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Hepatitis Surveillance Changes

By Elizabeth Lawlor, MS

Hepatitis C

Effective: October 1, 2013

Currently: When investigating hepatitis C cases, local health departments have focused on identifying reasons for testing (e.g., symptomatic, elevated liver enzymes) and conducting risk assessment interviews (the hepatitis C specific disease form in EpiTrax) for individuals 35 years of age and younger. This age group was chosen because these individuals are more likely to be acutely infected (contracted hepatitis C in the past six months), which increases the likelihood that a public health investigation can identify the transmission source and public health interventions can be implemented. For individuals older than 35, the goal is to determine reasons for testing and if the patient is symptomatic.

New procedures: Local health departments will be asked to focus on investigating newly reported hepatitis C cases in individuals 25 years and younger, as well as individuals 65 years and older. For all newly identified hepatitis C cases 25 years and younger, reasons for testing and a risk assessment interview will need to be completed. For individuals 65 years of age and older, reasons for testing, symptoms, and date of first diagnosis will need to be obtained. If a patient in this age group is being diagnosed for the first time, then a risk assessment interview will need to be completed. For all other individuals, the Kansas Department of Health and Environment (KDHE) is requesting that a form be faxed to the diagnosing physician to obtain reasons for testing and determine if the patient was symptomatic at time of testing. The disease investigation guidelines will be updated with these new policies, and a form will be provided.

Why: From 2008 to 2012, there were 35 outbreaks of viral hepatitis at healthcare facilities in the United States which resulted in over 100,000 at-risk individuals being notified for screening. It is possible

that transmission of viral hepatitis has occurred in Kansas healthcare facilities, but has remained undetected using current surveillance procedures. Frequently, individuals who are in an older age population have more healthcare exposures, and could be at greater risk for viral hepatitis transmission from these sources. For this reason, KDHE is changing the protocol with the aim that newly diagnosed individuals 65 years and older will be investigated more fully to ensure that if any healthcare transmission of viral hepatitis occurs it is identified and public health interventions can be implemented.

Hepatitis B

Effective: October 1, 2013

Currently: Local health departments investigate suspected hepatitis B acute cases where the only laboratory evidence is a hepatitis B core IgM antibody positive result.

New procedures: Local health departments will investigate suspected hepatitis B acute cases when there is **both** a hepatitis B core IgM antibody positive result and a positive hepatitis B surface antigen result. If only a core IgM positive result is submitted to KDHE without a surface antigen result, then a hepatitis B acute case will be created in EpiTrax, but will be closed immediately as 'Not a Case' by KDHE staff. If a subsequent surface antigen positive result is received, KDHE will reopen the case for the local health department to investigate.

Why: In 2012, the acute hepatitis B case definition from the Council of State and Territorial Epidemiologists changed from requiring either a hepatitis B surface antigen result **or** a core IgM antibody result to requiring **both** laboratory results. This change should decrease the work load for local health investigators by reducing the number of hepatitis B acute cases that need investigation.

Kansas Hospitals Doing Well in the Fight Against Healthcare-Associated Infections

By Joseph Scaletta

On September 26, KDHE will release encouraging new data on healthcare-associated infections (HAIs) in Kansas hospitals. Largely preventable, HAIs are infections that patients acquire during the delivery of clinical care that were not present upon admission. The report, which will be available online at www.kdheks.gov/epi/hai.htm on September 26, shows reductions in two important HAIs in intensive care unit settings: central line associated blood-stream infections (CLABSI) and catheter-associated urinary tract infections (CAUTI).

The CDC estimates that each year, Americans contract 1.7 million infections while being treated in hospitals. These infections cause approximately 99,000 deaths annually. In addition to the significant toll on patients' lives, HAIs represent an estimated \$30 billion in added healthcare costs.

"The HAI infection data reported today are a significant step forward in the prevention of infection and protection of patients in Kansas" said Robert Moser, M.D., KDHE Secretary and State Health Officer. "Fortunately, we have a robust network of skilled infection preventionists working tirelessly to improve healthcare quality and patient safety. Today, in Kansas, we are seeing progress in the fight against HAIs."

The report suggests that in 2011, Kansas facilities had significantly fewer HAIs than expected. Specifically, data suggest that Kansas facilities had 67% fewer blood stream infections from central-line devices and 26% fewer urinary tract infections from urinary catheter devices as compared to national reference data. Currently, over 70 facilities in Kansas (representing more than 95 percent of staffed ICU beds) report data on one or more HAIs to the KDHE HAI Program.

"Reductions in these HAIs reflect a strong commitment to patient safety by healthcare facilities throughout the state" said State Epidemiologist, D. Charles Hunt.

A companion document, specifically designed for patients, will also be made available at www.kdheks.gov/epi/hai.htm. This resource is intended to empower and engage patients by identifying practical steps patients can take to reduce their risk of acquiring CLABSI and CAUTI when hospitalized.

The KDHE HAI Program focuses on supporting HAI surveillance and reporting efforts and promotes adherence to nationally based guidelines and recommendations to reduce the occurrence of HAIs. With assistance from a multidisciplinary advisory group, comprised of stakeholders with expertise in infection prevention, KDHE has chosen specific HAI metrics and developed a state-wide plan to quantify and reduce the occurrence of HAIs.

Information about other types of HAIs will be included in future reports.



***Toolkit for
the Prevention of
Methicillin-Resistant
Staphylococcus aureus (MRSA),
in Organized Sports***

is now available at
www.kdheks.gov/epi/
(second to last link on left).

Greg Crawford, Director, Vital Statistics Data Analysis Section, Bureau of Epidemiology and Public Health Informatics, KDHE was selected as the recipient of the **Kansas Public Health Association Special Service Award**. Greg's work with the online tool Kansas Health Matters (<http://www.kansashealthmatters.org/>) was cited as a major milestone to improve access to information for community health assessment. Congratulations Greg!

Reported Diseases Counts - August 2013

Disease	State Case Status					Grand Total	3 Year Avg. 2010-2012
	Unclassified	Confirmed	Not a Case	Probable	Suspect		
	Count	Count	Count	Count	Count	Count	Count
Amebiasis (<i>Entamoeba histolytica</i>)	1	0	0	0	0	1	1
<i>Anaplasma phagocytophilum</i> (f. HGE)	1	0	1	0	0	2	3
Campylobacteriosis	64	18	0	0	18	100	78
Cryptosporidiosis	5	7	0	2	0	14	58
Cyclosporiasis	1	0	1	0	0	2	0
Dengue	1	0	0	2	1	4	1
Ehrlichiosis, <i>Ehrlichia chaffeensis</i> (f. HME)	9	2	4	4	1	20	7
Ehrlichiosis, <i>Ehrlichia ewingii</i>	1	1	0	0	0	2	0
Giardiasis	11	9	0	0	0	20	25
<i>Haemophilus influenzae</i> , invasive disease (Including Hib)	0	2	2	0	0	4	3
Hepatitis A	1	0	6	1	0	8	42
Hepatitis B virus infection, chronic	6	0	12	22	0	40	38
Hepatitis B, acute	0	0	2	0	0	2	4
Hepatitis C virus, past or present	90	52	20	2	9	173	213
Hepatitis C, acute	1	0	0	0	0	1	1
Legionellosis	4	5	1	0	0	10	4
Lyme Disease (<i>Borrelia burgdorferi</i>)	26	1	20	2	0	49	26
Malaria (<i>Plasmodium spp.</i>)	0	1	0	0	0	1	3
Meningitis, Bacterial Other	1	0	2	0	0	3	3
Methicillin- or oxacillin- resistant <i>Staphylococcus aureus</i> coagulase-positive (MRSA a.k.a. ORSA)	1	0	0	0	0	1	-
Norovirus	0	3	0	0	0	3	9
Outbreak Case - Unknown Etiology	0	0	0	2	0	2	3
Pertussis	18	12	5	9	4	48	103
Q Fever (<i>Coxiella burnetii</i>), Acute	3	0	0	0	0	3	1
Rabies, animal	2	7	1	1	3	14	10
Salmonellosis	4	52	2	0	0	58	74
Shiga toxin-producing <i>Escherichia coli</i> (STEC)	8	13	2	1	1	25	7
Shigellosis	2	6	0	0	0	8	15
Spotted Fever Rickettsiosis (RMSF)	27	0	16	15	1	59	46
Streptococcal disease, invasive, Group A	0	0	0	0	1	1	4
<i>Streptococcus pneumoniae</i> , invasive disease	1	2	0	0	0	3	4
Transmissible Spongiform Enceph (TSE / CJD)	3	0	0	0	0	3	1
Tularemia (<i>Francisella tularensis</i>)	5	0	0	2	2	9	3
Varicella (Chickenpox)	15	10	9	8	0	42	33
West Nile virus neuroinvasive disease	1	0	0	3	0	4	3
West Nile virus non-neuroinvasive disease	2	0	14	1	1	18	51
Yersiniosis	0	1	0	0	0	1	0
Grand Total	315	204	120	77	42	758	875

Vaccine-Preventable Disease Surveillance Indicators

by Chelsea Raybern, MPH

The completeness and quality of specific surveillance indicators for vaccine-preventable diseases (VPDs) reported to the KDHE from August 1 to August 31, 2013 is shown in the table below. The bolded percentages represent the indicators that have less than 90% completion. Changes have been made in how the completeness of two indicators are calculated: transmission setting and vaccination status. Initially, for completeness of indicators, fields that were marked as unknown or left blank were considered unanswered. Beginning with the surveillance indicators published in April for cases that were reported in March, unknown is considered a valid response for transmission setting and for vaccination status if the patient is older than 18 years. It is important to note that data reflected for the onset date indicator is pulled from the onset date field within the clinical tab in EpiTrax, not within the investigation tab. The case counts presented in this report are preliminary numbers and are subject to change.

Keep up the good work! The indicators date of birth and gender were completed for all VPDs reported from August 1 to August 31, 2013. Local health departments completed all indicators for the two *Haemophilus influenzae* cases and completed at least 90% of all indicators for varicella cases except for transmission setting. More than half of the pertussis indicators (date of birth, gender, race, ethnicity, hospitalization, and death) were at least 98% complete. When compared to last month's surveillance data, all reported diseases have shown improvement in completeness for at least one surveillance indicator. The percentages and numbers highlighted in red represent improvement.

Still room for improvement...All but two indicators for the *Streptococcus pneumoniae* cases were only 67% complete. Percent of completed investigations was much lower than 90% for half of the reported VPDs (pertussis and *Streptococcus pneumoniae*). When compared to July's surveillance data, the range number of days from report to case acceptance has worsened for *Streptococcus pneumoniae* and varicella cases; the range number of days for local health departments to accept these cases was zero to 13.

Please continue to focus on completing these fields in EpiTrax for all VPDs as the goal is to reach 90% or higher completion on all indicators. For questions regarding this data, please contact Chelsea Raybern at (785) 296-0339 or craybern@kdheks.gov.

VPD Indicators Reported from August 1 to August 31, 2013 in Kansas

Indicators	<i>Haemophilus influenzae</i> , invasive	Pertussis	<i>Streptococcus pneumoniae</i> , invasive	Varicella
Number of reported cases	2	45	3	31
% of cases with date of birth	100%	100%	100%	100%
% of cases with gender	100%	100%	100%	100%
% of cases with race	100%	98%	67%	97%
% of cases with ethnicity	100%	98%	67%	97%
% of cases with onset date	100%	89%	67%	97%
% of cases with hospitalized noted	100%	98%	67%	94%
% of cases with died noted	100%	98%	67%	100%
% of cases with vaccination status	100%	84%	67%*	90%
% of cases with transmission setting	N/A [§]	89%	N/A [§]	87%
% of investigations completed by local health departments [¶]	100%	71%	67%	90%
Median [†] # of days from report to case acceptance (range) [‡]	(0-2)	(0-7)	(0-13)	(0-13)

*Indicator considered complete if either polysaccharide or conjugate pneumococcal vaccine history is documented

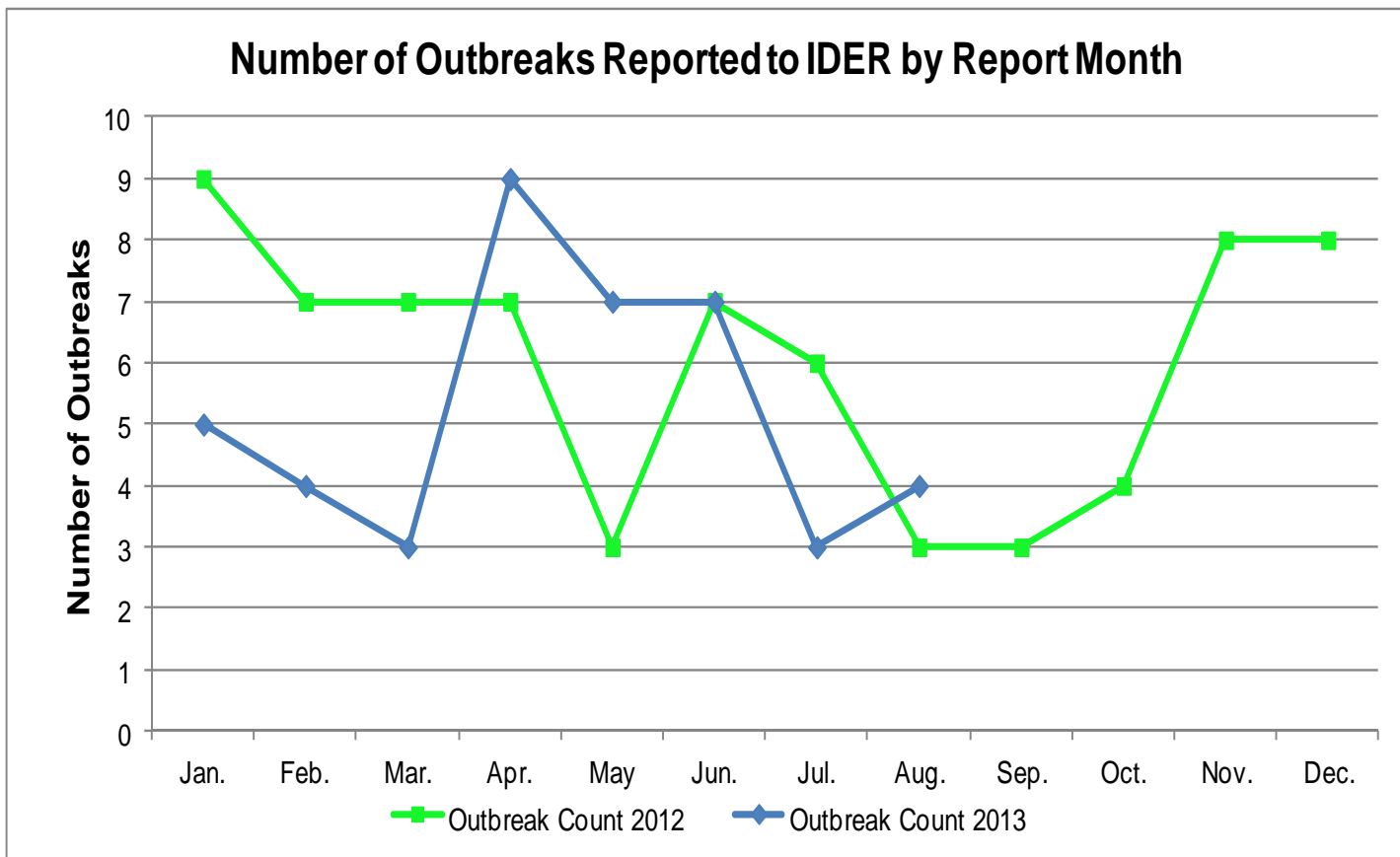
[§]Indicator field is not included in supplemental disease form.

[¶]Status includes when local health department completes investigation, approves the case, or when the case is closed by state.

[†]Median number of days from report to case acceptance is not included in this report yet will be in future newsletters.

[‡]Time from public health report date to when local health department accepts case.

MONTHLY OUTBREAK SUMMARIES



Facility Type	Organism	Transmission	County	Reported Date
Restaurant	Outbreak Case - Unknown Etiology	Food	Shawnee	8/5/2013
Other	Norovirus	Food	McPherson	8/14/2013
School or College	Varicella (Chickenpox)	Person-to-Person	Jackson	8/19/2013
Fair or Festival	Salmonellosis	Food	Rooks	8/29/2013