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INDEX

Topic	Page Number
State Lifts Order Restricting Use of Flu Vaccine	1
Current Influenza Status in United States and Michigan	2
Process for Ordering Flu Vaccine	2
Michigan Adds Three New Conditions to Newborn Screening Panel	3
U.S. Health Improving, but Rate of Improvement Slows	3
Health Professionals Address Rise in Pertussis	3
Michigan Medicaid Long Term Care Task Force	4

STATE LIFTS ORDER RESTRICTING USE OF FLU VACCINE

On Thursday, December 9th, Michigan Department of Community Health (MDCH) Director Janet Olszewski officially lifted a public health order that had restricted administration of influenza vaccine to only our most vulnerable citizens. “Since the national crisis with the influenza vaccine shortage began, our No. 1 goal in Michigan has been to ensure that our most vulnerable citizens had access to a limited vaccine supply,” Olszewski said. “We are now confident that our partners in public health have had ample opportunity to vaccinate high-risk individuals that have stepped forward.”

Several groups – including the Michigan Association of Local Public Health – recommended to Olszewski that the order be lifted. Prior to lifting the order, MDCH had contacted virtually all nursing homes throughout the state to assess vaccine supply status. A vast majority of them assured the department that senior citizens residing in their facilities had had an opportunity to be vaccinated. State and federal officials continue to stress that priority groups – as outlined by the Centers for Disease Control and Prevention (CDC) – should receive existing supplies of vaccine first.

“Providers should now also focus on vaccinating other priority groups that would be protected in a typical season, including individuals aged 50 or older, people that live with a family member that has a chronic disease, teachers, police officers, firefighters, and a broader range of health care workers,” said Dr. Dean Sienko, acting State Chief Medical Executive.

Olszewski made the decision to lift the order after consulting with Sienko, Chief Public Health Administrative Officer Jean Chabut, and other MDCH disease specialists about existing vaccine supply and influenza activity in Michigan.

Private and public sector health care providers in Michigan have received approximately 1.7 million doses of the flu vaccine, and another 200,000 are in the pipeline for an estimated 3.4 million people in Michigan considered to be in high risk groups. Olszewski issued the public health order on October 14 in the wake of a Chiron Corporation announcement that the company would be unable to ship vaccine to the U.S. for the 2004-05 flu season, leaving the nation with only half of its anticipated vaccine supply.

CURRENT INFLUENZA STATUS IN UNITED STATES AND MICHIGAN

During November 28-December 4, 2004, influenza activity overall was low in the United States. Forty-nine specimens tested by U.S. World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) collaborating laboratories were positive for influenza. The proportion of patient visits to sentinel providers for influenza-like illness (ILI) and the proportion of deaths attributed to pneumonia and influenza were below national baseline values. CDC has developed a system to monitor influenza activity level across the nation. The five levels of activity, from lowest to highest, are: no activity, sporadic, local, regional, and widespread. Two states and New York City reported regional influenza activity and four states reported local activity. Thirty-six states (including Michigan), the District of Columbia, and Puerto Rico reported sporadic influenza activity and eight states reported no influenza activity.

MDCH determines the activity level in Michigan based on many sources of information, including laboratory data, sentinel surveillance, Michigan Disease Surveillance System (MDSS) reports, and emergency department surveillance. As stated above, the influenza activity level in Michigan is currently SPORADIC.

For the 2004-2005 influenza season, the MDCH Bureau of Laboratories has confirmed influenza infection in 13 Michigan residents as of December 10, 2004. Eleven of them were type A and subtype H3N2, and two of them were type B (type B viruses do not have subtypes). Further analysis indicates that the 2004-2005 influenza vaccine should provide good protection against these viruses. For updated information about influenza in Michigan throughout the flu season, visit www.michigan.gov/influenza. National information on influenza activity may be found at the CDC website www.cdc.gov/flu.

PROCESS FOR ORDERING FLU VACCINE

Physicians can purchase Influenza vaccine from the supply allocated by CDC to Michigan. Orders for this vaccine must be placed through a local health department. To date, 80,000 doses have been ordered. Michigan has 200,000 doses left in its allocation and if these doses are not used they could go to another state - especially a state with a flu outbreak.

Standard Operating Procedures have been developed to facilitate ordering from this inventory of flu vaccine. All orders, whether eventually administered through private or public providers, must be processed through MDCH. Local Health Departments have been asked to serve in the role of collecting public and private orders from their jurisdictions and submitting their orders to the Division of Immunization. Distributors will bill each provider to whom they ship vaccine. The process will work most efficiently and effectively if local health departments and physicians work together to ensure that Michigan citizens who are in the priority groups are provided with flu vaccine through this distribution process.

A team of Local Health Department officials and MDCH staff (the Rapid Response Team) have been working together to determine the most equitable ways to diminish the gaps that exist in how vaccine has been distributed. Members of this team review each order that is requested before it is placed to make sure the current imbalance is not accentuated. This will be especially important if a jurisdiction requests a disproportionately large amount of vaccine.

If you want to order vaccine for your practice, have a staff member call the Health Department at (906) 779-7210 for assistance in completing the flu vaccine order. All private provider orders need to be verified by the Local Health Department prior to submission to the Division of Immunization.

MICHIGAN ADDS THREE NEW CONDITIONS TO NEWBORN SCREENING PANEL

On October 1st, 2004, the Michigan Department of Community Health Newborn Screening Program added three new conditions to the newborn screening panel including homocystinuria, citrullinemia, and argininosuccinic aciduria (ASA). With the addition of the new conditions, the State of Michigan now screens for eleven disorders of the newborn. The other conditions include phenylketonuria (PKU) (added in 1965), congenital hypothyroidism (added in 1977), galactosemia (added in 1984), biotinidase deficiency, maple syrup urine disease (MSUD) and hemoglobinopathies (all added in 1987), congenital adrenal hyperplasia (added in 1993), and medium-chain acyl-coenzyme A dehydrogenase deficiency (MCADD) (added in 2003). The American College of Medical Genetics (ACMG) will be recommending screening for at least 30 disorders in a report to be published in Fall 2004. Michigan plans to expand the Michigan Newborn Screening Panel to adhere to these recommendations in the year 2005 but will need legislative approval for the expansion.

To facilitate the expansion in screening, the Newborn Screening Program has awarded a contract to the Children's Hospital of Michigan for the creation of the Children's Hospital of Michigan Metabolic Clinic (CHMMC) for confirmatory testing and medical management of infants identified through newborn screening with metabolic conditions. All children with metabolic conditions identified through newborn screening will be referred by the state to this clinic. The CHMMC may be contacted at (313) 745-4513. In addition, the Newborn Screening Program has organized a Michigan Newborn Screening Parent Advisory Committee. For more information about this committee, please contact Dr. Rebecca Malouin at (517) 335-9027 or malouinr@michigan.gov. For further information about the expanded newborn screening, please contact Dr. Bill Young at (517) 335-8938 or youngw@michigan.gov.

U.S. HEALTH IMPROVING, BUT RATE OF IMPROVEMENT SLOWS

The 15th annual America's Health: State Health Ranking, released in conjunction with the recent American Public Health Association Annual Meeting in Washington, DC, shows a substantial improvement in America's overall health during the past 15 years. The report utilizes 18 measures that include prevalence of smoking, high school graduation rates, infant mortality rates, premature death, adequacy of prenatal care, rates of violent crime, and per capita public health spending to produce a composite assessment of each state's health. However, the report also shows that the rate of improvement is slowing significantly due to a combination of personal, community and public health issues.

Released by the United Health Foundation, the American Public Health Association, and Partnership for Prevention, this year's report reveals that during the 1990s health in the United States improved by an annual rate of 1.5 percent each year. However, during the 2000s, health in the U.S. has improved by an annual rate of only 0.2 percent each year. Minnesota is at the top of the list of healthiest states. New Hampshire, Vermont, Hawaii, Utah and Massachusetts round out the top six. Louisiana is ranked 50th, while Mississippi, Tennessee, South Carolina, and Arkansas complete the bottom five states. Visit http://rd.bcentral.com/?ID=2344183&s=64497434 for more information.

HEALTH PROFESSIONALS ADDRESS RISE IN PERTUSSIS

The Society for Adolescent Medicine (SAM) and the National Association of Pediatric Nurse Practitioners (NAPNAP) have created new tools and assembled educational resources for health professionals and parents to address increasing pertussis rates in recent years. The health professional resources are designed to assist clinicians with recognizing the prevalence of the illness in both its classic and mild forms and adequately diagnosing it. The increase in pertussis cases is caused by many factors including under-vaccination in infants, under or misdiagnosis of both classic and mild pertussis, and the increased transmission from older children, adolescents, and adults to susceptible infants and young children. According to the CDC, 90 percent of unvaccinated children living with someone with pertussis will contract the disease.

The CDC reports that since pertussis cases reached an all time low in 1976 with the introduction of a vaccine, whooping cough has made a very strong resurgence, tallying 8,296 cases nationwide in 2002 and 11,647 cases in 2003. Approximately 38 percent of reported cases in the U.S. last year occurred in children under the age of four and another 39 percent of reported cases affected adolescents between the ages of 10 and 19. For more

information on pertussis and the resources available for health professionals and parents, go on-line to http://rd.bcentral.com/?ID=2344182&s=64497434 and http://www.adolescenthealth.org/whoopingcough.html.

MICHIGAN MEDICAID LONG TERM CARE TASK FORCE

The Michigan Medicaid Long Term Care (LTC) Task Force was created by Governor Granholm in Executive Order No.1-2004. The twenty-one members of the task force were named on June 1,2004 and the first meeting was held on June 29 at the Radisson Hotel in Lansing. The MSU Institute for Health Care Studies is providing some staff suppport in cooperation with the Michigan Department of Community Health, the Office of Services to the Aging and other state agencies. A web site (http://www.ihcs.msu.edu/LTC/default.htm) has been developed to serve as the primary means of communication with the public and health care providers. The web site includes background documents relating to the task force's work, links to outside sources of information and an online forum for public comment. The charge of the task force according to the executive order is to:

1. Review existing reports and reviews of the efficiency and effectiveness of the current mechanisms and funding for the provision of Medicaid long-term care services in Michigan and identify consensus recommendations.

2. Examine and report on the current quality of Medicaid long-term care services in Michigan and make recommendations for improvement in the quality of Medicaid long-term care services and home-based and community-based long-term care services provided in Michigan.

3. Analyze and report on the relationship between state and federal Medicaid long-term care funding and its sustainability over the long term.

4. Identify and recommend benchmarks for measuring successes in this state's provision of Medicaid long-term care services and for expanding options for home-based and community-based long-term care services.

5. Identify and make recommendations to reduce barriers to the creation of and access to an efficient and effective system of a continuum of home-based, community-based, and institutional long-term care services in Michigan.