and 27 percent in 2008; however, this rate declined to 24 percent in 2009. Obstetricians/gynecologists were more likely to administer the vaccine series to completers than pediatricians. Clinics, nurses, family care practitioners, and specialists were less likely to administer the initial vaccines to completers than pediatricians. (Hirth JM. *Cancer*. 2012;doi:10.1002/cncr.27598. May 25, 2012)

\*Sign up for the free American Nurses Association (ANA) immunization e-newsletter, [ANA ImmuNews](#), and get e-mail notification of the latest immunization related news.

## **Adolescent Immunization Toolkit Brings Resources to Your Fingertips**

The [Adolescent Immunization Toolkit](#) is available at [www.michigan.gov/teenvaccines](http://www.michigan.gov/teenvaccines) to address all of your adolescent immunization needs. Here you will find helpful tools, such as:

- Quick Looks (one page summaries of immunization recommendations)
- Standing Orders
- Storage and Handling Resources
- Vaccine Administration Resources
- Vaccine Safety and Patient Education Resources (posters, flyers, brochures for your office)
- Adolescent Immunization Coverage Levels

## **Vaccines Recommended during Adolescence**

- Meningococcal
- Human papillomavirus
- Influenza
- Hepatitis A
- Hepatitis B
- Tetanus-diphtheria-pertussis
- Varicella (chickenpox)
- Measles-mumps-rubella
- Polio

## [CDC Immunization Update Webcast Scheduled for August 16](#)

The Immunization Update 2012 course is scheduled from 9 am to 11:30 am, and again from 12 noon to 2:30 pm. Both sessions will feature a live question-and-answer session. CDC's annual update will focus on the most recent and significant developments in the rapidly changing field of immunization. Topics will include influenza, pertussis outbreaks and Tdap, ACIP recommendations for health care personnel, pneumococcal conjugate vaccine for immunocompromised adults, vaccine storage and handling, and Vaccine Information Statements. To view a fact sheet with comprehensive information, including information on obtaining Continuing Education credits, go to: [www.cdc.gov/vaccines/ed/imzupdate/downloads/course-sheet.pdf](http://www.cdc.gov/vaccines/ed/imzupdate/downloads/course-sheet.pdf)

## CDC Releases Updated Recommendations for the Management of HBV-Infected Health Care Providers

On July 6, 2012, the Centers for Disease Control and Prevention (CDC) published a report to update the 1991 recommendations for the management of hepatitis B virus (HBV)-infected health care providers and students to reduce risk for transmitting HBV to patients during the conduct of exposure-prone invasive procedures. The full report is published online at [www.cdc.gov/mmwr/pdf/rr/rr6103.pdf](http://www.cdc.gov/mmwr/pdf/rr/rr6103.pdf).

The primary goal of this report is to promote patient safety while providing risk management and practice guidance to HBV-infected health care providers and students, particularly those performing exposure-prone procedures such as certain types of surgery. These updated recommendations reaffirm the 1991 CDC recommendation that HBV infection alone should not disqualify infected persons from the practice or study of surgery, dentistry, medicine, or allied health fields. The CDC Classification of Exposure-Prone Patient Care Procedures is included on page 4.

The previous recommendations have been updated to include the following changes:

- no pre-notification of patients of a health care provider's or student's HBV status;
- use of HBV DNA serum levels rather than hepatitis B e-antigen status to monitor infectivity; and,
- for those health care professionals requiring oversight, specific suggestions for composition of expert review panels and threshold value of serum HBV DNA considered "safe" for practice (less than 1,000 IU/ml).

These recommendations also explicitly address the issue of medical and dental students who are discovered to have chronic HBV infection. For most chronically HBV-infected providers and students who conform to current standards for infection control, HBV infection status alone does not require any curtailing of their practices or supervised learning experiences. These updated recommendations outline the criteria for safe clinical practice of HBV-infected providers and students that can be used by the appropriate occupational or student health authorities to develop their own institutional policies. The recommendations can be used by an institutional expert panel that monitors providers who perform exposure-prone procedures.

In addition to these recommendations, please refer to Immunization of Health Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), posted at [www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm).

## NFID Pneumococcal Disease Toolkit

The National Foundation for Infectious Diseases (NFID) has launched a new toolkit designed to help health departments raise awareness about pneumococcal disease and encourage adult immunization. We encourage you to begin using the toolkit as part of your adult immunization communications efforts.

The toolkit includes materials and resources in three sections for:

- Educating Health Care Professional Audiences
- Informing Public/Patient Audiences
- Conducting Media Outreach/Communications

These tools are available on NFID's website [Adultvaccination.org](http://Adultvaccination.org).

## Alternative Immunization Schedule Use on the Rise

### Abstract

Recent studies have described an increase in parental hesitancy regarding vaccines as well as increases in parental adoption of vaccine schedules that delay or limit receipt of recommended vaccines. This study quantifies potential prevalence and trends in alternative schedule compliance by measuring consistent shot-limiting in a metropolitan area of Oregon.

A total of 4,502 of 97,711 (4.6 percent) children met the definition of consistent shot-limiters. The proportion of consistent shot-limiters in the population increased from 2.5 percent to 9.5 percent between 2006 and 2009. Compared with those with no or episodic limiting, consistent shot-limiters by 9 months of age had fewer injections (6.4 vs. 10.4) but more visits when immunizations were administered (4.2 vs. 3.3). However, only a small minority of shot-limiters closely adhered to published alternative schedules.

The percentage of children consistently receiving 2 or fewer vaccine injections per visit between birth and age 9 months increased threefold within a 2-year period, suggesting an increase in acceptance of non-Advisory Committee on Immunization Practices vaccine schedules in this area.

Although less than 1 percent of parents choose not to immunize their children, this study found an increase in the number of infants who are consistently out of compliance with the ACIP schedule. Infants who never receive more than 1 or 2 injections on any visit are potentially using alternative vaccination schedules. Parental decisions to delay or avoid certain vaccines may have an impact on susceptibility of the individual child to vaccine-preventable diseases as well as on the community in which they live. Continued research is needed to understand the true impact of delaying vaccine receipt on individual disease incidence, as well as community immunity.

Source: Steve G. Robison, Holly Groom and Collette Young; July 2012 *Pediatrics*; originally published online June 18, 2012; DOI: 10.1542/peds.2011-3154

## MDCH 2012 Fall Immunization Conferences

*Registration will begin August 30.*

The dates and locations for the conferences are Oct. 9 (Gaylord), Oct. 11 (Marquette), Oct. 18 (Troy), Oct. 30 (Dearborn), Nov. 1 (Bay City), Nov. 2 (E. Lansing), Nov. 14 (Grand Rapids), and Nov. 15 (Kalamazoo).

On or about August 30, an email reminder to register for the conferences will be sent to all the recipients of this newsletter. As more details become available, they will be posted online at [www.michigan.gov/immunize](http://www.michigan.gov/immunize) (under Provider Information).

## Michigan's Immunization Timely Tips (MITT)

To subscribe, send an email to [cmarkzon@msms.org](mailto:cmarkzon@msms.org) and enter the word SUBSCRIBE in the subject line. Subscribers will receive the Michigan Immunization Timely Tips (MITT) newsletter, as well as additional immunization-related updates on a periodic basis. MITT is posted at [www.michigan.gov/immunize](http://www.michigan.gov/immunize) under the Provider Information section. For more information, contact Rosemary Franklin at [franklinr@michigan.gov](mailto:franklinr@michigan.gov).

## **CDC classification of exposure-prone patient care procedures**

### **Category I. Procedures known or likely to pose an increased risk of percutaneous injury to a health-care provider that have resulted in provider-to-patient transmission of HBV**

These procedures are limited to major abdominal, cardiothoracic, and orthopedic surgery, repair of major traumatic injuries, abdominal and vaginal hysterectomy, caesarean section, vaginal deliveries, and major oral or maxillofacial surgery (e.g., fracture reductions). Techniques that have been demonstrated to increase the risk for health-care provider percutaneous injury and provider-to-patient blood exposure include

- digital palpation of a needle tip in a body cavity and/or
- simultaneous presence of a health care provider's fingers and a needle or other sharp instrument or object (e.g., bone spicule) in a poorly visualized or highly confined anatomic site.

Category I procedures, especially those that have been implicated in HBV transmission, are not ordinarily performed by students fulfilling the essential functions of a medical or dental school education.

### **Category II. All other invasive and noninvasive procedures**

These and similar procedures are not included in Category I as they pose low or no risk for percutaneous injury to a health-care provider or, if a percutaneous injury occurs, it usually happens outside a patient's body and generally does not pose a risk for provider-to-patient blood exposure. These include

- surgical and obstetrical/gynecologic procedures that do not involve the techniques listed for Category I;
- use of needles or other sharp devices when health-care provider's hands are outside a body cavity (e.g., phlebotomy, placing and maintaining peripheral and central intravascular lines, administering medication by injection, performing needle biopsies, or lumbar puncture);
- dental procedures other than major oral or maxillofacial surgery;
- insertion of tubes (e.g., nasogastric, endotracheal, rectal, or urinary catheters);
- endoscopic or bronchoscopic procedures;
- internal examination with a gloved hand that does not involve the use of sharp devices (e.g., vaginal, oral, and rectal examination; and
- procedures that involve external physical touch (e.g., general physical or eye examinations or blood pressure checks).

<http://www.cdc.gov/mmwr/pdf/rr/rr6103.pdf>