

Bureau of Epidemiology & Public Health Informatics



EPI UPDATES

July
2018

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Updated Infectious Disease Regulations

by Justin Blanding, MPH

The Infectious Disease Epidemiology and Response Section has been conducting in-person regional trainings around the state on the updated disease regulations that went into effect on May 11, 2018. We would like to thank our partners for hosting and informing your communities about these trainings. There is still time for local health departments and mandatory reporters (e.g., physicians, nurses, administrators, laboratorians) to sign up for the last scheduled training in Barton County on September 5, 2018. Details regarding time and exact location are still being finalized, but we will inform you as soon as it is decided. At that time, participants can sign up for one or both sessions at Kansas TRAIN (www.train.org/ks/). The first session will review the changes to the reportable disease list, timeframes to report, specimen submission guidelines, and mandated reporting; the second course will review the changes to the isolation and quarantine regulation and the rabies control regulation. Please spread the word to anyone who has not already attended the training and that would benefit from attending.

We gathered some general questions that we have received during the trainings and compiled a FAQ below.

Is bacterial meningitis reportable and entered in EpiTrax?

Bacterial meningitis is no longer a reportable condition unless it is caused by *Neisseria meningitidis* (meningococcal disease), *Streptococcus pneumoniae* (pneumococcal meningitis), *Haemophilus influenzae*, or *Listeria monocytogenes*. However, if bacterial meningitis is suspected and these specific organisms have not been ruled out as the cause, please report it as "bacterial meningitis." It is important to note that suspected *Neisseria meningitidis* is a four-hour reportable disease while the others are reportable within 24 hours of lab confirmation. If an etiology has not been identified for a suspected bacterial meningitis case at the time it is reported, a CMR will be created with the disease event "Meningitis, Bacterial Other" until laboratory evidence confirms the cause as a disease that is reportable. At that time, the CMR will be updated to the appropriate disease event.

What is considered invasive *Streptococcus pneumoniae* and *Haemophilus influenzae*?

Invasive pneumococcal disease (*S. pneumoniae*) and invasive *Haemophilus influenzae* is defined as an infection confirmed by the isolation of *S. pneumoniae* or *H. influenzae* from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], and pleural, joint, or peritoneal fluid). Sputum is not a sterile site; therefore, isolation of these bacteria from sputum is not considered invasive disease. For a full list of normally sterile body sites, please visit: <http://www.health.state.mn.us/divs/idepc/dtopics/invbacterial/sterile.html>.

Do *Vibrio cholerae* lab results need to be called in within 4-hours to the Epidemiology Hotline?

When ingested, *Vibrio* bacteria can cause watery diarrhea, often accompanied by abdominal cramping, nausea, vomiting, fever, and chills. Severe illness is rare and typically occurs in people with a weakened immune system. *Vibrio cholerae* lab results do not need to be called into the epidemiology hotline unless the disease is suspected to be Cholera (i.e. *V. cholerae* O1 or O139). *Vibrio cholerae* has many different serogroups, however, only two can cause cholera.

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Those two serogroups are O1 and O139 (O139 is found only in Asia). Cholera should only be suspected if there is international travel to certain countries in Latin America, Africa, or Asia. If there is no international travel in the week prior to onset of symptoms then the most likely diagnosis would be vibriosis which is caused by a serogroup that is not toxigenic and is known as non-O1 and non-O139 *Vibrio cholerae* (often referred as vibriosis). These serogroups can cause diarrheal disease and have a natural reservoir in sea and coastal waters. In the U.S., transmission of *Vibrio* infections is primarily through consumption of raw or undercooked seafood, particularly oysters.

August Public Health Observances

National Immunization Awareness Month

<https://www.cdc.gov/vaccines/events/niam.html>



National Health Center Week (Aug. 13-19)

<https://healthcenterweek.org/>



Opioid Misuse Prevention Day (Aug 31)

<http://www.kdheks.gov/idp/pdomp.htm>



World Breastfeeding Week (Aug 1-7)

<http://worldbreastfeedingweek.org/>



Epi Spotlight - Amie Worthington

Amie Worthington is an epidemiologist with the Infectious Disease Epidemiology and Response Section (IDER) at the Kansas Department of Health and Environment (KDHE). She has worked in IDER since February 2010 and serves as the influenza surveillance coordinator and arboviral disease surveillance coordinator. Amie earned a Master of Public Health degree from Kansas State University in 2017 and a Bachelor of Science degree in Community Health from the University of Kansas in 2009.

Amie grew up in Silver Lake, KS and currently lives in Topeka. She is getting married in Manhattan, KS in August to her fiancé, Ryan Cook. While not wedding planning, Amie enjoys spending time with her friends and family; playing with her dog, Lilly; and cheering on the Jayhawks, Royals, and Chiefs.



UPDATE EPITRAX DATA QUALITY INDICATORS

by Sheri Tubach, MPH MS

The Bureau of Epidemiology and Public Health Informatics has implemented a set of monthly quality indicators and performance measures to encourage data quality improvement in EpiTrax and timeliness of investigations. For 2018, there have been some notable changes. I have now included four additional surveillance indicators; food handler, group living, health care worker, and daycare attendee or worker. These four fields are on the Epidemiological Tab in EpiTrax.

Additionally, I am no longer utilizing the fields 'Date LHD investigation started' or 'Date LHD investigation completed' to calculate the performance measures of disease control measures implemented or case investigation completed. Instead, I am calculating percent of cases that have the first interview attempted by the disease target and the percent of cases that have the interview completed by the disease target. Disease targets can be found in the table below. I hope that these performance measures will be more helpful in prioritizing case investigations.

For questions, contact Sheri Tubach at sheri.tubach@ks.gov

June 2018	State's Total Number of Cases* = 328	
EpiTrax Indicators		
EpiTrax Field	Number of Cases with Field Completed	Percent Completed
Address City	326	99
Address County	328	100
Address Zip	324	99
Date of Birth	327	100
Daycare attendee or worker†	290	88
Died	296	90
Ethnicity†	284	87
Food handler†	158	48
Group living†	150	46
Healthcare worker†	65	20
Hospitalized	113	34
Occupation	156	48
Onset Date	256	78
Pregnancy††	130	87
Race †	294	90
Sex †	328	100
Persons Interviewed	184	56
Persons Lost to Follow-Up	24	7
Persons Refused Interview	2	1
Persons Not Interviewed	118	36
	Number of Cases	Percent of Cases
Interview was attempted within the target for each disease [^]	150	43
Case investigations were completed within the target for each disease [^]	139	44

*Calculations do not include Hepatitis B - chronic, Hepatitis C - Chronic or acute, or Animal Rabies

** Out-of-state, discarded, deleted or those deemed to be not a case are not included in this calculation.

† Unknown considered incomplete.

†† Pregnancy completeness calculated on females only

[^] See the table below for interview attempt and completed case interview targets

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Disease Targets

Diseases	Disease Control (Days)*	Completed Case Investigation (Days)**
Anthrax; Botulism; Brucellosis; Cholera; Diphtheria; Hantavirus Pulmonary Syndrome; Hepatitis A; Influenza deaths in children <18 years of age; Measles; Meningitis, bacterial; Meningococccemia; Mumps; Plague; Poliomyelitis; Q Fever; Rabies, human; Rubella; Severe acute respiratory syndrome (SARS); Smallpox; Tetanus; Tularemia; Viral hemorrhagic fever; Yellow fever	1	3
Varicella	1	5
Pertussis	1	14
Campylobacter infections; Cryptosporidiosis; Cyclospora infection; Giardiasis; Hemolytic uremic syndrome, post diarrheal; Hepatitis B, acute; Legionellosis; Listeriosis; Salmonellosis, including typhoid fever; Shigellosis; Shiga-toxin <i>Escherichia coli</i> (STEC); Trichinosis; Vibriosis (not cholera)	3	5
Arboviral disease (including West Nile virus, Chikungunya, and Dengue); <i>Haemophilus influenzae</i> , invasive disease; <i>Streptococcus pneumoniae</i> , invasive	3	7
Ehrlichiosis / Anaplasmosis; Lyme disease; Malaria; Spotted Fever Rickettsiosis	3	14
Hepatitis B, chronic; Hepatitis C, chronic; Hepatitis C, acute; Leprosy (Hansen disease); Psittacosis; Streptococcal invasive, drug-resistant disease from Group A Streptococcus; Toxic shock syndrome, streptococcal and staphylococcal; Transmissible spongiform encephalopathy (TSE) or prion disease	N/A	N/A

***Disease Control:** Calculated by using EpiTrax Fields: (Date LHD Investigation Started) OR (Call Attempt 1 date for Salmonellosis and STEC) - (Date Reported to Public Health) OR (Date Reported to KDHE)

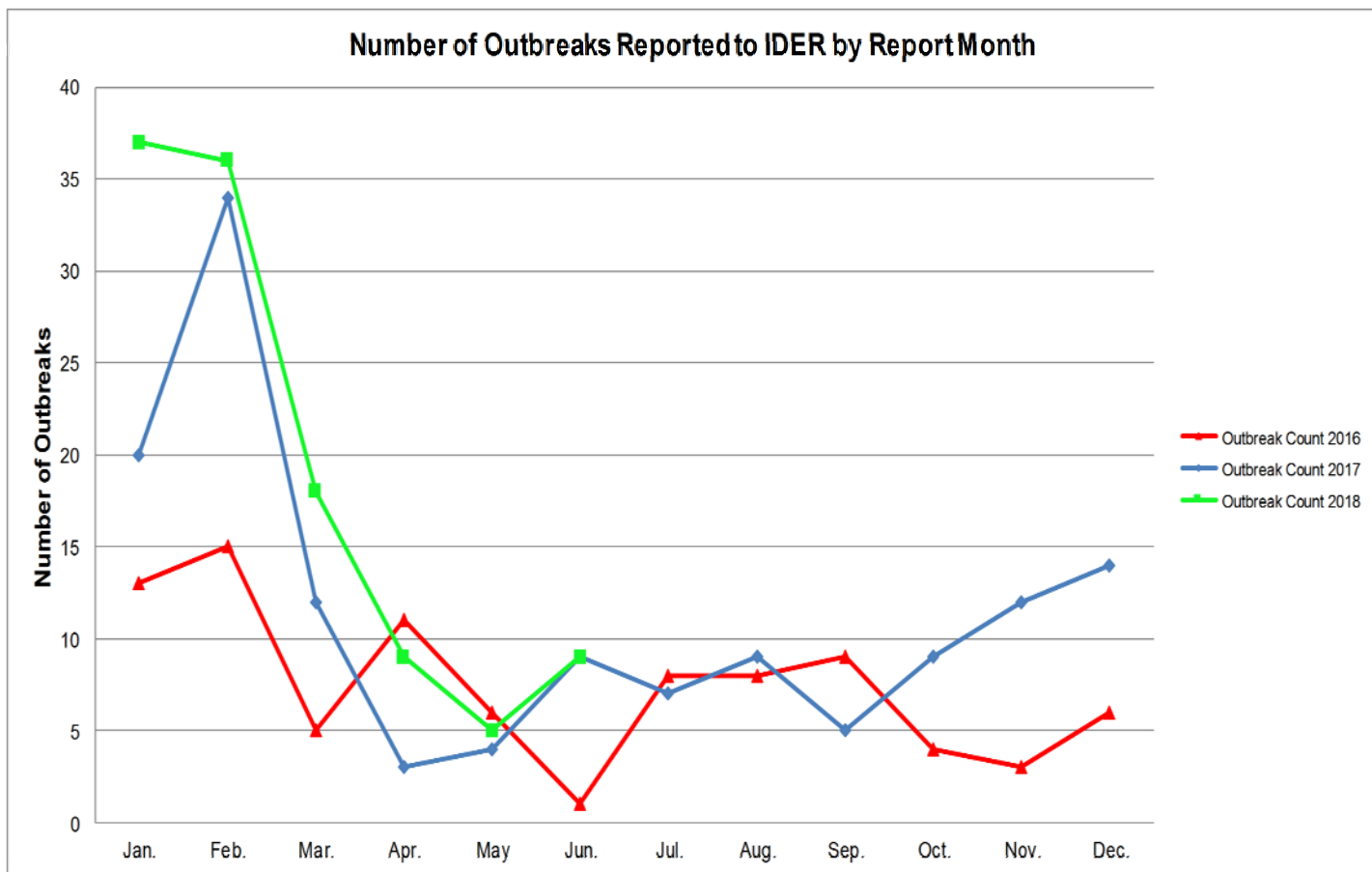
****Completed Case Investigation:** Calculated by using EpiTrax fields: (Date LHD Investigation Completed) - (Date Reported to Public Health) OR (Date Reported to KDHE)

Monthly Disease Counts

Please refer to the Cumulative Case Reports of Diseases (http://www.kdheks.gov/epi/case_reports_by_county.htm) for current case count information.



Outbreaks Report



Date Reported	Facility Type	Transmission/Exposure	Disease/Condition	County
6/1/2018	Restaurant	Food	Unknown Etiology	Brown
6/5/2018	Restaurant	Food	Unknown Etiology	Johnson
6/5/2018	Restaurant	Food	Unknown Etiology	Johnson
6/11/2018	Hospital	Unknown	Clostridium difficile	Wyandotte
6/13/2018	Restaurant	Food	Unknown Etiology	Coffey
6/15/2018	Hotel or motel	Water	Legionellosis	Franklin
6/15/2018	Restaurant	Food	Unknown Etiology	Johnson
6/17/2018	Recreational water	Person-to-person	Norovirus	Wyandotte
6/18/2018	Unknown	Food	Cyclosporiasis	Anderson

Vaccine-Preventable Disease Surveillance Indicators

by Allison Zaldivar, MPH

The completeness and quality of specific surveillance indicators for vaccine-preventable diseases (VPDs) reported to the Kansas Department of Health and Environment (KDHE) from April 1 to June 30, 2018 can be found in the table below. As always, the bolded percentages represent the indicators that have less than 90% completion and the data presented in the chart is preliminary and subject to change.

Keep up the good work! All but two indicators surpassed the 90% completion goal this quarter. Most indicators reached 100% completion!

Still room for improvement... Both *Haemophilus influenzae* and mumps had one indicator fall below the 90% benchmark. The indicators that did not meet the completion goal are bolded in the chart below.

A reminder—due to your hard work in completing these fields in EpiTrax, it has been decided that VPD surveillance indicators will be monitored and published on a quarterly basis. For questions regarding this data, please contact Allison Zaldivar at (785) 368-8208 or Allison.Zaldivar@ks.gov.

VPD Indicators Reported during Quarter 2 (April 1 to June 30, 2018) in Kansas

Indicators	<i>Haemophilus influenzae</i> , invasive	Measles	Mumps	Pertussis	<i>Streptococcus pneumoniae</i> , invasive	Varicella
Number of reported cases	8	3	1	13	47	48
% of cases with date of birth	100%	100%	100%	100%	100%	100%
% of cases with gender	100%	100%	100%	100%	100%	100%
% of cases with race	100%	100%	100%	100%	100%	100%
% of cases with ethnicity	100%	100%	100%	100%	100%	100%
% of cases with onset date [‡]	88%	100%	100%	100%	98%	100%
% of cases with hospitalized noted	100%	100%	100%	100%	100%	100%
% of cases with died noted	100%	100%	100%	100%	100%	100%
% of cases with vaccination status*	100%	100%	100%	92%	100%§	100%
% of cases with transmission setting [¶]	N/A**	100%	100%	100%	N/A**	100%
% of cases with completed symptom profiles	N/A**	100%	67%	95%	N/A**	99%

*Excludes cases with a State Case Status of "Suspect", "Out of State", or "Not a Case."

‡Data is pulled from onset date field within the clinical tab, not the investigation tab.

*Unknown is considered a valid response if patient is older than 18 years of age.

**Indicator field is not included in supplemental disease form; *S. pneumoniae* and *H. influenzae* do not have clinical case definitions.

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

¶Unknown is considered a valid response for this indicator