

Minnesota Influenza Vaccination Plan, 2004-05

The Minnesota Influenza Vaccination Plan is issued by the Minnesota Department of Health (MDH) and endorsed by the Minnesota Coalition on Adult Immunization and the Minnesota Immunization Practices Advisory Committee. The plan is targeted to all facilities that directly or indirectly provide influenza vaccination services in Minnesota, including traditional sites (e.g., medical clinics, hospitals, home care agencies, local public health agencies, long-term care facilities, and occupational health programs) as well as nontraditional sites (e.g., pharmacies, retail stores [including food and drug stores], vaccination vendors, worksites, senior centers, and community centers).

Protecting all Minnesotans against influenza requires the collaboration of healthcare providers and public health professionals statewide. Knowing who needs influenza vaccine and making sure they receive it are the best ways to protect Minnesotans against influenza and its complications.

What's New in the 2004-2005 ACIP Influenza Recommendations?

The Advisory Committee on Immunization Practices (ACIP), which advises the Centers for Disease Control and Prevention on the safest and most effective ways to use available vaccines, released its 2004-2005 influenza recommendations, "Prevention and Control of Influenza," on May 28, 2004. The Minnesota Influenza Vaccination Plan is based on the ACIP recommendations and on the overall availability and supply of the influenza vaccine. ACIP's 2004-2005 recommendations include the 4 principal changes

or updates mentioned below. For a complete copy of the recommendations, visit MDH's immunization Web site at www.health.state.mn.us/immunize.

1. **New groups recommended for vaccination**

The following groups are now recommended to be vaccinated against influenza:

- All children 6 through 23 months of age
- Household contacts and out-of-home caregivers of children 0 through 23 months of age
- All women who will be pregnant at any time during the influenza season, regardless of their stage of pregnancy

2. **Clarification of the use of live attenuated influenza vaccine (LAIV)**

LAIV is an option for vaccination of healthy persons 5 through 49 years of age, including those who are in close contact with persons at high risk for influenza. No preference exists for using inactivated vaccine in healthcare workers or other persons who have close contact with persons with "lesser degrees" of immunosuppression, e.g., persons with diabetes, persons with HIV, or those on corticosteroid therapy. Inactivated influenza vaccine is preferred over LAIV, however, for household members, healthcare workers, and others who have close contact with severely immunosuppressed persons (e.g., persons with stem cell transplants or severe combined immunodeficiency) during periods *when such persons require care in a protected environment*. If a healthcare worker receives LAIV, he or

she should refrain from contact with severely immunosuppressed patients for 7 days after receiving the vaccine.

Severely immunosuppressed persons should not administer LAIV. However, other persons at high risk for influenza complications (e.g., persons with asthma, heart disease, pregnancy, or diabetes) may administer LAIV.

3. **The 2004-2005 trivalent vaccine virus strains**

- A/Fujian/411/2002 (H3N2)-like antigen
- A/New Caledonia/20/99 (H1N1)-like antigen
- B/Shanghai/361/2002-like antigen

For the A/Fujian/411/2002 (H3N2)-like antigen, manufacturers may use the antigenically equivalent A/Wyoming/3/

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2003 (H3N2) virus, and for the B/Shanghai/361/2002-like antigen, manufacturers may use the antigenically equivalent B/Jilin/20/2003 virus or B/Jiangsu/10/2003 virus.

4. In the event of a vaccine shortage

CDC and other agencies have been assessing the vaccine supply status throughout the manufacturing period in order to determine the need to modify the 2004-2005 influenza plan to include tiered vaccination of different risk groups. If there are indications of a delay or shortage of vaccine, the Minnesota Influenza Vaccination Plan may be modified to ensure vaccination of the highest priority groups, and healthcare providers will be notified. Influenza updates will be posted at www.mdhflu.com. At this time, vaccine supply projections anticipate that more than 100 million doses will be available for the 2004-2005 season.

A Message for Healthcare Workers

In its 2004-2005 influenza recommendations, ACIP includes a strong message for healthcare workers about getting vaccinated. Persons can transmit influenza to others 24 to 48 hours before the onset of symptoms, yet a recent assessment of influenza immunization rates revealed that only 36% of the healthcare workforce is vaccinated against influenza.¹ ACIP cites 2 studies that found that when healthcare workers in long-term care facilities are vaccinated, the incidence of patient deaths decreased.^{2,3} Influenza vaccination of healthcare workers protects both the workers and their patients and reduces the level of disease within the community. Measures should be taken to offer influenza vaccination in healthcare-related workplaces to all employees.

Who Should Be Vaccinated and When?

Persons at high risk of serious influenza-related complications

Vaccinate these people as soon as you receive vaccine, starting in September:

- Persons 50 years of age or older
- Residents of nursing homes and other chronic care facilities
- Adults and children who have heart disease, asthma, or other chronic disorders of the pulmonary or cardiovascular systems
- Adults and children who required regular medical follow-up or hospitalization during the preceding year because of diabetes, kidney diseases, blood disorders, metabolic disorders, or immunosuppression, including HIV/AIDS and other chronic diseases
- All pregnant women; vaccination can occur in any trimester
- Children (aged 6 months to 18 years) who are receiving long-term aspirin therapy
- Children aged 6-23 months

NOTE: Children under 6 months of age cannot be vaccinated against influenza; however, their close contacts and out-of-home caregivers *should* be vaccinated.

Persons who can transmit influenza to high-risk persons

Vaccinate these people as soon as you receive vaccine, starting in September:

- Physicians, nurses, and other staff in hospital and outpatient settings.
- Employees of nursing homes and chronic care facilities who have contact with patients or residents
- Employees of assisted living and other residences for persons in high-risk groups.
- Employees of healthcare facilities who do not provide direct patient care
- Providers of home care to persons at high risk (e.g., visiting nurses and volunteer workers)
- Household contacts of persons in groups at high risk (see above)
- Household contacts and out-of-home caregivers of children aged 0-23 months

Children under 9 years of age

Children who are under 9 years of age and are receiving influenza vaccine for

the first time need a booster dose 4 weeks after the initial dose. Children under 9 years of age who have been previously vaccinated at any time with 1 dose of influenza vaccine need only 1 dose during the 2004-2005 season.

Low-risk persons

Because influenza vaccine supply is expected to be ample this year, healthcare providers should immunize people who are at moderate or low risk whenever they see them. You do not need to ask them to wait until November. This group includes persons in institutional settings (e.g., college students and incarcerated persons), persons who provide essential community services, healthy persons in the workplace, and anyone who wants to reduce the likelihood of becoming ill with influenza.

Vaccinate until the end of influenza season

It is never too late to get vaccinated, even if influenza is already in the community. In Minnesota, influenza season sometimes lasts until late April or early May.

References:

1. Unpublished data from the National Health Interview Survey (NHIS), National Immunization Program (NIP), Centers for Disease Control and Prevention (CDC), 2003. In: CDC. Prevention and control of influenza. Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR Recomm Rep*. 2003;52(RR-8):1-34.
2. Potter J, Stott DJ, Roberts MA, et al. Influenza vaccination of health care workers in long term-care hospitals reduces the mortality of elderly patients. *J Infect Dis*. 1997;175:1-6.
3. Carman WF, Elder AG, Wallace LA, et al. Effects of influenza vaccination of health-care workers on mortality of elderly people in long term care: a randomised controlled trial. *Lancet*. 2000;355:93-97.

Pertussis Update

Nationally, reported cases of pertussis (whooping cough) have increased in recent weeks. Last year at this time, 4,791 cases of pertussis had been reported to the Centers for Disease Control and Prevention compared with 7,830 to date in 2004. The recent increase in reported cases is not necessarily unexpected given that pertussis normally peaks every 3 to 5 years, and the most recent peak incidence year was 2000 (Figure 1).

Cases have also increased in Wisconsin, North Dakota, and Minnesota. In 2004, as of the week of August 23, Wisconsin reported more than 1,500 cases; most occurred primarily in the southeastern region of the state. North Dakota reported more than 500 cases. In 2003, Wisconsin reported a total of 708 pertussis cases and North Dakota reported a total of 7 cases.

In Minnesota, more than 200 cases of pertussis were reported in 2004 as of August 23. Minnesota reported 207 total cases (4.2 per 100,000 population) in 2003, the lowest number reported since 1994. Two pertussis-related deaths occurred in Minnesota in 2003—1 elderly woman and 1 child; both had serious pre-existing medical conditions.

Minnesota will likely report continued increases in cases, as pertussis tends to peak in late summer and fall. Furthermore, given that pertussis is endemic and considered to be under-diagnosed and under-reported, media reports and healthcare notifications of the increase in cases that have already occurred in 2004 will likely cause a rise in the number of cases reported during the remainder of the year.

Vaccination Rates and Efficacy

Pertussis remains endemic in Minnesota, despite the fact that pertussis vaccination rates are high in the state (96.3% of children aged 19 to 35 months have received at least 3

doses of vaccine). Pertussis vaccine is 70% to 90% effective after the primary series of 3 doses. Protection begins to wane several years after the last dose is received, leaving adolescents and adults susceptible to the disease. These cases serve as a source of infection for infants and younger children who are at greater risk for rare complications, including pneumonia, seizures, encephalopathy, and death.

Action Steps for Providers

- Pertussis should be considered in the differential diagnosis for
 - Individuals exhibiting any prolonged cough, especially coughs lasting longer than 2 weeks;
 - Individuals exhibiting paroxysmal cough and/or post-tussive vomiting or whoop;
 - Individuals exhibiting a cough illness who have had a known exposure to a case of pertussis within 3 weeks prior to the onset of the cough; and
 - Infants and other individuals with symptoms consistent with pertussis and who are critically ill or at high risk of

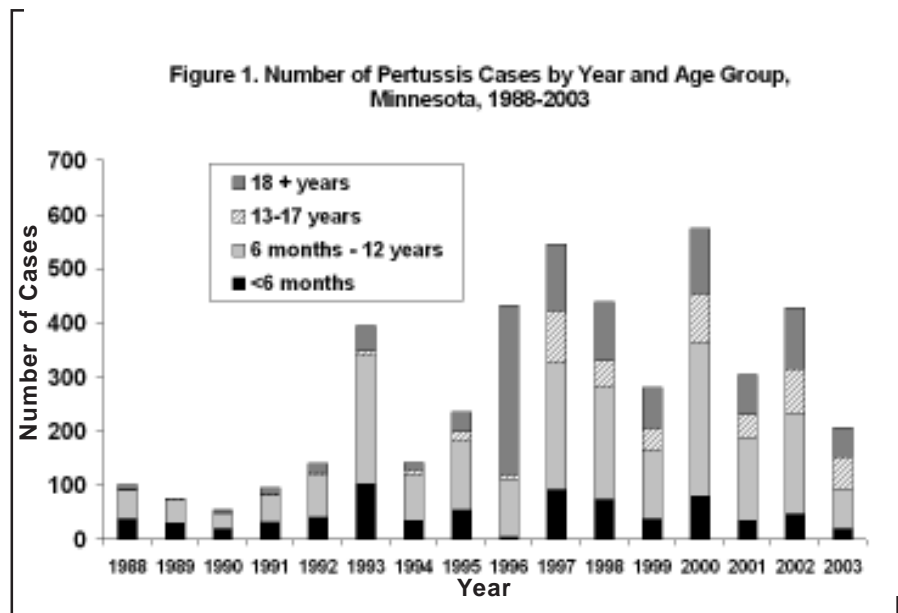
serious complications of pertussis.

- Suspect cases should be tested for pertussis.
- Antimicrobial treatment of cases and prophylaxis of close contacts are critical to preventing the spread of pertussis.

Visit the Minnesota Department of Health (MDH) Web site (www.health.state.mn.us/divs/idepc/diseases/pertussis/stats/stats04.html) for a summary of reported pertussis cases in Minnesota to date in 2004, a fact sheet for healthcare providers, and information on treatment and prophylaxis options. Contact your local health department or MDH (612-676-5414 or 1-877-676-5414) if you have questions or concerns, or to report suspect cases of pertussis.

Accelerated DTaP Vaccine Schedule

North Dakota has recommended that North Dakota providers use the accelerated DTaP vaccine schedule. MDH, however, does not currently recommend any changes to the routine DTaP vaccine schedule.



Active Surveillance for Pertussis in Dakota and Ramsey Counties

Disease caused by *Bordetella pertussis* remains a significant cause of morbidity in the United States. Despite high vaccination coverage levels, pertussis (whooping cough) is the only vaccine-preventable disease that has a reported increase in overall cases and in infant mortality in the United States over the past decade. The Centers for Disease Control and Prevention has funded the Minnesota Department of Health (MDH) to conduct active surveillance for pertussis in Ramsey and Dakota counties, beginning September 30, 2004. Together these counties account for 32% of reported cases of pertussis in the Twin Cities 7-County Metropolitan Area and 24% of Minnesota cases.

The purpose of this 5-year project is to:
1) conduct surveillance in a defined

geographic area to better characterize the epidemiology of pertussis disease across pediatric, adolescent, and adult age groups, and 2) link disease surveillance data with immunization registry data to evaluate vaccine effectiveness.

Specific goals of the project include

- Enhancing methods to evaluate the burden of pertussis disease across age groups;
- Developing improved methods for pertussis surveillance that could be applied in other geographical areas;
- Evaluating the effectiveness of pertussis vaccination by linking disease surveillance with immunization registry data on vaccination coverage; and

- Developing a project site that could be used to assess the impact of an adolescent/adult pertussis vaccine that may soon be licensed and recommended for use in the United States.

MDH is working with the Saint Paul-Ramsey County Department of Public Health and the Dakota County Public Health Department on this project. Staff at these agencies will identify and contact reporting sources in their jurisdiction regarding active surveillance.

If you have questions about this project or are a healthcare provider in Dakota County or Ramsey County and wish to obtain additional information, please contact MDH at 612-676-5414 or 1-877-676-5414 (toll-free).

Progress and Challenges in Reducing Cancer Deaths Among Women in Minnesota

Cancer became the leading cause of death in Minnesota in 2000.¹ The primary causes of cancer deaths among women are lung and bronchus cancer, breast cancer, and colorectal cancer; these 3 cancers accounted for nearly half of all female cancer deaths in Minnesota in 2001 (Table 1).

Substantial progress has been made in reducing breast and colorectal cancer mortality (Figure 1). Despite recent increases in breast cancer incidence in Minnesota,² breast cancer mortality declined by 22% over the 14-year period 1988-2001, primarily due to wider use of screening and improved treatment. Both the incidence and mortality of colorectal cancer steadily declined over the same period for reasons that are less well understood, but which may be related to increased screening.³ The female lung cancer mortality rate, on the other hand, increased by 33% between 1988 and 2001. Lung cancer became the leading cancer killer among women in Minnesota in 1992 (Figure 1), and now

accounts for 1 of every 4 female cancer deaths.

Among men nationally, smoking rates began to decline in the 1960s, and lung cancer mortality began declining in the early 1990s.⁴ Women have given up the smoking habit more slowly, and lung cancer deaths among women continue to climb nationally⁴ as well as in Minnesota. Even if every woman quit smoking today, lung cancer mortality

would continue to be a major public health problem for many years. Nonetheless, telephone surveys of Minnesota adults show that smoking rates among women in Minnesota did not substantially decline between 1990 and 2003 (Figure 2). In 2003, 19.9% of Minnesota women aged 18 or older reported that they were current smokers, compared to 20.3% nation-

continued...

**Table 1. Deaths Among Women from 3 Leading Cancers
Minnesota, 1988 and 2001**

Year	All Cancer Deaths	Lung & Bronchus	Breast	Colorectal
1988	3,895	618	765	482
2001	4,296	996	685	458
Percent change, adjusted for population growth and aging*	4% increase	33% increase	22% decrease	19% decrease

*Overall percent change in the age-adjusted (U.S. 2000) mortality rate per 100,000 females, comparing averages for 1988-1989 and 2000-2001.

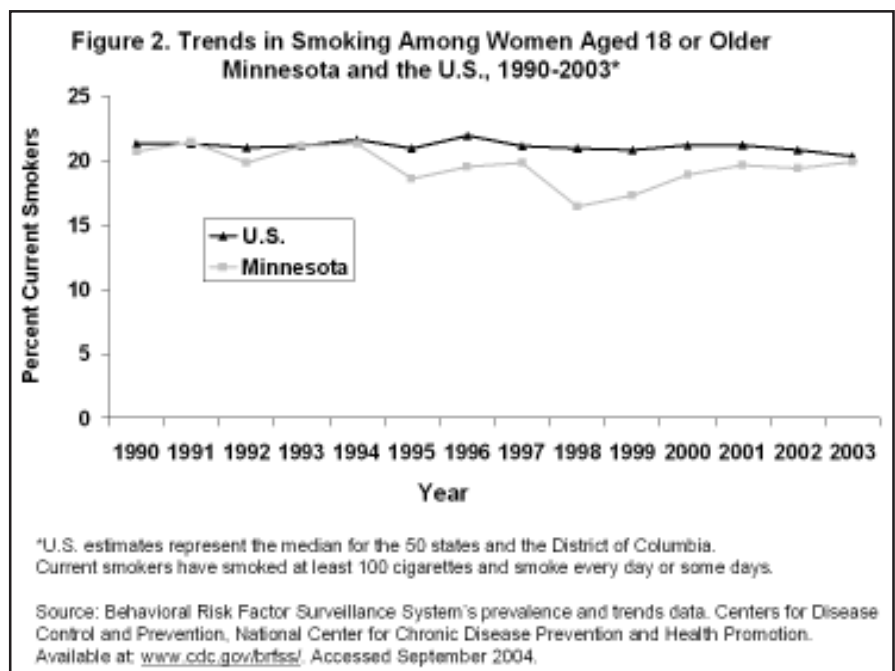
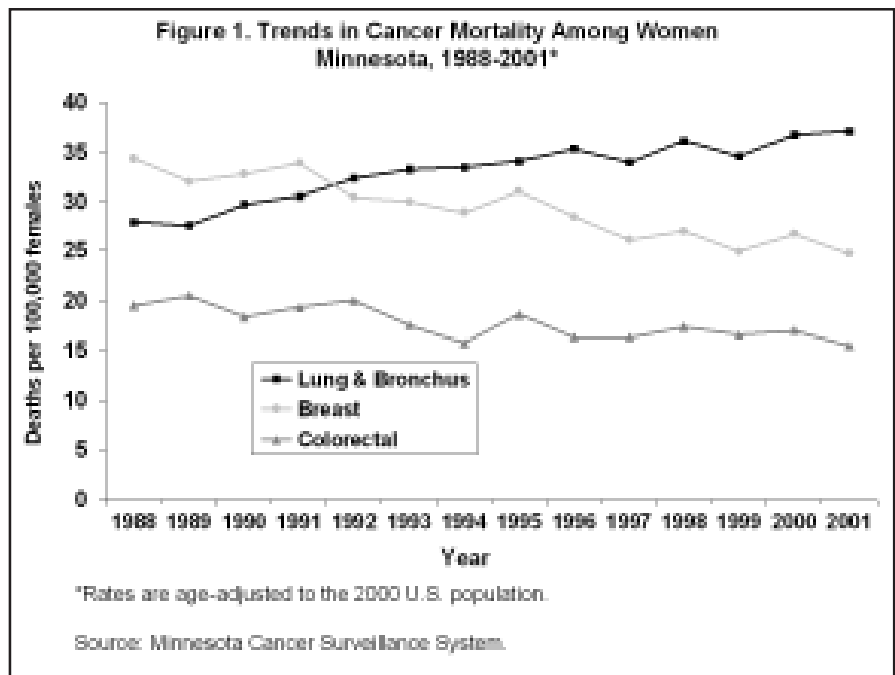
ally, a difference that is not statistically significant.

These figures should be a wake-up call for women, their healthcare providers, women's health advocates, and policymakers. A stronger commitment to reduce the use of tobacco products among all Minnesotans is needed to reduce the burden of cancer in our state. Healthcare providers are in a unique position to reach smokers, as approximately 70% of smokers visit a doctor each year.⁵ Best practices identified by the Centers for Disease Control and Prevention include wider access to telephone quit lines, inclusion of tobacco treatment as a health benefit, and integration of tobacco cessation into routine healthcare delivery.⁶

Cancer Plan Minnesota, the comprehensive cancer control plan that is currently being developed for the state, will include effective strategies to reduce tobacco use and exposure to secondhand smoke. To provide input and to find out how you can help move the cancer plan to action, attend the Cancer Plan Minnesota Summit in November 2004. (See "Cancer Plan Minnesota Will Address Cancer Survivorship in Minnesota" on p. 58.)

References:

1. Minnesota Department of Health. Cancer is the new leading cause of death in Minnesota as deaths from heart disease decrease. *Disease Control Newsletter*. November 2003;31:74. Available at: www.health.state.mn.us/divs/idepc/newsletters/dcn/nov03/bcancer.html. Accessed August 2004.
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6. Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—August 1999*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. 1999. Available at: www.cdc.gov/tobacco/bestprac.htm. Accessed August 2004.

Cancer Plan Minnesota Will Address Cancer Survivorship in Minnesota

Approximately 23,600 Minnesotans were diagnosed with a potentially serious cancer in 2001, the most recent year for which reporting is complete.¹ The number of Minnesotans living with a history of cancer, however, is nearly 7 times that number. Recently released estimates by the Minnesota Cancer Surveillance System indicate that 156,620 Minnesotans alive on January 1, 2000, or 3.2% of the Minnesota population, had received a diagnosis of a potentially serious cancer at some point in the past.² Of these survivors, 59,690 (38%) had been diagnosed within the previous 5 years.²

The number of survivors for the 10 cancers with the largest number of survivors is shown in Table 1. This distribution is very similar to that reported for cancer survivors nationally.³

The growing number of cancer survivors both nationally and in Minnesota is focusing attention on the psychological, social, economic, and healthcare challenges facing this group of people and their families. Cancer Plan Minnesota, the comprehensive cancer control plan that is being developed for the state, will include objectives and strategies to improve the quality of life of cancer survivors through better treatment, palliative care, and support services.

These strategies and others related to reducing the burden of cancer in Minnesota will be the focus of Cancer Plan Minnesota's summit, "Working Together: Aiming for Action," on November 16, 2004. Cancer Plan

Minnesota is a broadly based collaboration that includes the American Cancer Society, the Minnesota Department of Health, comprehensive cancer centers at the University of Minnesota and the Mayo Clinic, other state and local agencies, insurers, advocates, providers, researchers, and community organizations. The plan's steering committee and work groups have been developing goals, objectives, and strategies during the last year, and the draft plan will be provided to summit participants. The keynote speaker at the summit will be Dileep Bal, MD, chief of the Cancer Control Branch of the California Department of Health Services and former national president of the American Cancer Society. A panel of diverse stakeholders in cancer control will give feedback on the draft plan and insights regarding the challenges of putting the plan into action. In the

afternoon breakout sessions, participants will create action plans for specific strategies. For more information, visit the Cancer Plan Minnesota Web site at www.cancerplanmn.org or contact Elizabeth Moe at (612) 676-5220.

References:

1. Minnesota Cancer Surveillance System. *Cancer in Minnesota, 2001: Preliminary Report*. Minneapolis, MN: Minnesota Cancer Surveillance System. March 2004. Available at: www.health.state.mn.us/divs/hpcd/cdee/mcss. Accessed August 2004.
2. Perkins C, Bushhouse S. *Estimated Minnesota Cancer Prevalence, January 1, 2000*. Minneapolis, MN: Minnesota Cancer Surveillance System. April 2004. Available at: www.health.state.mn.us/divs/hpcd/cdee/mcss. Accessed August 2004.
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Table 1. Estimated Number of Minnesotans Ever Diagnosed with Cancer and Alive on January 1, 2000

	Survivors	% of Survivors
All sites combined*	156,620	
Breast	37,640	24.0
Prostate	28,480	18.2
Colon and rectum	17,550	11.2
Uterus	9,650	6.2
Urinary bladder	8,100	5.2
Melanoma of the skin	8,100	5.2
Non-Hodgkin's lymphoma	5,740	3.7
Lung and bronchus	5,040	3.2
Thyroid	4,640	3.0
Kidney and renal pelvis	4,170	2.7

*Excludes common (non-melanoma) skin cancers and *in situ* cancers, except urinary bladder cancer.

10th Annual Emerging Infections in Clinical Practice and Emerging Health Threats Conference November 12, 2004

Preliminary Program Includes:

- Pandemic Influenza; Harbinger of Things to Come - Robert G. Webster, St. Jude Children's Research Hospital, Memphis
- Antibiotic Resistance and the Healthcare Setting: A Powerful Combination - Robert A. Weinstein, Cook County Hospital, Chicago
- New Developments in Antibiotics - James M. Steckelberg, Mayo Clinic
- Thrust and Parry: The Lung and Pneumonia - Edward N. Janoff, Minneapolis VA Medical Center
- International Travel Medicine: Avoiding Unwelcome Holiday Souvenirs - David N. Williams, Hennepin County Medical Center
- Hot Topics from the Minnesota Department of Health - Richard N. Danila
- Hepatitis: New Developments - Stacey Vlahakis, Mayo Clinic
- Infectious Agents and the Blood Supply - J. Jeffrey McCullough, University of Minnesota
- National Preparedness: New Risks, New Challenges - Michael T. Osterholm, University of Minnesota

Annual Emerging Infections in Clinical Practice and Emerging Health Threats Conference, November 12, 2004 Radisson Hotel Metrodome, Minneapolis

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Medical resident/fellow OR Medical student (fee waived, excl. lunch; ltd. space; pre-registration req'd)



Save the Date!
**Cancer Plan Minnesota
Summit 2004**
Working Together: Aiming for Action
November 16, 2004
Radisson Riverfront Hotel
St. Paul, Minnesota
8:30 am – 4:30 pm, followed by a reception

Dianne Mandernach, Commissioner of Health

Division of Infectious Disease Epidemiology, Prevention and Control

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The *Disease Control Newsletter* is available on the MDH Acute Disease Investigation and Control (ADIC) Section web site (<http://www.health.state.mn.us/divs/idepc/newsletters/dcn/index.html>).

If you require this document in another format such as large print, Braille, or cassette tape, call 612-676-5414 or, in Greater Minnesota, call 1-877-676-5414