

# Vaccinate Vermont

Vermont Department of Health

December 2017

## IMMUNIZATION & INFECTIOUS DISEASE CONFERENCE VERMONT



SAVE THE DATE

May 3, 2018

Stowe Mountain Lodge, Stowe, VT

The Vermont Department of Health will host the 2018 Vermont Immunization and Infectious Disease Conference on May 3, 2018 at the Stowe Mountain Lodge, Stowe, VT. The one day conference will include plenary and breakout sessions on the most current immunization and infectious disease topics.

Physicians, NP's, PA's, school nurses, health educators, medical assistants and health profession students are encouraged to attend.

Continuing medical and nursing education credits will be offered.

Registration opens February 2018.

## IMMUNIZATION PROGRAM UPDATES

### Less temperature recording, is it possible?

Beginning January 1, 2018, providers will be *required* to assess and record maximum and minimum (Max/Min) temperatures of vaccine storage units at the start of each clinic day. The Max/Min temperatures must be recorded on paper temperature logs. The values recorded are those obtained since midnight (00 Day on the data logger) after Max/Min was reset automatically.

Additionally, it is *recommended* that the current temperature and Max/Min temperatures for the previous day be reviewed for each unit, prior to administering vaccine.

New paper temperature logs will be mailed to all practices prior to January 2018. For additional paper temperature logs please e-mail: [AHS.VDHIimmunizationProgram@vermont.gov](mailto:AHS.VDHIimmunizationProgram@vermont.gov) with your request.

### VIMS Makes Ordering Vaccines Easier

The Vaccine Inventory Management System (VIMS) is now live. It was created by ingenious Vermont Department of Health IT developers in collaboration with the Immunization Program. This system replaces VTrckS as the vaccine ordering and inventory management tool for all state supplied vaccines. Access to VTrckS has been terminated for all practices. To date, 170 VFC and VFA practices have received one-on-one VIMS training by Katie Martinez; the majority reporting significant improvement in efficiency, accuracy and ease of use.

We're proud of this system and want to ensure all users are able to reap the benefits. The User Guide is currently available on our [website](#). Quick Guides and a comprehensive FAQ will be posted shortly. As these resources are developed, we welcome your insights, questions and suggestions.

Practices who have not been trained on VIMS should email [AHS.VDHIimmunizationProgram@vermont.gov](mailto:AHS.VDHIimmunizationProgram@vermont.gov) to schedule.

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## NEW HERPES ZOSTER VACCINE RECEIVES PREFERRED RECOMMENDATION

To avoid confusion, trade names will be used for the zoster vaccine live (ZVL)- “Zostavax™” and the herpes zoster subunit (HZ/su) vaccine “Shingrix™”.

The incidence of herpes zoster for persons 50 years and older is approximately four cases per 1,000 population per year. The incidence increases with age as does the likelihood of developing post herpetic neuralgia (PHN). Since 2006, the zoster-live vaccine (Zostavax™) is the only vaccine recommended for those 60 years and older to prevent herpes zoster and its’ complications. In October 2017, the FDA licensed a new herpes zoster subunit vaccine (Shingrix™). Less than a week after FDA licensure, the Advisory Committee on Immunization Practices (ACIP) gave a preferential recommendation for the use of Shingrix™ in all immunocompetent adults 50 years and older.

Shingrix™ vaccine consists of a protein subunit combined with an adjuvant (AS01B) system. It is a refrigerated vaccine that must be reconstituted and is administered in 2 doses, 2 months apart. Clinical trials have indicated that it is 97% effective in preventing herpes zoster in those 50-69 years and 91% effective in those 70 years and older. Efficacy against post herpetic neuralgia was 91% for participants 50 years and older. Overall, Shingrix™ efficacy was 98% in the first year following immunization and remained at ≥85% for the remaining three years of the Phase III study conducted by GlaxoSmithKline, the vaccine manufacturer. Over 37,000 study participants received the vaccine. Specific recommendations for immunosuppressed individuals are expected in February 2018.

One caveat - Shingrix™ was highly reactogenic. Over 13% of those receiving the vaccine reported symptoms including pain, myalgia, or chills - that may interfere with daily life for 1-2 days. Patients should be advised to expect a possible reaction. The ACIP noted that the benefits clearly outweigh the harms associated with reactogenicity.

**Ordering:** As soon as Shingrix™ is available to order from the CDC contract, the Immunization Program will make it available to all VFA practices for patients age 50-64 years.

In summary, Shingrix™ is:

- Recommended for immunocompetent adults age 50 and older, in a two-dose series at least eight weeks apart
- Recommended for individuals who previously received Zostavax™
- Should be administered at least 8 weeks after Zostavax™
- Preferred over Zostavax™

## FROM THE REGISTRY: SHINGRIX – CAN YOUR ELECTRONIC HEALTH RECORD HANDLE IT?

If your practice has decided to order and administer Shingrix, it will be important to be able to track in your electronic health record (and report to the Immunization Registry) that you have administered this new formulation, and not just “zoster.” Even if you are not going to administer Shingrix, you will want to be able to accurately record a dose of Shingrix administered elsewhere.

Talk with your EHR vendor to be sure that new vaccine CVX codes are being added to your system (See page 3). It may be necessary to specifically request that Shingrix and Zostavax and “Zoster, unspecified” are enabled as choices in your EHR. Make sure that your practice users are familiar with the fact that these two vaccines are very different, and should be recorded as such. We discourage the use of “unspecified” as that makes it difficult for another provider to determine whether an individual is up to date and can lead to unnecessary immunization.

How do you figure out what a patient who has previously received zoster should receive? Log in to the Immunization Registry and use the Forecaster report or Recommendations button.

## CVX CODES FOR ZOSTER VACCINES

Your Electronic Health Record should allow you to record the following immunizations, and store/send the CVX codes below:

Vaccine Antigen Name	Short Description	CVX
Zoster live	Zostavax	121
Zoster subunit	Shingrix	187
Zoster, unspecified formulation	Zoster unspecified	188

For more detail or clarification, you may contact the Immunization Registry Manager at (802) 951-4094 or access one of the links below.

For a detailed list of codes and labels associated with commonly administered vaccine: [http://www.healthvermont.gov/sites/default/files/documents/2016/12/IMR\\_Vaccine\\_Name\\_and\\_Code\\_Resource\\_Guide.pdf](http://www.healthvermont.gov/sites/default/files/documents/2016/12/IMR_Vaccine_Name_and_Code_Resource_Guide.pdf)

For a complete list of CVX codes, see: <https://www2a.cdc.gov/vaccines/iis/iisstandards/vaccines.asp?rpt=cvx>

## HEPATITIS A OUTBREAKS

Since March 2017, there have been multiple hepatitis A outbreaks, with three states primarily impacted: California, Michigan and Utah.

The outbreaks have occurred due to person to person transmission and by contact with fecally contaminated environments. Those affected are primarily persons who are homeless, use injection and non-injection drugs, and their close contacts. State and county public health departments are working with community partners to halt the hepatitis A outbreaks by focusing on three key areas: vaccination, sanitation and education.



The largest of the outbreaks is occurring in San Diego where a local public health emergency was declared on September 1, 2017. As of November 20, there were 561 cases, 378 hospitalizations and 20 deaths in San

Diego county alone, due to hepatitis A.

Sources: [http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community\\_epidemiology/dc/Hepatitis\\_A.html](http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/dc/Hepatitis_A.html)

<https://www.cdc.gov/hepatitis/outbreaks/index.htm>

### What does this mean for Vermont?

In Vermont, there have been 3 cases of hepatitis A reported in 2017 and 5 in 2016.

The demand for Hepatitis A vaccine nationally has increased over the past 6 months. To address supply constraints CDC is managing the allocation to states of the adult Hepatitis A vaccines.

- For all VFA practices, the brand and presentation (vial or syringe) available to order may change from month to month. We expect Vermont's allocation will be adequate to meet your need for adult Hepatitis A vaccine.
- The two brands of Hepatitis A vaccine, Vaqta and Havrix, are interchangeable.
- The supply of pediatric hepatitis A vaccine is not affected.

Recommendations for vaccination: <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5507a1.htm>

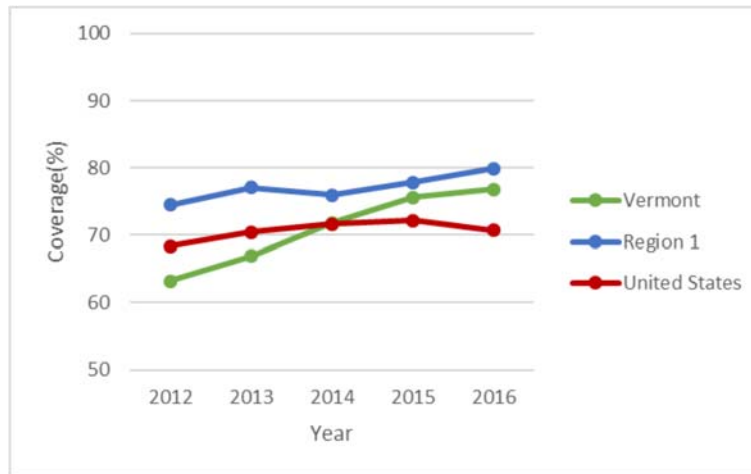
Immunization schedule for adults: <https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined->

## NATIONAL IMMUNIZATION SURVEY (NIS)

### NIS-Child

- Data from the 2016 National Immunization Survey-Child (NIS-Child) indicate that immunization rates for Vermont children 19-35 months generally remained high and steady in 2016. There was no statistically significant difference in coverage between 2015 to 2016 for any recommended vaccine.

#### Combined 7-vaccine\* coverage among children 19-35 months, Vermont, Region 1, and the United States



\*Combined 7-vaccine coverage includes 4 or more doses of DTaP, 3 or more doses of Polio, 1 or more doses of MMR, Hib full series (3 or 4 doses, depending on product type received), 3 or more doses of HepB, 1 or more doses of Varicella, and 4 or more doses of PCV

- Vermont's Hepatitis A rates have risen slightly in recent years but did not improve from 2015 to 2016. The rate for 2+ doses was 56.8%, about 4 percentage points below national levels. Vermont's rates are particularly low in comparison to other states in the New England region, where vaccine access is similar. Coverage is about 10 percentage points lower in Vermont than in New England overall.
- Coverage for HepB birth dose remains well below the national level, with only 48.8% of babies born in Vermont receiving the vaccination, compared to 71.1% nationally.
- Information on [Hepatitis A](#) and [Hepatitis B](#) dosing can be found in previous issues of Vaccinate Vermont.

At or Above National Average	Below National Average
Diphtheria, tetanus, & acellular pertussis (DTaP)	Hepatitis A
Polio	Hepatitis B birth dose
Measles, mumps, and rubella (MMR)	
Haemophilus influenzae type b (Hib)	
Hepatitis B	
Varicella	
Pneumococcal conjugate (PCV13)	
Rotavirus	
7-vaccine series (4:3:1:3:3:1:4)*	

### NIS-Teen

Vermont's rates for teens age 13-17 years were above US rates for all three vaccines reported in the 2016 National Immunization Survey-Teen. Coverage was 94% for Tdap and 86% for meningococcal. For HPV vaccination, 58% of females and 53% of males were up-to-date. The percentage of both females and males receiving 1+ doses of HPV vaccine continues to rise steadily, increasing about 2.5 and 3.5 percentage points for females and males, respectively.

## FLU SURVEILLANCE

Influenza activity in Vermont for the 2017-2018 season has been reported as sporadic, but activity around the New England region is increasing.

Since initial activity was detected in Vermont, in the week ending on October 14, the percent of weekly emergency room visits due to Influenza-like Illness (ILI) ranged from 0.7% to 1.6%. Outpatient providers in the state reported that between 0.7 and 1.2% of patients had ILI. One outbreak was reported, at a long-term care facility in southwest Vermont.

However, higher levels of activity have been reported elsewhere in the region, with outbreaks occurring in many areas of New Hampshire, Connecticut, and Massachusetts.

Flu activity continues to increase as we progress into the winter months. Historically, rates have peaked between December and March. Surveillance data suggest that this year's peak activity may occur on the early end of this range. Since the flu vaccine can take two weeks to be effective, patients should be vaccinated as soon as possible to be protected.

Influenza vaccination is recommended for all persons 6 months of age and older. Last year, in 2016-2017, the overall influenza vaccination rate in Vermont was 47.3%. Rates were lowest for adults 18-49 years of age. Of particular concern was a 12-percentage point drop in vaccination rates for high risk adults 18-49. Vaccination rates in this group were only 33%, no different from the rate for same-age adults without high-risk conditions.

## FLU ON FACEBOOK



Ahead of flu season, the Immunization Program launched a Facebook campaign aimed at reminding Vermonters of the importance of getting vaccinated for influenza. The campaign emphasized the value of vaccinating to protect oneself, as well as those who are either unable to receive a flu shot or whose immune systems are unlikely to muster a strong response when faced with the virus. So far, the campaign has been seen nearly 150,000 times by people in Vermont. As we start to see flu activity ramp up for the 2017-2018 season, hopefully this extra outreach will help remind people that any extra protection we can get from influenza is well worth it!

**You can help spread the word!** As health care providers, your voices are among the most trusted in Vermont communities. If you use Facebook, help get the message out – every extra bit of protection against influenza counts! [Find the Health Department on Facebook](#) and share some of our recent campaign posts.