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Electronic Distribution of the Connecticut Epidemiologist Newsletter

The first issue of the Connecticut Epidemiologist Newsletter was published in 1981. Since then, it has served as an informational and educational tool for health care providers and public health professionals in Connecticut. The Connecticut Epidemiologist has published articles concerning infectious and noninfectious diseases, statistical information, outbreak investigation updates, and other public health issues.

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Free Influenza Testing

Isolation and identification of circulating influenza virus strains is an important part of the Connecticut Department of Public Health's (DPH) influenza surveillance system. The DPH encourages physicians to submit throat swabs from patients with a typical influenza syndrome (abrupt onset of fever, myalgia, and cough) to the DPH Laboratory for virus

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isolation. Specimens should be collected no later than 3 days after onset of symptoms and sent immediately to the DPH Laboratory, on wet ice if possible.

Throat swab collection kits (VRCs) may be obtained by calling the DPH Laboratory at 860-509-8501. Health care providers can submit specimens for influenza testing **at no charge** from **October 1, 2002 through March 31, 2003**. Please check "**181 V Influenza surveillance**" on the microbiology test requisition form. Please provide all other necessary information as well. If you have any questions on specimen collection, handling, or transport, please contact the Virus Laboratory at 860-509-8553.

Influenza and Pneumococcal Vaccination Coverage

Recommendations to provide annual influenza vaccination and one dose of pneumococcal vaccine to all persons aged ≥ 65 years are intended to reduce the morbidity and mortality associated with influenza and pneumococcal disease (1,2).

This report presents data on influenza and pneumococcal vaccination levels for persons aged ≥ 65 years from 1993-2001. The data are from the Behavioral Risk factor Survey System (BRFSS). Flu and pneumococcal questions are asked every other year. In Connecticut, the survey is coordinated by the Division of Chronic Diseases, Department of Public Health (DPH), through a contract to randomly interview non-institutionalized adults.

The survey questions were: "Have you received a flu shot within the past 12 months?" (Figure 1) and "Have you ever had a pneumonia vaccination" (Figure 2).

Figure 1

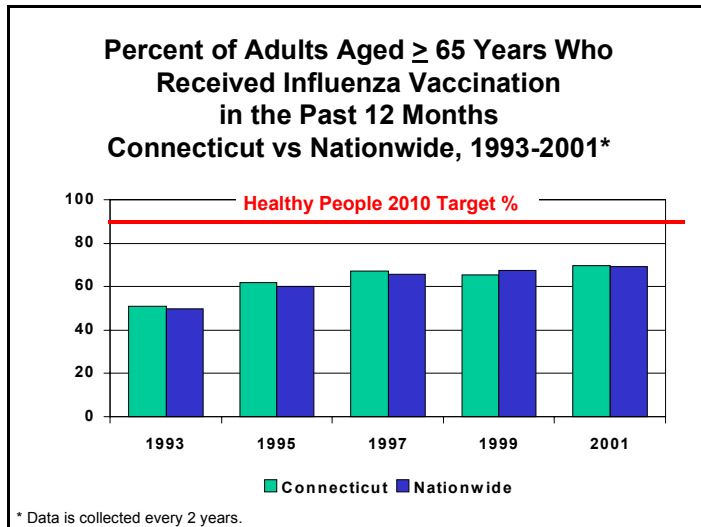
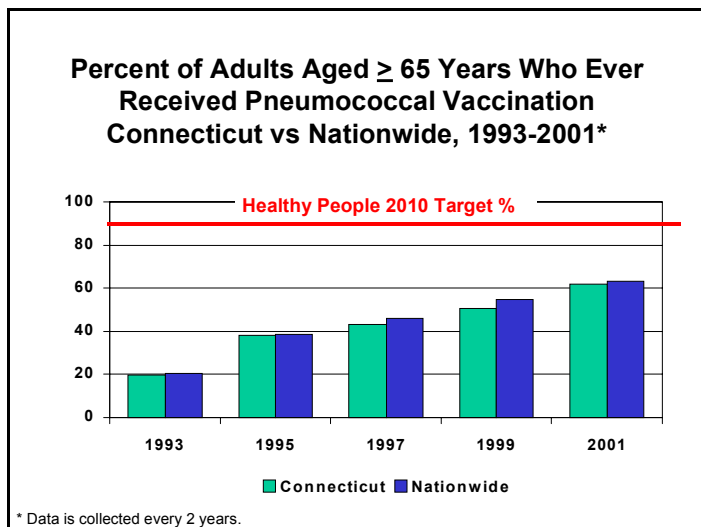


Figure 2



Editorial Note:

Two vaccine-preventable diseases, influenza and pneumococcal disease, contribute to the mortality of older persons in the United States (US). Influenza caused an average of 20,000 deaths per year during influenza epidemics in the US from 1969 to 1996; persons aged ≥ 65 years accounted for approximately 90% of these deaths (3). Pneumococcal disease caused approximately 3,400 deaths among persons aged ≥ 65 years in the US in 1998. National health objectives for 2010 include increasing influenza and pneumococcal vaccination levels to $\geq 90\%$ among persons aged ≥ 65 years. Connecticut and national

data show vaccination increases; however, more needs to be done to achieve the Healthy People 2010 objectives.

The trivalent influenza vaccine recommended for the 2002-2003 season includes A/Moscow/10/99 (H3N2)-like, A/New Caledonia/20/99 (H1N1)-like, and B/Hong Kong/330/2001-like antigens (4). The current Centers for Disease Control and Prevention (CDC) estimate of available influenza vaccine doses is between 92 and 97 million doses. This compares to 87 million doses produced for the 2001-2002 flu season (5). While there were some delivery delays during the past two seasons, indications are that this season's supply will arrive as promised for preordered vaccine. The past delays have affected the scheduling of vaccinations at both the mass immunizer and individual practitioner level. Mass immunizers are reluctant to set schedules for clinics because of uncertainty of vaccine availability. In addition to the delay in delivery, manufacturers are no longer crediting providers for the return of unused doses. For these reasons, individual practitioners are asking their patients to obtain vaccinations at clinics.

In April 2002, the Connecticut General Assembly passed Public Act No. 02-10, An Act Concerning the Prevention of Influenza and Pneumonia in Nursing Homes (Effective October 1, 2002) (6). According to the Act, the Commissioner of Public Health shall adopt regulations, in accordance with chapter 54, concerning the health, safety, and welfare of patients in nursing home facilities, classification of violations relating to such facilities, medical staff qualifications, record-keeping, nursing service, dietary service, personnel qualifications, and general operational conditions.

The regulations shall:

- (1) Assure that each patient admitted to a nursing home facility is protected by adequate immunization against influenza and pneumococcal disease in accordance with the recommendations of the national Advisory Committee on Immunization Practices, established by the Secretary of Health and Human Services;
- (2) Specify that each patient be protected annually against influenza and be vaccinated against pneumonia in accordance with the recommendations of the National Advisory

- Committee on Immunization; and
- (3) Provide appropriate exemptions for patients for whom such immunizations are medically contraindicated and for patients who object to such immunization on religious grounds.

Reported by: D Rosen, Immunizations Services, DPH.

References

1. ACIP. Prevention of Pneumococcal Disease. MMWR 1997; 46 (no. RR-8): 1,11,12.
2. ACIP. Prevention and Control of Influenza. MMWR 2002; 51 (no RR-03) 2,6.
3. Influenza and Pneumococcal Vaccination Levels Among Persons Aged >65 Years-United State, 2001. MMWR 2002: 51: 1019-1024.
4. Update: Influenza Activity-United States and worldwide, 2001-2002 Season, Composition of the 2002- 2003 Influenza Vaccine. MMWR 2002: 51: 503-506.
5. Influenza Vaccine Bulletin #3 Flu Season 2002-2003, CDC publications.
6. PA-02-10 An Act Concerning the Prevention of Influenza and Pneumonia in Nursing Homes <http://www.cga.state.ct.us/2002/act/Pa/2002PA-00010-R00SB-00213-PA.htm>.

Outbreaks in Long-term Care Facilities, Connecticut, 1997 - 2001

In Connecticut, outbreaks (foodborne involving ≥ 2 persons, institutional, unusual disease or illness) are reportable to the Department of Public Health (DPH) and the local health department. When an institutional outbreak is reported, the DPH assists the infection control practitioner to investigate the outbreak and institute control measures. In April 1997, the Epidemiology Program established a computerized database to better track outbreaks. From April 1997 through December 2001, a total of 1233 outbreaks were reported to the DPH, Epidemiology Program (Figure 1). Of these, 1188 (96%) were reported from long-term care facilities (LTCF).

Among outbreaks reported by LTCF, 774 (65%) were outbreaks of respiratory illnesses, 384 (32%) gastrointestinal illnesses, and 30 (3%) were due to other conditions (e.g., scabies).

Respiratory Outbreaks

Respiratory outbreaks reported by LTCF declined from 231 outbreaks in 1998 to 96 in 2001 (Figure 2). The annual average number of outbreaks reported each year was 175. Approximately 60% of all outbreaks were reported during the winter months of

Figure 1: Number of Reported LTCF Outbreaks, Connecticut, 1997-2001

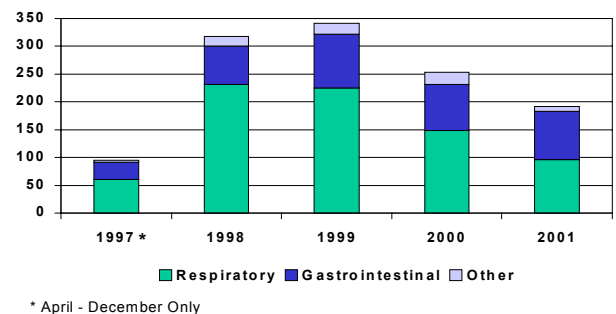
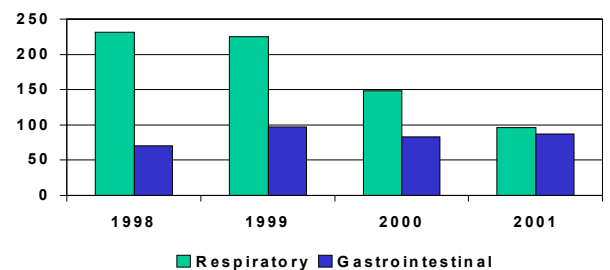


Figure 2: Number of LTCF Outbreaks, Respiratory vs Gastrointestinal, Connecticut, 1998-2001



December, January and February. The median number of ill residents per outbreak at the time the outbreak was reported was nine (range 2 – 115 persons).

Gastrointestinal Outbreaks

The number of gastrointestinal outbreaks reported by LTCF remained steady between 1998 and 2001 (Figure 2). The annual average number of outbreaks reported each year was 85. Sixty-four percent of outbreaks were reported during the winter months. The median number of ill residents per outbreak at the time the outbreak was reported was eleven (range 3 – 68 persons).

Reported by: Q Phan, P Mshar, Epidemiology and Emerging Infections Program, DPH.

Editorial Note

The Centers for Disease Control and Prevention (CDC) estimate that 1.5 million nosocomial infections occur in residents of LTCF each year. This translates to an average of one infection per

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resident per year. The most common infections in LTCF are urinary tract infections, respiratory infections (including pneumonia and influenza), infected pressure ulcers, gastroenteritis, and conjunctivitis (1).

In the LTCF setting, development and support of strong infection control programs that can monitor the occurrence of institutionally acquired infections and initiate control strategies to prevent the spread of epidemic infections are necessary (1). The transmission of diseases in LTCF most frequently occurs by direct contact (e.g., by hands), but airborne, vehicle, and vector-borne spread may occur. Health care personnel go from person to person, serving as important sources for transmission by the contact route. Vehicle transmission occurs through items such as food or water, and airborne spread occurs by dissemination of droplet nuclei or particles in the air. Disease transmission in LTCF may be amplified by lack of convenient hand washing facilities, lack of private rooms, or deficiencies in ventilation systems (2).

References

1. Garibaldi RA. Residential care and the elderly: the burden of infection. *J Hosp Infect* 1999 Dec;43 Suppl:S9-18.
2. Smith PW, Rusnak PG. Infection Prevention and Control in the Long-Term-Care Facility. *Am J Infect Control*. 1997; 25: 488-512.

New Staff

Adult Immunizations Coordinator

The Department of Public Health, Immunization Program, has recently received funding to hire an Adult Immunization Coordinator. Debbye Rosen, BSN, MS, formerly of the TB Control Program, has been hired to fill this position. She is responsible for adult immunization activities including assessment of immunization coverage rates in adults, efforts to increase adult rates of influenza and pneumococcal vaccination, and promotion of vaccination of high-risk adults against hepatitis A and B. She can be reached at (860) 509-7929.

For Public Health Emergencies after 4:30 p.m. and on weekends call the Department of Public Health (860) 509-8000

<p>Joxel Garcia, MD, MBA., Commissioner of Health</p> <p>James L. Hadler, MD, MPH State Epidemiologist Division of Infectious Diseases</p>	<p>AIDS Epidemiology (860) 509-7900 Epidemiology (860) 509-7994 Immunizations (860) 509-7929 Pulmonary Diseases (860) 509-7722 Sexually Transmitted Diseases (STD) (860) 509-7920</p>	<p>Connecticut Epidemiologist</p> <p>Editor: Matthew L. Cartter, MD, MPH Assistant Editor: Starr-Hope Ertel</p>
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