



Celebrate National Infant Immunization Week



April 25 through May 2, 2009

National Infant Immunization Week is an annual observance to highlight the importance of protecting infants from vaccine-preventable diseases and to celebrate the achievements of immunization programs and their partners in promoting healthy communities. What better time to make sure your patients are up-to-date with their immunizations?

Here's an idea...

- When you receive your monthly colored report from CIRTS, and you pull the immunization history, take five minutes to look at the record and see if the child is up-to-date or not.
- If the child is missing an immunization, put the record aside and make a call to the family to come back in to finish up.

If you don't have the time, call your local IAP Coordinator and ask them to follow up with those children.

It's everyone's job to make sure our children are protected. Let's try this week to work as a team to make this happen.

If you are doing something special in your office to bring awareness to the importance of immunizing children, please call **Carolann Kapur, Connecticut Immunization Program at (860) 509-7732** and she will post your event on the Department of Public Health website and publish a printed list of events going on around the state that will go out statewide.



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HiB Update

In recent months there has been an increase in reported cases of Haemophilus influenzae type B (Hib) disease in children under age five years. Minnesota reported five Hib cases with one death. Pennsylvania reported four Hib cases and has isolates from three additional cases of Haemophilus influenzae invasive disease that have not yet been serotyped. Three of the seven PA cases died.

The increase in Hib cases may be due to a nationwide shortage of Hib vaccine that began in December 2007 and is ongoing. Problems with production of Hib-containing vaccine by Merck (PedvaxHIB) has left Sanofi Pasteur (ActHIB, Pentacel) the only manufacturer of Hib-containing vaccine approved for use in the U.S. Until the supplies are restored, CDC issued a recommendation to defer the Hib booster (routinely administered at 12-15 months) for children

who are not at high risk of Hib infection. This recommendation is still in effect.

There is currently enough Hib-containing vaccine for all U.S. children to complete the three-dose primary series at 2, 4 and 6 months of age. The CT Immunization program is providing Pentacel (DTaP/IPV/Hib combination) and limited quantities of ActHib for all children in your practice. However, preliminary national information from sentinel immunization registries indicate up to 10% lower coverage for the third Hib dose compared with other vaccines (DTaP, PCV7) commonly administered at the same visit.

Some of the challenges in using the currently available Hib-

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Local IAP Coordinators

Bridgeport

Joan Lane
203-372-5503

Danbury

Irene Litwak
203-730-5240

East Hartford

Marie Rorrio
860-291-7322

Hartford

Tish Rick Lopez
Sandra Abella
860-547-1426 x7048

Ledge Light

Martin Tolentino
Katie Baldwin
860-448-4882 x356

Meriden

Ana Guajardo
203-630-4251

Naugatuck Valley

Elizabeth Green
203-881-3255

New Britain

Ramona Anderson
860-612-2777

New Haven

Jennifer Hall
203-946-7097

Norwalk

Pam Bates
203-854-7728

Stamford

Cinthia Vera
203-977-5098

Torrington

Sue Sawula
860-489-0436

Waterbury

Randy York
203-346-3907

West Haven

Betty Murphy
203-937-3665

Windham

Vacant
860-423-4534

Other areas

Johanna Castaneda
860-509-7241

CIRTS -Recipe For Success

Last fall IAP Coordinators and Immunization Program staff delivered certificates and plaques to providers who had achieved high immunization coverage in their 2 year old patients. Providers were asked how they managed to achieve such good immunization levels. Here are some of the secrets to their success:

1. **Set up the next appointment before the patient leaves the office.**
2. **Make reminder calls the day before the appointment.**
3. **At every opportunity (including sick visits) look at the child's shot record to make sure the child is up-to-date.**
4. **Educate parents about the importance of immunizations.**
5. **Post the immunization schedule in a place where all staff can see it.**
6. **Complete the CIRTS compliancy report right away.**



CIRTS Success Stories

We all know that having a statewide immunization registry is a value to all of us, namely having a permanent record of our child's or patient's shot history at our fingertips whenever and wherever we need it regardless of where the child goes for care. Read these real-life stories about how CIRTS has proved to be a treasure to all of us—provider, parent, and the community alike.

- CIRTS receives a call from a pediatric office looking for shot records on a child coming to their practice for

the first time, without a shot record. The practice calls CIRTS and within minutes a complete record is faxed to the new practice regardless of where the child has been seen before.

- A doctor sees a newborn baby for their first well-child checkup. The doctor isn't sure if the child received their first Hep B shot at birth. The doctor calls CIRTS, and the first Hep B date is faxed to the office while the baby is in the waiting room.
- A family needs to get their toddler into daycare but their doctor retired and left no information as to where to obtain their medical information. The mom calls CIRTS and we immediately send the immunization record so the child can attend day care without the mom missing any work.
- A family relocates to CT from New Orleans after Katrina hit. Because the state of LA has a registry, the immunization record was saved. By coordinating with the LA registry we were able to get access to the child's immunization record to avoid having the child repeat all their shots.

“I'm so glad CT has a registry. I wouldn't have been able to get my child into day care.”

Court Says ‘Measles Vaccine Not to Blame for Autism’

Three rulings related to autism and vaccine injury compensation cases were issued on February 12th by the U.S. Court of Federal Claims. The rulings were part of the Omnibus Autism Proceeding created by the National Vaccine Injury Compensation Program to handle the large volume of claims that vaccines induce autism. In each of the rulings the Court held that the measles, mumps, rubella vaccine, whether administered alone or in conjunction with thimerosal-containing vaccines, were not causal factors in the development of autism or autism spectrum disorders.



In a statement the U.S. Department of Health and Human Services said: ***"The medical and scientific communities have carefully and thoroughly reviewed the evidence concerning the vaccine-autism theory and have found no association between vaccines and autism. If parents have questions or concerns about childhood vaccines, they should talk with their child's health care provider."*** Hopefully, the determination by the Court will help reassure parents that vaccines do not cause autism.

Vaccine-Preventable Disease Reporting

Systematic reporting of various diseases in the United States began in 1874 when the State Board of Health of Massachusetts inaugurated a plan for the weekly voluntary reporting of prevalent diseases by physicians. Today, all states and territories of the United States participate in a national morbidity reporting system and regularly report aggregate or case-specific data for over 50 infectious diseases and related conditions to the Centers for Disease Control and Prevention (CDC). Surveillance data provide the basis for determining public health priorities and for planning and implementing prevention and control programs. Policymakers use these data to determine overall priorities for resources for public health programs and, in certain instances, these data may be the basis for geographic distribution of funds for treatment.

Infectious disease surveillance systems rely primarily on receipt of case reports from physicians and other health care providers. Infectious diseases are grouped into 2 categories: Category 1 Disease which must be reported immediately by telephone on the day of recognition or strong suspicion of

**Reported Vaccine-Preventable Diseases, CT
2004-2008**

	2004	2005	2006	2007	2008
Measles	0	0	0	0	0
Mumps	0	0	0	2	0
Rubella	0	0	1	0	1
Pertussis	67	69	126	89	54
Tetanus	0	0	0	0	0
Hib	1	0	0	0	0
Varicella	1910	1710	1725	1439	857

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**2009 CME Teleconference
Schedule Co-Sponsored by:
DPH & CT-AAP**

April 21
**Adolescent Confidentiality:
Balancing Provider Responsi-
bilities and Patient Rights**

Speakers:
*Dr. Sheryl Ryan, Yale Univer-
sity*
*Jennifer Cox, JD, Cox &
Osowiecki, LLC*

April 30
Topic: WIC Food Package

Speaker: TBD

June 11
Topic: WIC Breastfeeding

Speaker: Dr. Ada Fenick

June 23
Topic: Rotavirus

Speakers:
*Dr. Marietta Vazquez, Yale
University*
Dr. Alice Guh, DPH

September TBD
Topic: School Health

Speaker: TBD

October TBD
Topic: Immunization

Speaker: TBD

*For update information on
2009 Teleconferences visit the
Immunizations website at
[www.ct.gov/dph/
immunizations](http://www.ct.gov/dph/immunizations)*

Vote and Vax



On November 4, 2008, cities and towns in Connecticut

participated in an historic election day. While many people contributed to the overall democratic process of electing our leaders, several cities and towns participated in another exciting event that also contributed to the health of our nation. Vote and Vax clinics, providing influenza and pneumococcal vaccinations in polling places, took place in nine communities.

In 2006, the original Vote and Vax projects were piloted through funding from the Robert Wood Johnson Foundation. The efforts were also supported by SPARC (Sickness Prevention Achieved through Regional Collaboration) a tri-state (NY, CT, MA) agency.¹ The goal of the 25 participating public health agencies was to determine if it was possible to deliver flu shots in voting locations. The idea sprang from the notion that people who were at the location to vote

might take the opportunity to get vaccinated because it was easy and readily available. Historically, the population that votes is similar to the population that is recommended for vaccination. In addition, voting locations must meet accessibility requirements thus opening an opportunity for all people to participate. That year, close to 14,000 people were vaccinated, 80% in the CDC priority groups and 28% first-time flu vaccinees.

Fast forward to 2008 and the potential for a massive anticipated voter turnout in the election. With the success of the earlier efforts and funding from the Anthem Blue Cross and Blue Shield Foundation, several Connecticut cities and towns worked together to implement a Vote and Vax project. Planning began in late spring for the November election. The statewide Influenza and Pneumococcal Coalition was the focal point of the project. The Connecticut Public Health Research and Education Fund Inc. for the Connecticut Public Health Association acted as fiduciary. Local Health Departments and Visiting Nurse Associations provided the vaccinators.

The results of the project are encouraging. Over 1200 people were vaccinated in 9 cities: Bridgeport, Danbury, East Hartland, Hartford, Milford, New Milford, North Haven, Plainfield and Ridgefield. Of the population vaccinated, 70% were in the CDC priority groups, 30% were not vaccinated last year, and 27% said they were not likely to have been vaccinated if the Vote and Vax clinics were not available. In addition, Milford used the clinic to do a preparedness drill and Plainfield used the clinic to give residents other public health messages. Most of the participating cities will consider sponsoring a Vote and Vax clinic again for this year.

If you are interested in learning more about Vote and Vax, you can view www.voteandvax.org or call Debbye Rosen at Immunization Program, Department of Public Health at 860-509-7729, e-mail debbye.rosen@ct.gov

¹ Adams, Mary and Shenson, Douglas; *The Vote and Vax Program: Public Health at Polling Places; Journal Public Health Management and Practice*, 2008, 14 (3)1-5.

VFC Program

Vaccine Storage and Handling



Procedures Proper storage and handling of vaccines should be a part of each provider's standard operating procedure. Improperly stored vaccines may not protect patients and could result in providers having to privately purchase replacement vaccines.

Here are a few helpful Vaccine Handling Tips:

Store Vaccine Correctly and Monitor Temperatures

Be sure that thermometers are placed in both the refrigerator and freezer. Monitor and record refrigerator and freezer temperatures twice daily—at the beginning and end of each day. Maintain refrigerator temperature at 35°—46° F (2°—8°C), and freezer temperature at 5° F (-15° C) or colder.

Safeguard Electrical Supply

Make sure the refrigerator is plugged into an outlet in a protected area where it cannot be accidentally disconnected. Label the refrigerator, electrical outlets, fuses, and breakers

on the power circuit with information that clearly identifies the perishable nature of vaccines and the immediate steps to be taken in case of interruption of power. Use “DO NOT UNPLUG” stickers.

New Vaccine Order Forms (VOF)

Our new, letter-size vaccine order forms were mailed to all providers in February. Please discard all older forms and only use the letter size form. The revised vaccine form is copy-friendly and will save the state on printing and mailing costs. Providers will be responsible for copying their own vaccine forms. If a provider changes addresses, please contact the Immunization Program so we can send out a new master copy of the VOF for your office.

Note: If the main office contact person is not on site when vaccines are delivered, alternate staff must be responsible for unpacking, checking over shipment, and properly storing vaccines.

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containing vaccine, reluctance to switch inventory and schedules, misunderstanding about what constitutes primary versus booster doses, concerns about “over-vaccination” resulting from switching to the Sanofi Hib-containing vaccine, may explain the drop-off of the third Hib dose. However, it is imperative that providers ensure that all children are appropriately immunized with the primary series, especially given the current deferral of the booster dose.

Recommendations for children NOT at high-risk to receive the primary Hib series, until the Hib vaccine shortage resolves, are outlined in the table at right. Children at increased risk of Hib disease should continue to receive the full series of Hib vaccine (including the booster dose) for whichever product they receive. Children at increased risk of Hib disease include those with asplenia, sickle cell disease, human immunodeficiency virus infection and certain other immunodeficiency syndromes, and malignant neoplasms, as well as children who are American Indian/Alaska Native.

- If the child is at least 6 weeks but less than 12 months of age and has received zero, one, or two Hib doses, schedule him/her for the first or next dose(s) immediately with a minimum of four weeks between the doses for a total of three doses. These children will need a booster dose when the Hib vaccine shortage is over.
- If the child is between 12 and 14 months of age and has not had any doses of Hib vaccine, schedule appointments for two doses, eight weeks apart.
- If the child is between 12 and 14 months old and has received Hib vaccine but did not complete the primary series before they turned 1 year old (i.e. had 1 dose of PedvaxHIB® (Merck product) OR 1-2 doses of ActHIB® or Pentacel® (Sanofi product), schedule an appointment for 1 additional dose, a minimum of eight weeks from the last dose.
- If the child is at least 15 months of age but less than 5 years of age and has not received any doses of Hib vaccine OR has not completed the primary series (i.e., had 1 dose of PedvaxHIB® OR 1-2 doses of ActHIB® or Pentacel®), schedule an appointment for one dose.
- If the child is 5 years old or older and hasn't received any Hib vaccine, Hib vaccine is not necessary.

For more information on Hib, visit the CDC's website at www.cdc.gov/vaccines

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disease and then have a report mailed within 12 hours, and Category 2 Disease which requires a report by mail within 12 hours of recognition or strong suspicion of disease. Every health care provider who treats or examines any person who has or is suspected to have a reportable disease shall report the case to the local director of health and to the Department of Public Health. A complete list of reportable diseases can be found on the State of Connecticut Case Report Form PD-23. This form can be obtained by calling (860)509-7994 or visiting the Connecticut Department of Public Health website <http://www.ct.gov/dph/epidemiology> and clicking on the reportable diseases link.

The Immunization Program investigates the following vaccine-preventable diseases: Measles, Mumps, Rubella, Chickenpox, Meningococcal disease, Pertussis, Pneumococcal disease, Poliomyelitis and Tetanus. The first step in reporting strong suspicion of one of the diseases listed above is to call (860)509-7929. Upon receipt of the report, an Epidemiologist will initiate a case investigation. The purpose of the investigation is to collect the required demographic and clinical information, investigate contacts, and to recommend control measures to reduce further transmission of the disease.

Effective infectious disease control requires a collaborative effort between all the parties involved. Please help to do your part in fulfilling the department's mission of reducing disability and death which result from diseases that can be prevented through vaccination. Feel free to call the Immunization Program with any questions you may have about the reporting process.



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