Indiana Department of Health

CLINICIAN UPDATES

GUY CROWDER, M.D., M.P.H.T.M.
CHIEF MEDICAL OFFICER

5/24/2024

OUR MISSION:

To promote, protect, and improve the health and safety of all Hoosiers.

OUR VISION:

Every Hoosier reaches optimal health regardless of where they live, learn, work, or play.

Conflict of interest

I have no conflicts of interest to disclose

CMEs

CME credits are available
for participating in this webinar.

https://redcap.isdh.in.gov/surveys/?s=THMMALTW8C9YNKRL

Indiana Department of Health

Continuing medical education

Please complete this survey

Clinician Survey

Health First Indiana

- All 92 Indiana counties have opted in to Health First Indiana (HFI) funding for 2025
- In January 2025, $150 million in Health First Indiana funding will be distributed among the 92 counties. New counties opting in to HFI for next year are Crawford, Fountain, Harrison, Johnson, Wells and Whitley. Historically, Indiana's counties shared $6.9 million in public health funding annually from the state. In 2024, the first year of the new legislation, 86 counties opted-in and received a total of $75 million.
- Counties determine how the funding will help provide access to core public health services that address issues such as childhood lead poisoning, heart disease, tobacco cessation, obesity, and maternal and infant mortality to improve Indiana's health outcomes.
- Visit www.healthfirstindiana.in.gov to see information about Health First Indiana, including a description of core public health services, county-level health metrics and funding details.
- Take the pledge: The Indiana Hospital Association (IHA) and Indiana Chamber of Commerce have committed to supporting public health efforts throughout Indiana, calling on healthcare systems and employers across the state to pledge their support for this initiative.

Press Release

Indiana Department of Health

WATER SAFETY AND DROWNING PREVENTION: REDUCING FATALITIES IN INDIANA

ALLIE HOUSTON
FATALITY PREVENTION PROGRAMS DIRECTOR

5/24/24

Did you know?

On average, in the United States, **4,000** fatal drownings occur every year.

This is an average 11 drowning deaths per day.

Indiana Department of Health

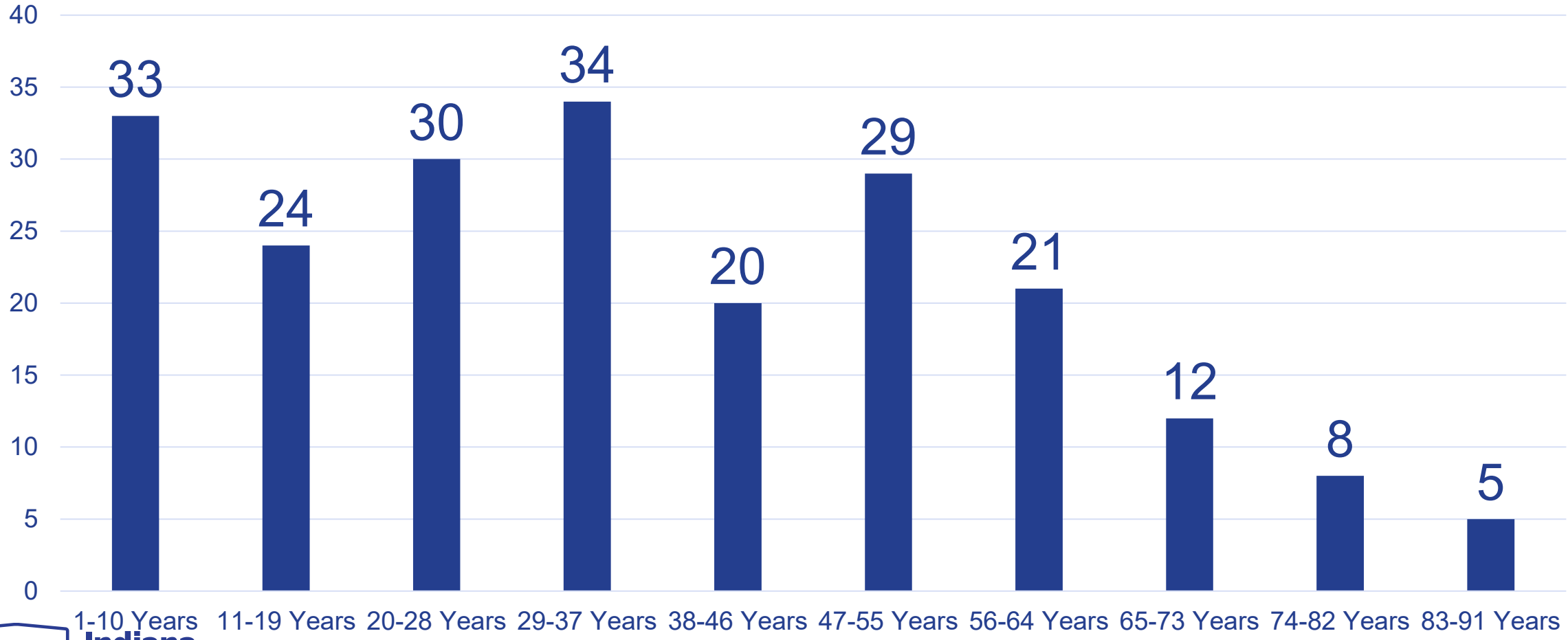
Source: National Center for Injury Prevention and Control, CDC, 2024

Did you know?

- Drowning is a leading cause of unintentional injury-related death in children ages 14 years and younger
- Nearly half of drowning deaths are among infants and toddlers
- Infants (0 to 12 months) are most likely to drown in bathtubs
- Most drowning deaths among children ages 1 through 4 years happen in residential swimming pools
- The likelihood of drowning in open water (such as retention ponds, lakes, rivers and oceans) increases with age

Source: National Center for Injury Prevention and Control, CDC, 2024

2018-2021 Drowning deaths by age (n=216)



Indiana Department of Health

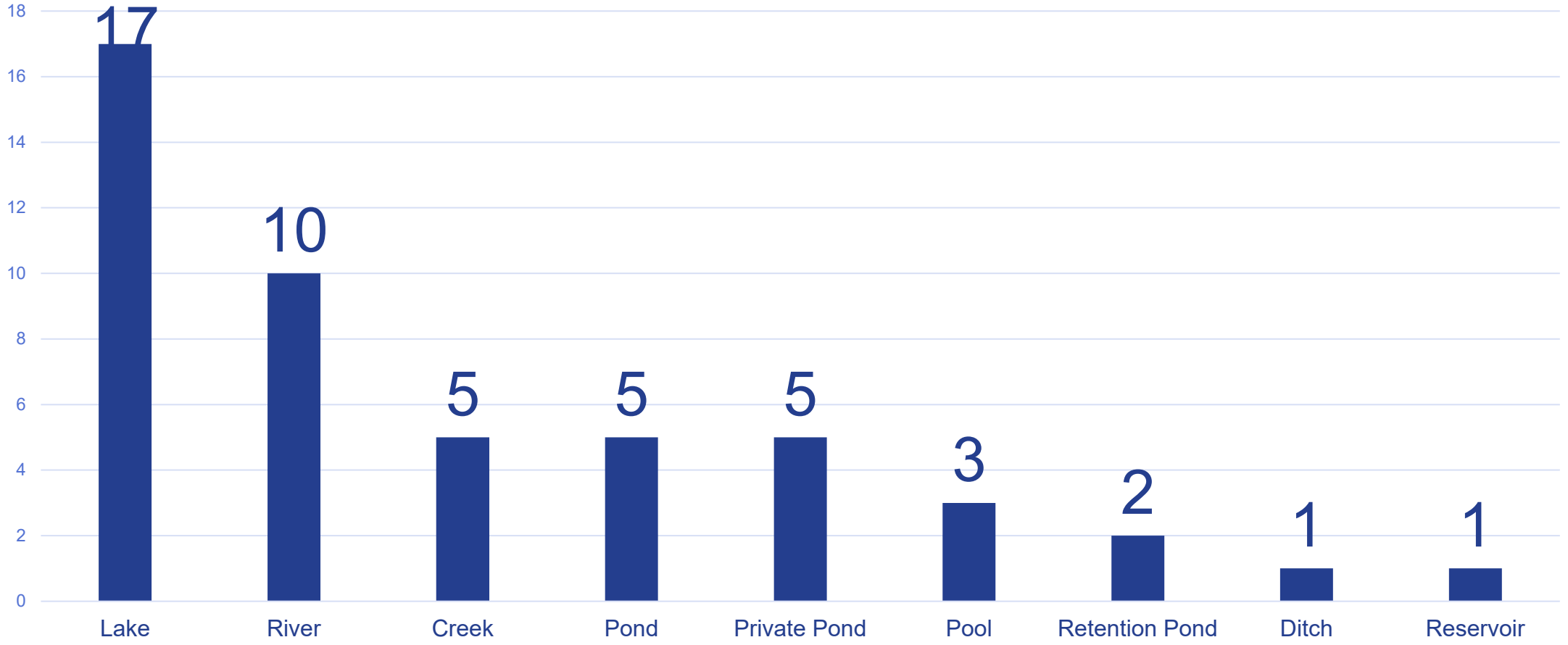
Source: Indiana Department of Natural Resources, 2023

2018-2021 Drowning deaths by personal flotation device presence and use (n=216)

Indiana Department of Health

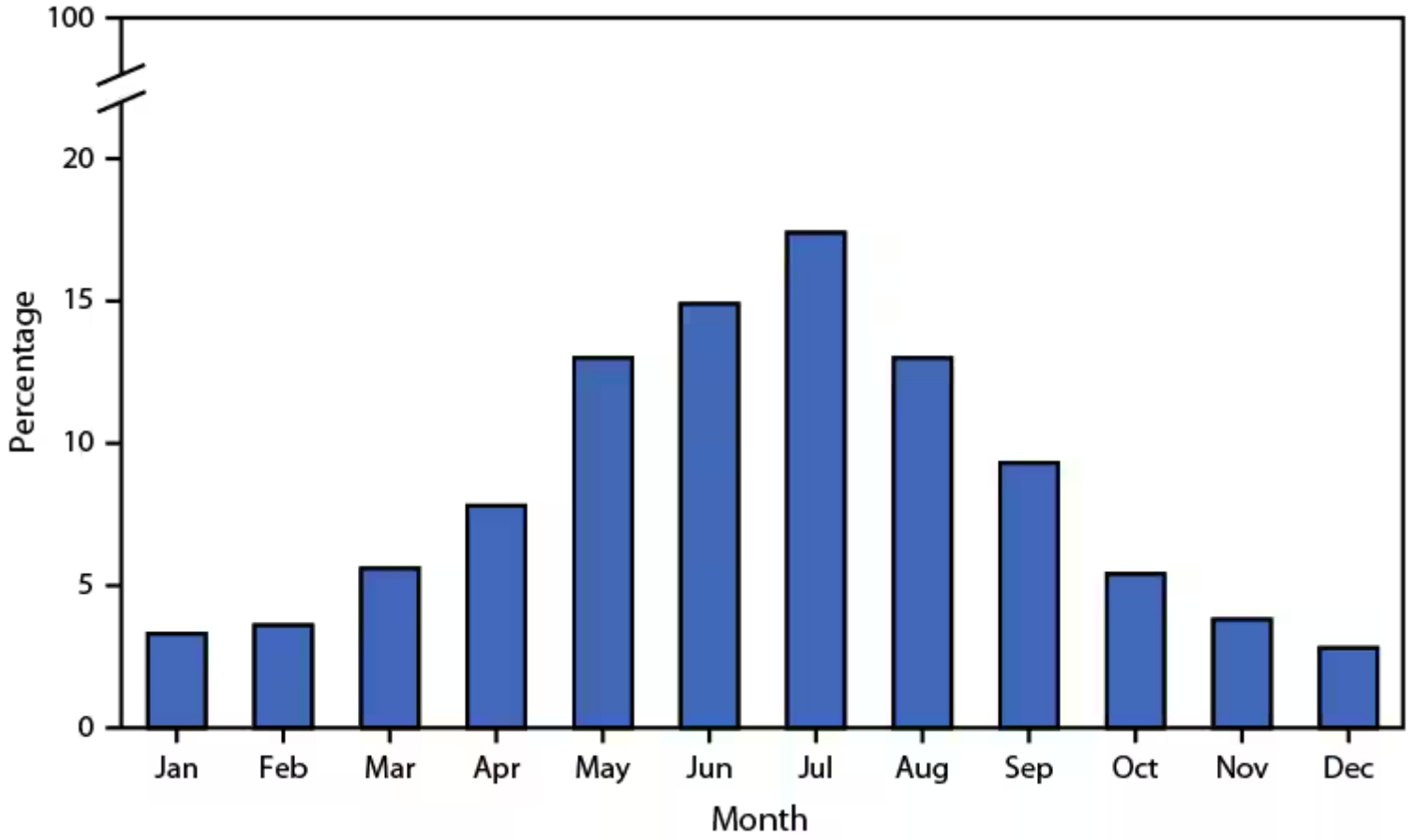
Source: Indiana Department of Natural Resources, 2023

2018-2021 Drowning deaths of children by body of water (n=49)



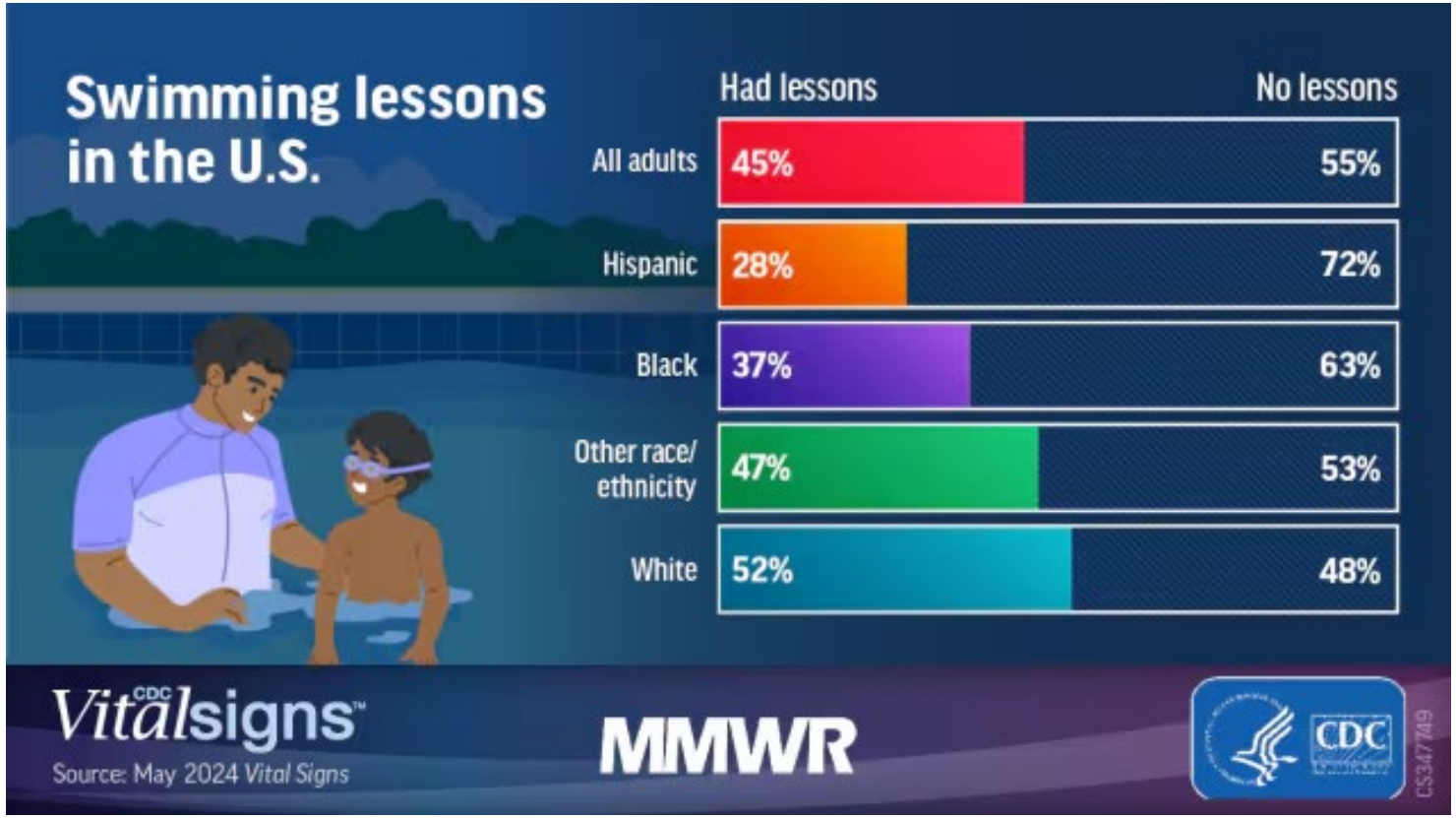
Source: Indiana Department of Health Vital Records, Indiana Department of Health Office of Data and Analytics, 2023

2020-2022 Distribution of deaths involving injuries from watercrafts



Source: National Center for Injury Prevention and Control, CDC, 2024

2019-2023 Swimming lesson participation (self reported)



Source: National Center for Injury Prevention and Control, MMWR, CDC, 2024

Local recommendations for prevention

- Homeowners Associations in neighborhoods with retention ponds, community pools and/or household pools should provide information to families about water safety, including local options for swimming lessons and obtaining flotation devices
- Babysitter courses should provide education about child safety that addresses the differences in risk when swimming in open water versus pools
- Hold a community safety event where local firefighters bring their trucks and gear for children to see and provide water safety information to families
- Partner with local pool businesses and encourage them to provide safety lessons and water safety resources before a purchase of a pool or home installation is completed

Available trainings

W. Water

A. Awareness in

R. Residential

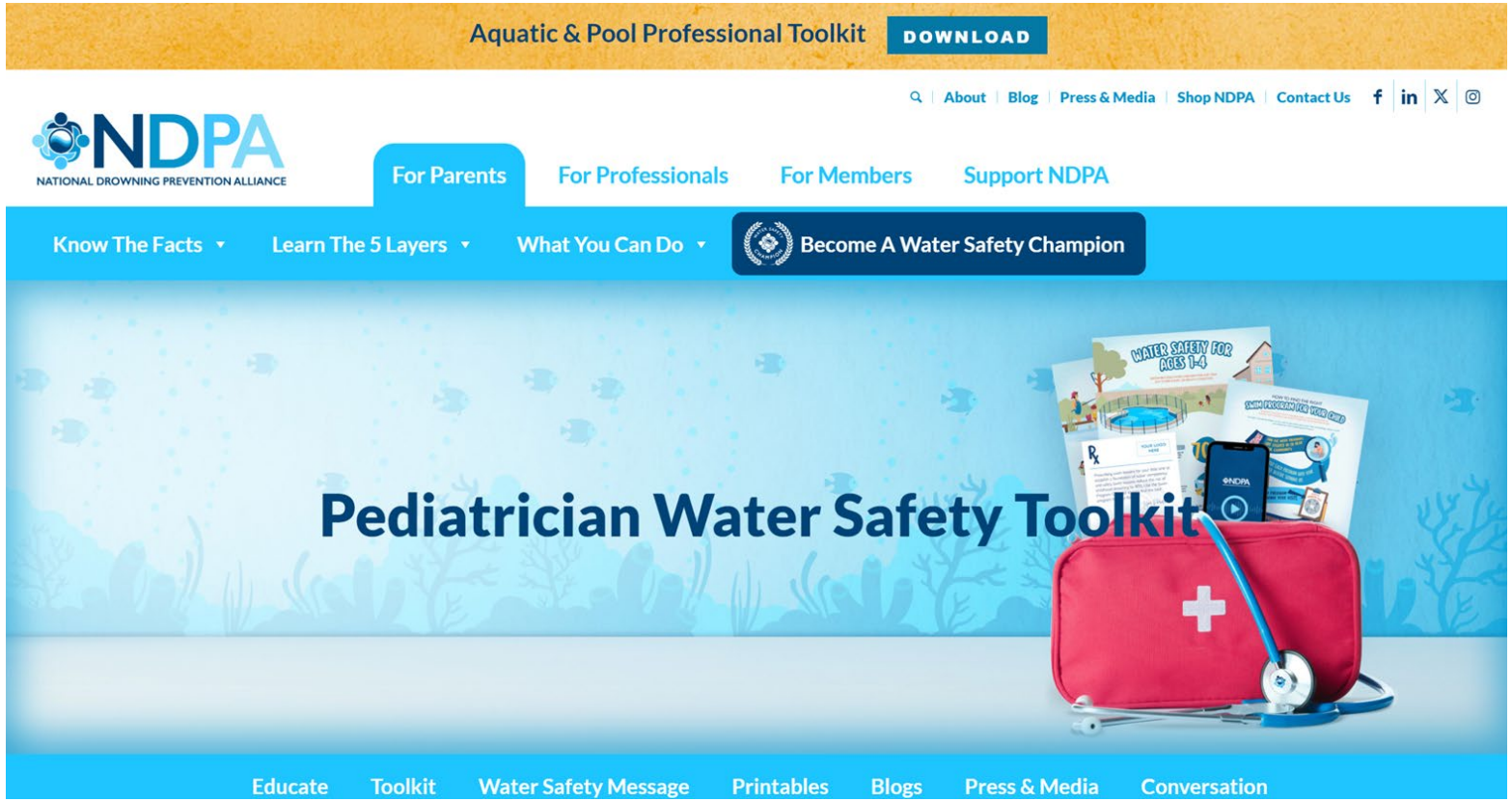
N. Neighborhoods

There are two versions of this training, both of which are available to communities. There is a training for adults and another for children.

The WARN training identifies risk factors and provides safety tips and guidance to prevent drowning fatalities.

Resources for pediatricians

The National Drowning Prevention Alliance has a toolkit for pediatricians with a variety of different resources at no cost.



ndpa.org/pediatrician-toolkit

Water safety next steps

- Connect families with their local health departments for additional resources!
- Have conversations with families about water safety
  - Ask parents if their children have access to a pool
  - Provide families with resources about local swimming lessons
  - Ask families about their water safety plan for when they are at pools, ponds, and other bodies of water
  - Show families how to find more information about water safety

Questions?

Allie Houston
Fatality Prevention Programs Director
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Indiana Department of Health

CLINICIAN UPDATE SCHOOL IMMUNIZATIONS

DAVE McCORMICK
DIRECTOR, IMMUNIZATION DIVISION

05/24/2024

Required and Recommended School Immunizations, Indiana 2024-2025

Indiana Department of Health

Updated 1.30.2024

Grade	Required		Recommended
Pre-K	3 Hepatitis B 4 DTaP (Diphtheria, Tetanus and Pertussis) 3 Polio	1 Varicella (Chickenpox) 1 MMR (Measles, Mumps and Rubella) 2 Hepatitis A	Annual influenza COVID-19
K-5	3 Hepatitis B 5 DTaP 4 Polio	2 Varicella 2 MMR 2 Hepatitis A	Annual influenza COVID-19
6-11	3 Hepatitis B 5 DTaP 4 Polio 2 Varicella	2 MMR 2 Hepatitis A 1 MCV4 (Meningococcal) 1 Tdap (Tetanus, Diphtheria and Pertussis)	Annual influenza 2 or 3 HPV (Human papillomavirus) COVID-19
12	3 Hepatitis B 5 DTaP 4 Polio 2 Varicella	2 MMR 2 Hepatitis A 2 MCV4 1 Tdap	Annual influenza 2 or 3 HPV 2 MenB (Meningococcal) COVID-19

HepB: The minimum age for the third dose of Hepatitis B is 24 weeks of age.

DTaP: Four doses of DTaP/DTP/DT are acceptable if fourth dose was administered on or after the fourth birthday.

Polio*: Three doses of Polio are acceptable for all grade levels if the third dose was given on or after the fourth birthday and at least six months after the previous dose.
*For students in grades K-12, the final dose must be administered on or after the fourth birthday and be administered at least six months after the previous dose.

Varicella: Physician documentation of disease history, including month and year, is proof of immunity for children entering preschool through 12th grade. Parent report of disease history is not acceptable.

Tdap: There is no minimum interval from the last Td dose.

MCV4: Individuals who receive their first dose on or after their 16th birthday only need one dose of MCV4.

Hepatitis A: The minimum interval between first and second dose is six calendar months. Two doses are required for all grade levels.

For additional immunization information, visit: **in.gov/health/immunization**
or call **1 (800) 701-0704** during normal business hours.

Required and Recommended School Immunizations (Proposed) (in.gov)

Indiana Code Requirements

- **IC 20-34-4-2** IDOH will publish a two-year calendar of immunization requirements and recommendations by November 30th each year. The calendar must include immunization requirements for the following year and recommendations for the immunization requirements for the year after the following school year.
- **IC 20-34-4-3** IDOH will provide DOE with educational materials about HPV related illnesses and cancers and the HPV vaccine for dissemination to parents/guardians of all sixth-grade students.
- **IC 20-34-4-4** The parent of any student not fully vaccinated shall present the student to a healthcare provider authorized to administer the immunizations. The healthcare provider shall enter vaccination information into the state immunization data registry per IC 16-38-5-1.
- **IC 20-34-4-5** Students should be fully vaccinated on the first day of school. One 20-day waiver may be granted by the school.
- **IC 20-34-3-3** (Medical exemption) / **IC 20-34-3-2** (Religious objection)

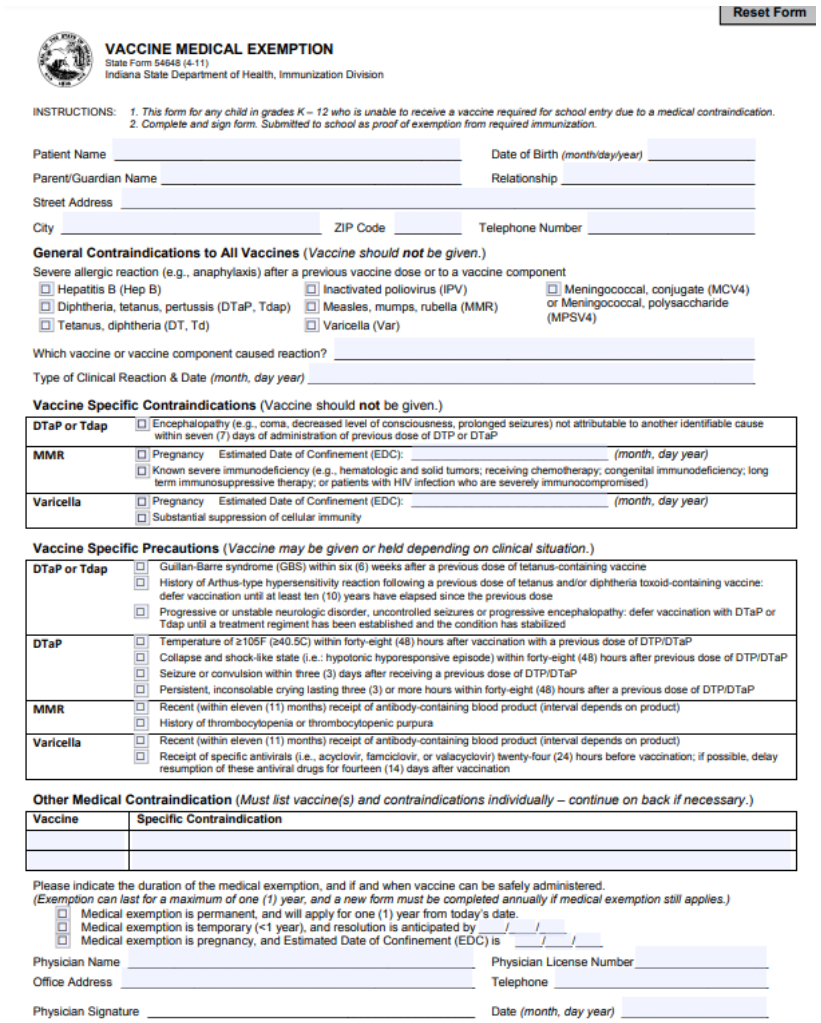
Medical Exemptions/Religious Objections

Medical Exemption (IC 20-34-3-3)

- Vaccine/antigen specific
- Vaccine requirement/recommendation age
- Annual reassessment
- State form 54648 – must have physician signature

Religious Objection (IC 20-34-3-2)

- Vaccine/antigen specific
- Annual reassessment
- No state form – written statement from parent/guardian



Reset Form

VACCINE MEDICAL EXEMPTION
State Form 54648 (4-11)
Indiana State Department of Health, Immunization Division

INSTRUCTIONS: *1. This form for any child in grades K – 12 who is unable to receive a vaccine required for school entry due to a medical contraindication.*
2. Complete and sign form. Submitted to school as proof of exemption from required immunization.

Patient Name _____ Date of Birth *(month/day/year)* _____
Parent/Guardian Name _____ Relationship _____
Street Address _____
City _____ ZIP Code _____ Telephone Number _____

General Contraindications to All Vaccines (*Vaccine should **not** be given.*)
Severe allergic reaction (e.g., anaphylaxis) after a previous vaccine dose or to a vaccine component
☐ Hepatitis B (Hep B)
☐ Diphtheria, tetanus, pertussis (DTaP, Tdap)
☐ Tetanus, diphtheria (DT, Td)
☐ Inactivated poliovirus (IPV)
☐ Measles, mumps, rubella (MMR)
☐ Varicella (Var)
☐ Meningococcal, conjugate (MCV4) or Meningococcal, polysaccharide (MPSV4)

Which vaccine or vaccine component caused reaction? _____
Type of Clinical Reaction & Date *(month, day year)* _____

Vaccine Specific Contraindications (Vaccine should **not** be given.)

DTaP or Tdap	☐ Encephalopathy (e.g., coma, decreased level of consciousness, prolonged seizures) not attributable to another identifiable cause within seven (7) days of administration of previous dose of DTP or DTaP
MMR	☐ Pregnancy Estimated Date of Confinement (EDC): _____ *(month, day year)* ☐ Known severe immunodeficiency (e.g., hematologic and solid tumors; receiving chemotherapy; congenital immunodeficiency; long term immunosuppressive therapy; or patients with HIV infection who are severely immunocompromised)
Varicella	☐ Pregnancy Estimated Date of Confinement (EDC): _____ *(month, day year)* ☐ Substantial suppression of cellular immunity

Vaccine Specific Precautions (*Vaccine may be given or held depending on clinical situation.*)

DTaP or Tdap	☐ Guillan-Barre syndrome (GBS) within six (6) weeks after a previous dose of tetanus-containing vaccine ☐ History of Arthus-type hypersensitivity reaction following a previous dose of tetanus and/or diphtheria toxoid-containing vaccine: defer vaccination until at least ten (10) years have elapsed since the previous dose ☐ Progressive or unstable neurologic disorder, uncontrolled seizures or progressive encephalopathy: defer vaccination with DTaP or Tdap until a treatment regiment has been established and the condition has stabilized
DTaP	☐ Temperature of ≥105F (≥40.5C) within forty-eight (48) hours after vaccination with a previous dose of DTP/DTaP ☐ Collapse and shock-like state (i.e.: hypotonic hyporesponsive episode) within forty-eight (48) hours after previous dose of DTP/DTaP ☐ Seizure or convulsion within three (3) days after receiving a previous dose of DTP/DTaP ☐ Persistent, inconsolable crying lasting three (3) or more hours within forty-eight (48) hours after a previous dose of DTP/DTaP
MMR	☐ Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) ☐ History of thrombocytopenia or thrombocytopenic purpura
Varicella	☐ Recent (within eleven (11) months) receipt of antibody-containing blood product (interval depends on product) ☐ Receipt of specific antivirals (i.e., acyclovir, famciclovir, or valacyclovir) twenty-four (24) hours before vaccination; if possible, delay resumption of these antiviral drugs for fourteen (14) days after vaccination

Other Medical Contraindication (*Must list vaccine(s) and contraindications individually – continue on back if necessary.*)

Vaccine	Specific Contraindication

Please indicate the duration of the medical exemption, and if and when vaccine can be safely administered.
(Exemption can last for a maximum of one (1) year, and a new form must be completed annually if medical exemption still applies.)
☐ Medical exemption is permanent, and will apply for one (1) year from today's date.
☐ Medical exemption is temporary (<1 year), and resolution is anticipated by ___/___/___
☐ Medical exemption is pregnancy, and Estimated Date of Confinement (EDC) is ___/___/___

Physician Name _____ Physician License Number _____
Office Address _____ Telephone _____
Physician Signature _____ Date *(month, day year)* _____

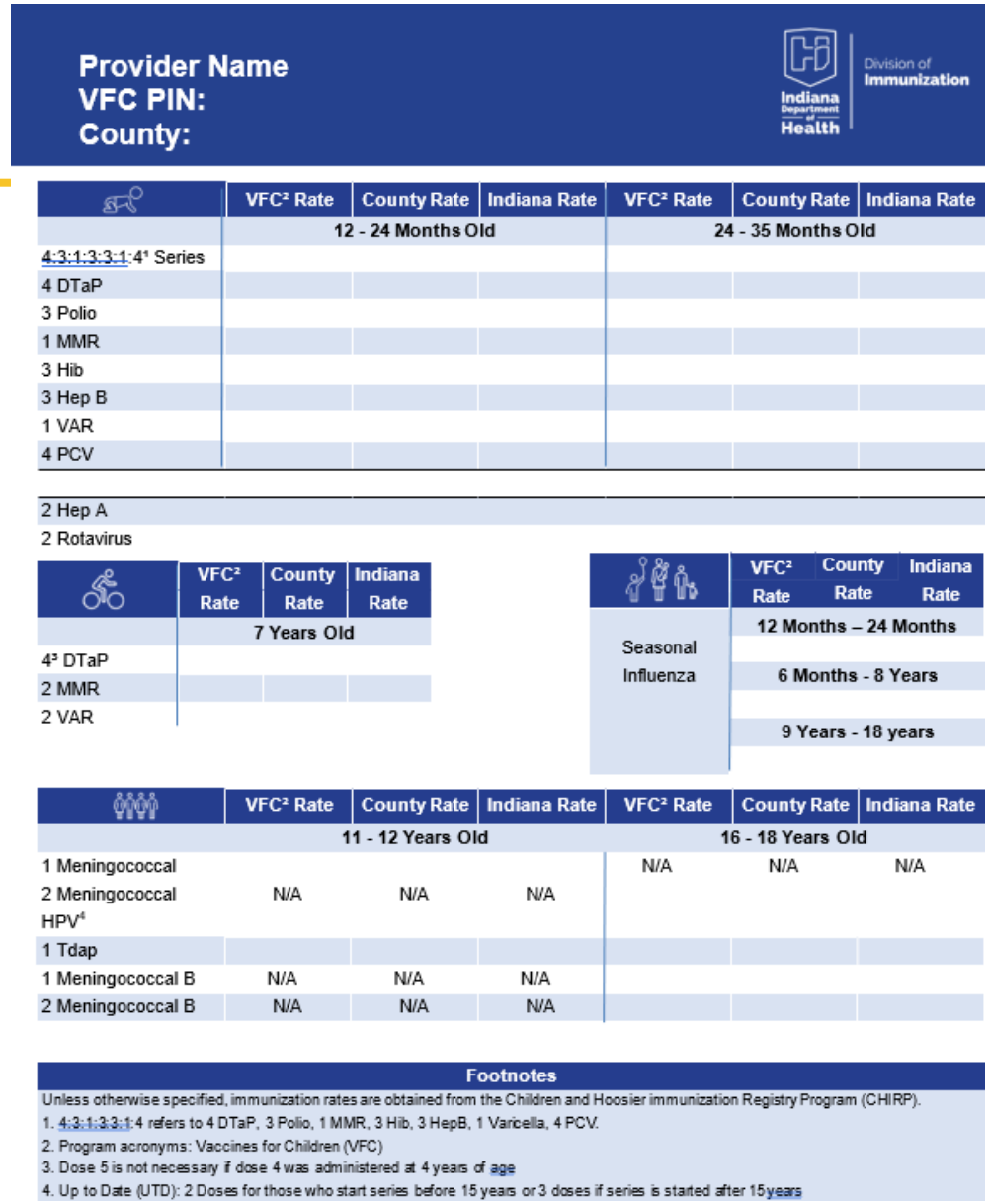
Indiana Department of Health

Start Smart

Indiana's Routine Vaccination Campaign

VFC Coverage Report

- Feedback to providers on coverage rates by practice
- Aligns IQIP, HEDIS, School
- Excellent communication tool
- Data quality measure pilot



Provider Name
VFC PIN:
County:

Indiana Department of Health — Division of Immunization

	VFC² Rate	County Rate	Indiana Rate	VFC² Rate	County Rate	Indiana Rate
	12 - 24 Months Old			24 - 35 Months Old		
4:3:1:3:3:1:4[4] Series						
4 DTaP						
3 Polio						
1 MMR						
3 Hib						
3 Hep B						
1 VAR						
4 PCV						
2 Hep A						
2 Rotavirus						

	VFC² Rate	County Rate	Indiana Rate
	7 Years Old		
4[3] DTaP			
2 MMR			
2 VAR			

	VFC² Rate	County Rate	Indiana Rate
Seasonal Influenza	12 Months – 24 Months		
	6 Months - 8 Years		
	9 Years - 18 years		

	VFC² Rate	County Rate	Indiana Rate	VFC² Rate	County Rate	Indiana Rate
	11 - 12 Years Old			16 - 18 Years Old		
1 Meningococcal				N/A	N/A	N/A
2 Meningococcal HPV[4]	N/A	N/A	N/A			
1 Tdap						
1 Meningococcal B	N/A	N/A	N/A			
2 Meningococcal B	N/A	N/A	N/A			

Footnotes

Unless otherwise specified, immunization rates are obtained from the Children and Hoosier immunization Registry Program (CHIRP).
1. 4:3:1:3:3:1:4 refers to 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 HepB, 1 Varicella, 4 PCV.
2. Program acronyms: Vaccines for Children (VFC)
3. Dose 5 is not necessary if dose 4 was administered at 4 years of age
4. Up to Date (UTD): 2 Doses for those who start series before 15 years or 3 doses if series is started after 15 years

Indiana Department of Health

Questions?

Dave McCormick
Director, Immunization Division
dmccormick@health.in.gov

Indiana Department of Health

LEAD POISONING: 2024 TESTING, REPORTING, AND PROGRAM PRIORITIES

PAUL KRIEVINS
DIRECTOR, LEAD AND HEALTHY HOMES

5/24/2024

Universal Testing Requirement

Effective 1/1/2023, all providers are required to offer testing to the parents of children at the following intervals:

- Within 3 months of the child's 1st birthday AND within 3 months of the child's 2nd birthday
- As soon as possible if the child is under age 7 and does not have a prior blood lead test

Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening requirements match the IDOH universal testing requirement above.

Impact of Universal Testing/Lowered Elevation Threshold

- 60% increase in the number of children tested in ‘23 (40,447 more kids)

- In 2023, 1,862 kids with a confirmed elevated lead level
  - 1,045 with levels in excess of 5.0 µg/dL
  - 817 with levels between 3.5-4.9 µg/dL

- 1,570 new providers (19.2%↑) in 2023 when compared with 2022

Rate of kids tested with 10+ µg/dL went down

Rate of kids tested with any level 3.5+ µg/dL went up

Not Just Old Paint…

- Four confirmed lead cases in 2023 tied to applesauce pouches
- Leaded water line inventory and replacement underway in multiple Indiana communities
- Increasing prevalence of lead in spices (turmeric), imported cosmetics (face cream), and antiques (toy box)

If You're Already Testing

- Medicaid comparison reports available by physician
- Encourage pregnant moms to get tested
- Check CHIRP to make sure your lead tests are being reported to IDOH

If You're Not Testing

- Consider offering in-office testing either through point-of-care or filter paper testing
- Talk with your local health department about referrals for testing. Nearly 70 of 92 counties now offer free lead testing
- A local health department may call you if a child in your care tests high. Please share info and support

IDOH offers free capillary test supplies and lab analysis

Reporting

All blood lead tests, **REGARDLESS OF RESULT,** are required to be reported to IDOH within one week after receiving the result

- For more information on reporting requirements please check out our website
- Any result above 3.5 µg/dL will go to the child's local health department. They will help encourage re-testing, provide nurse support as needed, and provide in-home environmental testing as appropriate.
- This requirement applies to any provider, reference lab, or testing lab that touches a blood lead test.
  - *Please don't assume someone else is sending in the result*

Indiana Department of Health

Questions?

Paul Krievins
Division Director, Lead and Healthy Homes
pkrievins@health.in.gov

Useful Resources

Indiana Department of Health

Free HIV, HCV, Syphilis testing at Walgreens - June 27

https://www.greaterthan.org/free-testing-nhtd-2024/

Clinician Consultation Funded by HRSA

NATIONAL CLINICIAN CONSULTATION CENTER

- The National Clinician Consultation Center provides rapid expert consultation and advice on management of HIV/AIDS, perinatal HIV, pre-exposure prophylaxis, and post-exposure prophylaxis management for HIV and hepatitis B and C.
- The clinical consultants are HIV-treatment experienced physicians, clinical pharmacists, nurses, and NPs from the University of California, San Francisco.
- Sponsored by HRSA, CDC, and UCSF

Clinician Consultation | National Clinician Consultation Center (ucsf.edu)

Infectious Diseases of Public Health Importance

Indiana Department of Health

Syphilis CALL TO ACTION!

IDOH Congenital Syphilis Task Force toolkit – Recommendations went live 5/1

- Perform syphilis testing on all patients upon finding a positive pregnancy test
- Test all pregnant patients three times during pregnancy (at initial prenatal visit, again at 28-32 weeks of gestation, and then at delivery)
- Meet people where they are with syphilis testing and treatment outside of settings in which pregnant patients are typically encountered. This could include emergency departments, urgent cares, primary care visits, jail/prison intake, local health departments, community programs, and addiction programs.
- Perform screening and treatment of all sexually active women and their partners for syphilis in counties with high syphilis rates
- Perform screening and appropriate treatment for those with other risk factors for syphilis (have unprotected sex and do not use condoms or do not use them correctly, have multiple sex partners, have a sex partner who has syphilis and have sex with a partner who has multiple sex partners)
- Treat all pregnant women who are infected with syphilis immediately upon diagnosis, according to their clinical stage of infection. Treatment must be with penicillin G benzathine (Bicillin LA)

https://on.in.gov/CongenitalSyphilisToolkit

Congenital and Adult Syphilis Toolkit

Health: Congenital and Adult Syphilis Toolkit (in.gov)

Increased Syphilis Testing and Treatment

Interpretation of Syphilis Serology

Adult Syphilis Clinical Staging and Treatment

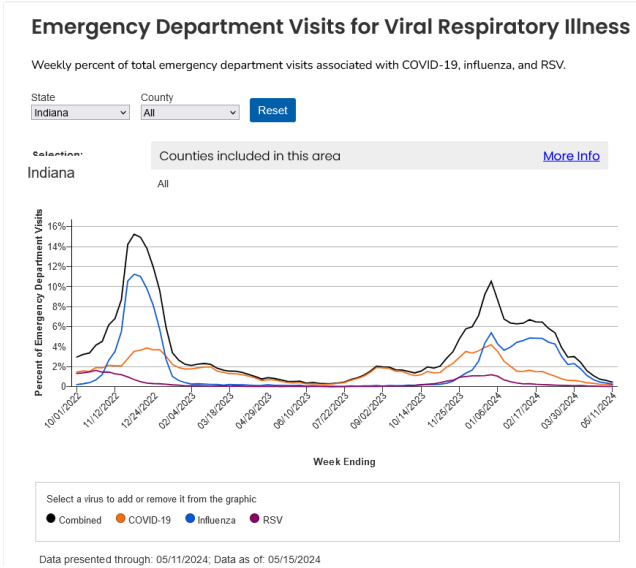
Syphilis During Pregnancy and Congenital Syphilis

Congenital Syphilis Evaluation and Treatment Algorithm

Respiratory infections

As of reporting on Friday, May 17, 2024

- The amount of respiratory illness (fever plus cough or sore throat) causing people to seek healthcare is low nationally. This week, no jurisdictions experienced moderate, high, or very high activity.
- Nationally, emergency department visits with diagnosed COVID-19, influenza, and RSV are at low levels.
- Nationally, influenza test positivity decreased and RSV and COVID-19 test positivity remained stable at low levels compared to the previous week.



Indiana Department of Health

Respiratory Virus Activity Levels (cdc.gov)

Respiratory Syncytial Virus (RSV) Vaccine Administration Errors in Infants and Young Children

A recent CDC study published in Pediatrics showed:

- Between August 2023 and March 2024, VAERS received 34 reports of adult RSV vaccines (approved for aged 60 and older) given to children aged 2 years or younger.
  - Most error reports did not describe an adverse event

Healthcare providers and facilities should ensure use of the correct RSV prevention product in the correct population and take actions to prevent vaccine administration errors with measures such as

- automating error prevention alerts in electronic health record systems
- ensuring proper education and training on vaccine recommendations,
- paying close attention to labeling, and
- following proper storage and administration best practices.

Healthcare providers are encouraged to report vaccine administration errors to VAERS.

COVID-19 Therapeutics Reporting

- Please report the status of all **HHS-distributed COVID-19 therapeutics by June 30**, to close the ASPR COVID-19 therapeutics distribution program for non-federal entities
- HHS-distributed therapeutics reporting, including monoclonal antibodies and oral antivirals, is required until all product received has been accounted for as administered, transferred, wasted, or returned
- For non-expired oral antivirals, this reconciliation may also include on-hand inventory that has not yet been dispensed
- Please confirm the status of all therapeutics in HPOP
- If you have any questions, please reach out to Joe Branam at jbranam@health.in.gov

NHSN reporting changes

Effective May 1, hospitals are no longer required to report Hospital Respiratory Pathogen, Bed Capacity, and Supply Data (i.e., 'COVID-19 Hospital' data) to HHS through NHSN.

The COVID-19-related data reporting is important in supporting surveillance of, and response to, COVID-19 and other respiratory illnesses. Given the value of these data for patient safety and public health, CDC strongly encourages ongoing, voluntary reporting of the data through NHSN.

COVID-19 Hospital Data Reporting | NHSN | CDC

Highly Pathogenic Avian Influenza (HPAI)

Indiana Department of Health

HPAI update

- As of 5/23/24, 58 dairy herds affected in 9 states.
  - Indiana has **NOT** had any cows affected in our state
- Human infection risk remains **LOW**
  - Michigan human case
    - Mild illness with conjunctivitis. Patient was undergoing symptom monitoring due to exposure to ill cow.
  - Australia human case
    - Pediatric case following exposure to birds in India. **Genetically different** than what has been seen in the United States (case was due to South Asian clade known to circulate in India and Bangladesh)
- Based on current evidence from FDA, the **commercial pasteurized milk supply is considered safe** because the pasteurization process is effective in killing H5N1 bird flu.

Recommendations if Suspecting Avian Flu

1. Confirm if patient has symptoms consistent with avian influenza, including respiratory symptoms, conjunctivitis, or gastrointestinal symptoms.
   - REMINDER - fever may not be present for someone with avian flu and/or conjunctivitis may be the only symptom reported
2. Ask patients if they have had any exposure to poultry, cattle, or other farm animals and/or their environments including attending a fair or animal exhibition.
3. If signs/symptoms and exposure are compatible with avian influenza infection:
   - Isolate patient and follow infection control recommendations
   - Collect appropriate specimen for testing at IDOH Lab
     - CDC – Specimen Collection and Testing for Patients with Novel Influenza A Viruses
   - Initiate empiric antiviral treatment as soon as possible
   - Notify IDOH – Normal business hours: 317-233-7125; After Hours/Weekends: 317-233-1325

IDOH Influenza Surveillance

Influenza surveillance occurs year-round in Indiana, and we actively take part in the following activities during the summer months:

- Syndromic Surveillance Monitoring (i.e., emergency departments and urgent cares)
- Maintaining the IDOH Influenza Dashboard (updating weekly)
- Maintaining close working relationships with our animal health partners
- Updating and publishing educational materials regarding influenza and animals
- Reaching out to hospitals, labs, and healthcare providers to submit influenza positive specimens to IDOH Laboratory for subtyping
  - **Asking that clinicians submit ANY influenza positive specimens to IDOH Laboratory for subtyping throughout the summer**

Readout of CDC Call with State Public Health Partners on H5N1 Influenza Monitoring

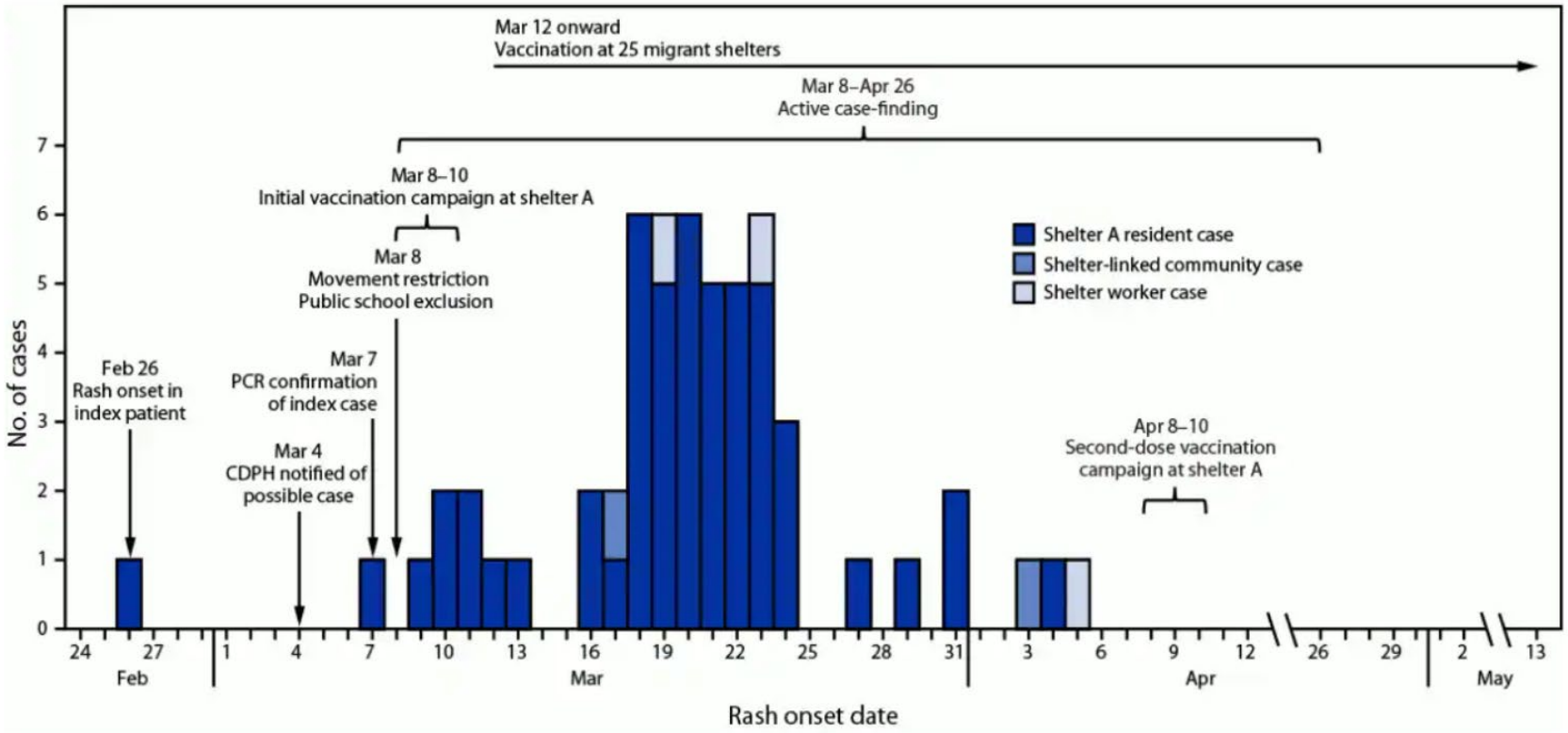
Measles

Indiana Department of Health

Measles Outbreak in a Migrant Shelter in Chicago

Measles is a highly infectious, vaccine-preventable disease. Fifty-seven measles cases were associated with residence in or contact with persons in a migrant shelter in Chicago, Illinois. Most cases occurred in unvaccinated persons.

FIGURE. Measles cases associated with a migrant shelter (shelter A),* by rash onset date† and public health interventions§ — Chicago, Illinois, February 26–May 13, 2024



Abbreviations: CDPH = Chicago Department of Public Health; PCR = polymerase chain reaction.

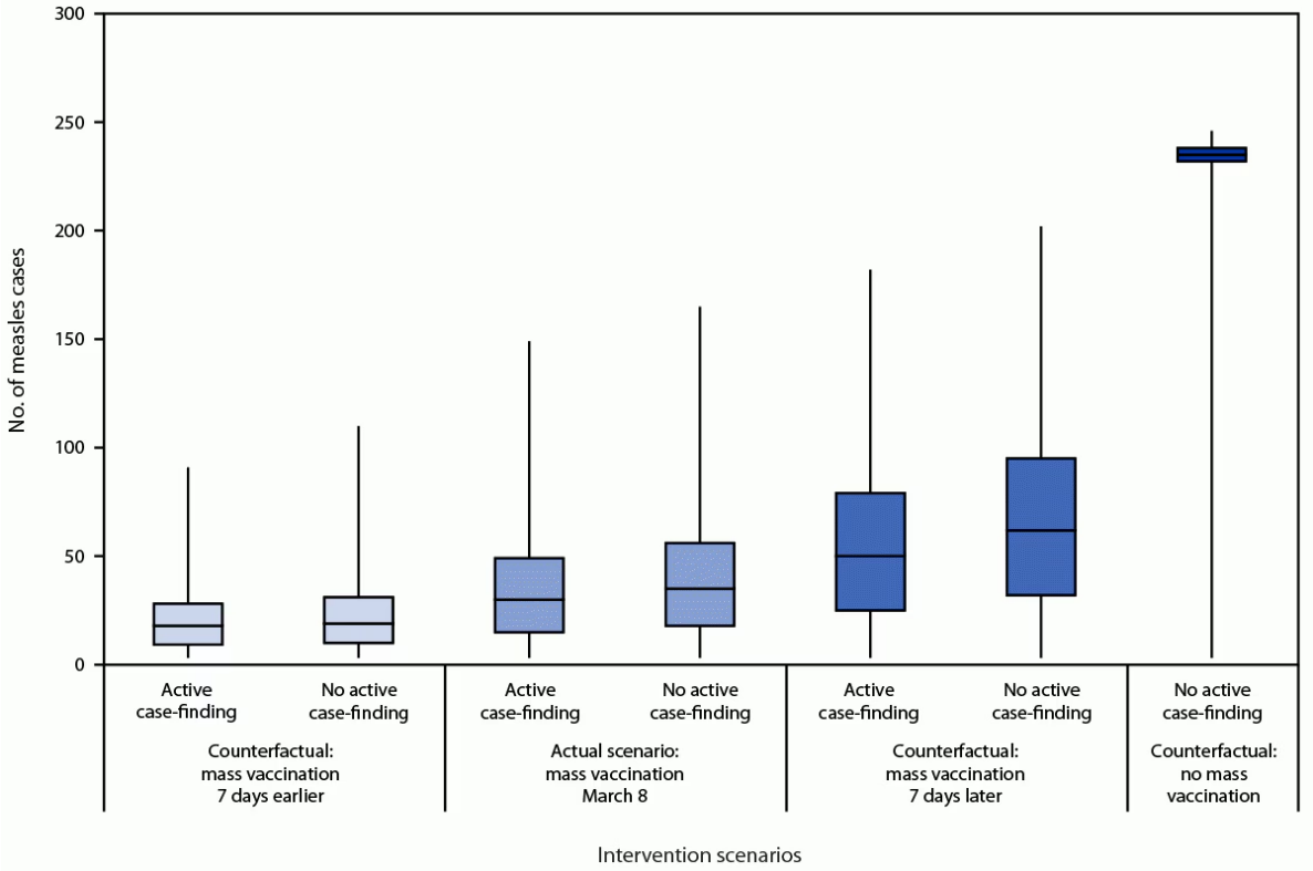
Indiana Department of Health

[Measles Outbreak Associated with a Migrant Shelter — Chicago, Illinois, February–May 2024 | MMWR (cdc.gov)]

Measles Outbreak in a Migrant Shelter in Chicago

CDC developed dynamic models of shelter residents in real time to produce forecasts and assess the impact of interventions on outbreak size and duration.

These models aided expectation-setting and resource planning and underscored the need for vaccination campaigns.



Indiana Department of Health

Real-Time Use of a Dynamic Model To Measure the Impact of Public Health Interventions on Measles Outbreak Size and Duration — Chicago, Illinois, 2024 | MMWR (cdc.gov)

Measles Reporting - Indiana

Measles_Reporting-Guidance.pdf

Reportable Condition Reporting Guidance

Indiana Department of Health — Infectious Disease Epidemiology & Prevention Division

Condition Name:

Measles (Rubeola)

Condition Name in NBS:

Measles (Rubeola)

Reporting Timeframe:

Immediately

TO REPORT:

Step 1: Call **317-233-7125**

317-233-1325 (After hours)

Step 2:

- NBS users: Report conditions via Morbidity Report in **NBS**
- Non-NBS users: Report with **this** form

Associated Reportable Laboratory Results

- Measles virus identified by culture or PCR.
- IgG seroconversion or a significant rise in measles immunoglobulin G antibody.
- Positive serologic test for measles immunoglobulin M (IgM) antibody.

Condition Specific Reporting Details

- Clinical, Epidemiologic, Lab Report, and Treatment information sections within the NBS Morbidity Report.

Additional Documentation to Include

- Relevant clinical notes, if available.

For more information on Measles (Rubeola) please visit:

https://www.in.gov/health/idepd/diseases-and-conditions-resource-page/measles/

For more information on reportable conditions: https://www.in.gov/health/erc/infectious-disease-epidemiology/infectious-disease-epidemiology/communicable-disease-reporting/

Indiana Department of Health

Updated: June 2023

Mpox updates

MMWR on Effectiveness of Jynneos in the real world:

- Mpox virus infection after receipt of 2 JYNNEOS doses is estimated to have occurred in <1% of fully vaccinated persons and comprises a small proportion of national cases
- Among those who experienced infection after having received a complete 2-dose series and for whom complete data were available, infections have been milder than those among unvaccinated persons
- Disparate time intervals from vaccination to infection among fully vaccinated individuals suggest that immunity is not waning

MMWR on Mpox trends:

- The global mpox outbreak began in 2022
- At peak in 2022, approximately 3,000 cases per week were reported
- Then cases declined sharply and remain significantly lower (approximately 59 reported cases per week during October 1, 2023–April 30, 2024)
- Most new mpox cases occur in unvaccinated patients

Infections to Consider in the Context of Travel

- Democratic Republic of the Congo: clade I mpox- more virulent than clade II U.S. Preparedness and Response to Increasing Clade I Mpox Cases in the Democratic Republic of the Congo — United States, 2024 | MMWR (cdc.gov)
- Afghanistan and Pakistan are the remaining countries with endemic transmission of wild poliovirus (WPV); however, multiple countries and regions are experiencing circulating vaccine-derived poliovirus (cVDPV) outbreaks (8 new countries in 2023 compared to 2022). Progress Toward Poliomyelitis Eradication — Worldwide, January 2022–December 2023 | MMWR (cdc.gov)
- Medical Tourism: Extrapulmonary *Mycobacterium abscessus* subspecies *massiliense* Infections from Stem Cell Treatment Clinics in Mexico- Three cases have been reported (AZ and CO)Notes from the Field: Potential Outbreak of Extrapulmonary Mycobacterium abscessus subspecies massiliense Infections from Stem Cell Treatment Clinics in Mexico — Arizona and Colorado, 2022 | MMWR (cdc.gov)
- Dengue fever if traveling to Puerto Rico. N= 964 cases since Jan 1, above epidemic threshold level for 15 weeks. DENV-1 was predominant in 2023, DENV-2 and 3 this year so far. PR declared PHE due to Dengue on 3/25/24 Dengue: global epi and the latest in vaccines and other prevention tools (informz.net)

Infections to Consider in the Context of Travel

- Since April 2024, 12 cases of meningococcal disease linked to Kingdom of Saudi Arabia travel for Umrah have been reported to national public health agencies in the United States (5 cases), France (4 cases), and the United Kingdom (3 cases). Ten cases were caused by Neisseria meningitidis serogroup W (NmW), one U.S. case was caused by serogroup C (NmC), and the serogroup is unknown for one U.S. case. Of nine patients with known vaccination status, all were unvaccinated. Meningococcal Disease Cases Linked to Travel to the Kingdom of Saudi Arabia (KSA): Ensure Pilgrims are Current on Meningococcal Vaccination (cdc.gov)
- Approximately 2,000 malaria cases are imported into the United States annually, mostly among U.S. residents with recent travel to areas with endemic malaria. In 2023, reports of imported malaria in three U.S. southern border jurisdictions increased from cases reported in 2022. Enhanced case investigations documenting traveler residency indicated higher percentages of malaria infections among new arrivals to the United States who traveled through at least one country with endemic malaria, including crossing land borders. Notes from the Field: Increases in Imported Malaria Cases — Three Southern U.S. Border Jurisdictions, 2023 | MMWR (cdc.gov)

Other Public Health Updates

Indiana Department of Health

USPSTF
Updated Breast Cancer Screening Recommendations

Summary of Recommendations

Population	Recommendation	Grade
Women aged 40 to 74 years	The USPSTF recommends biennial screening mammography for women aged 40 to 74 years.	B
Women 75 years or older	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women 75 years or older.	I
Women with dense breasts	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of supplemental screening for breast cancer using breast ultrasonography or magnetic resonance imaging (MRI) in women identified to have dense breasts on an otherwise negative screening mammogram.	I

See the "Practice Considerations" section for more information on the patient population to whom this recommendation applies and on screening mammography modalities. USPSTF indicates US Preventive Services Task Force.

See the Summary of Recommendations figure.

Indiana Department of Health

[Screening for Breast Cancer: US Preventive Services Task Force Recommendation Statement | Breast Cancer | JAMA | JAMA Network]

[Recommendation: Breast Cancer: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)]

Smoking During Perinatal Period

- In 2021, among women with a recent live birth,
  - 12.1% reported smoking before pregnancy,
  - 5.4% reported smoking during pregnancy, and
  - 7.2% reported smoking during the postpartum period.
- Smoking behaviors varied by demographic characteristics and jurisdiction.
- Overall, 73.7% of women reported being asked about smoking by a health care provider at any health care visit before pregnancy. That rate jumps to 93.7% at any prenatal visit, and down to 57.3% at a postpartum checkup.

Indiana Department of Health

[Cigarette Smoking Among Pregnant Women During the Perinatal Period: Prevalence and Health Care Provider Inquiries — Pregnancy Risk Assessment Monitoring System, United States, 2021 | MMWR (cdc.gov)]

Quit Now Indiana

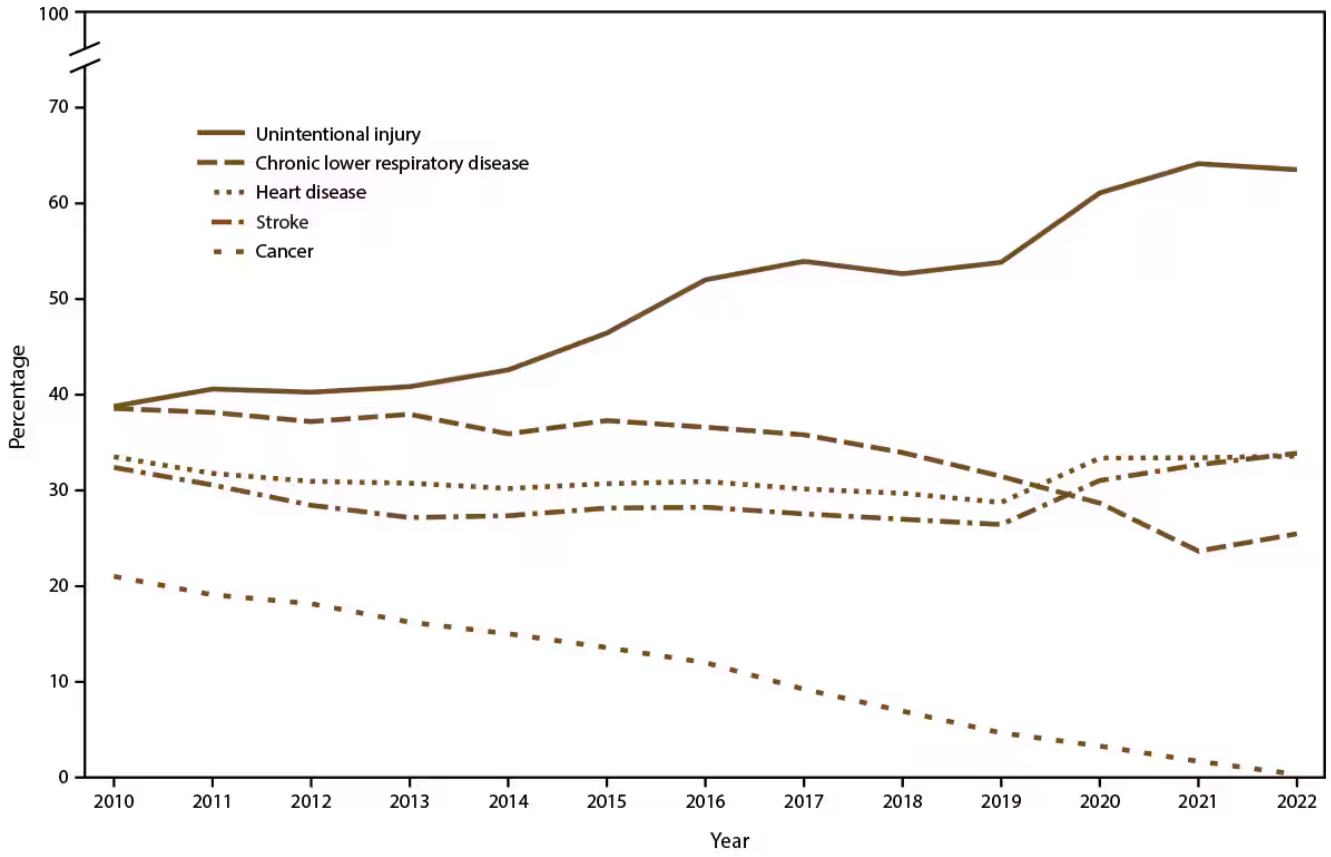
- One-on-one coaching for people who have decided to quit
- Resources for Healthcare Providers who want to improve patient outcomes
- Best Practices for Employers who want to implement smoke-free policies
- Support for Family and Friends who want to help loved ones stop smoking
- Tools for Tobacco Control partners to complement their current programs

- Provider resources You Can Help — Quit Now Indiana
- Free educational materials Educational Materials — Quit Now Indiana
- Referring patients to Quit Now Indiana is simple and effective. You Can Help — Quit Now Indiana

Preventable Premature Deaths from the Five Leading Causes of Death in Nonmetropolitan and Metropolitan Counties, United States, 2010–2022

During 2010–2022, the percentage of preventable premature deaths among persons aged <80 years in the United States

- increased for unintentional injury and stroke,
- decreased for cancer and chronic lower respiratory disease (CLRD), and
- remained stable for heart disease.



Indiana Department of Health

Preventable Premature Deaths from the Five Leading Causes of Death in Nonmetropolitan and Metropolitan Counties, United States, 2010–2022 | MMWR (cdc.gov)

Preventable Premature Deaths from the Five Leading Causes of Death in Nonmetropolitan and Metropolitan Counties, United States, 2010–2022

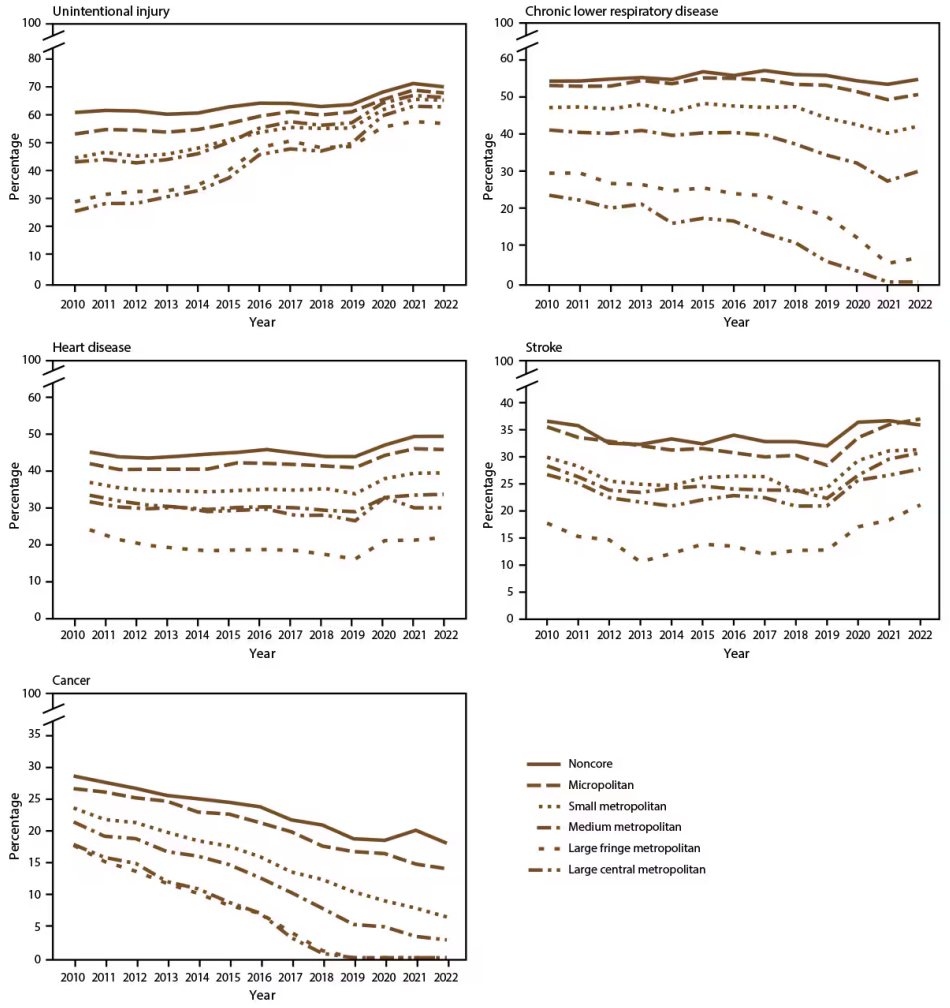
- The percentages of preventable premature deaths from the five leading causes of death were higher in rural counties in all years during 2010–2022.

Indiana Department of Health

Preventable Premature Deaths from the Five Leading Causes of Death in Nonmetropolitan and Metropolitan Counties, United States, 2010–2022 | MMWR (cdc.gov)

Preventable Premature Deaths from the Five Leading Causes of Death in Nonmetropolitan and Metropolitan Counties, United States, 2010–2022

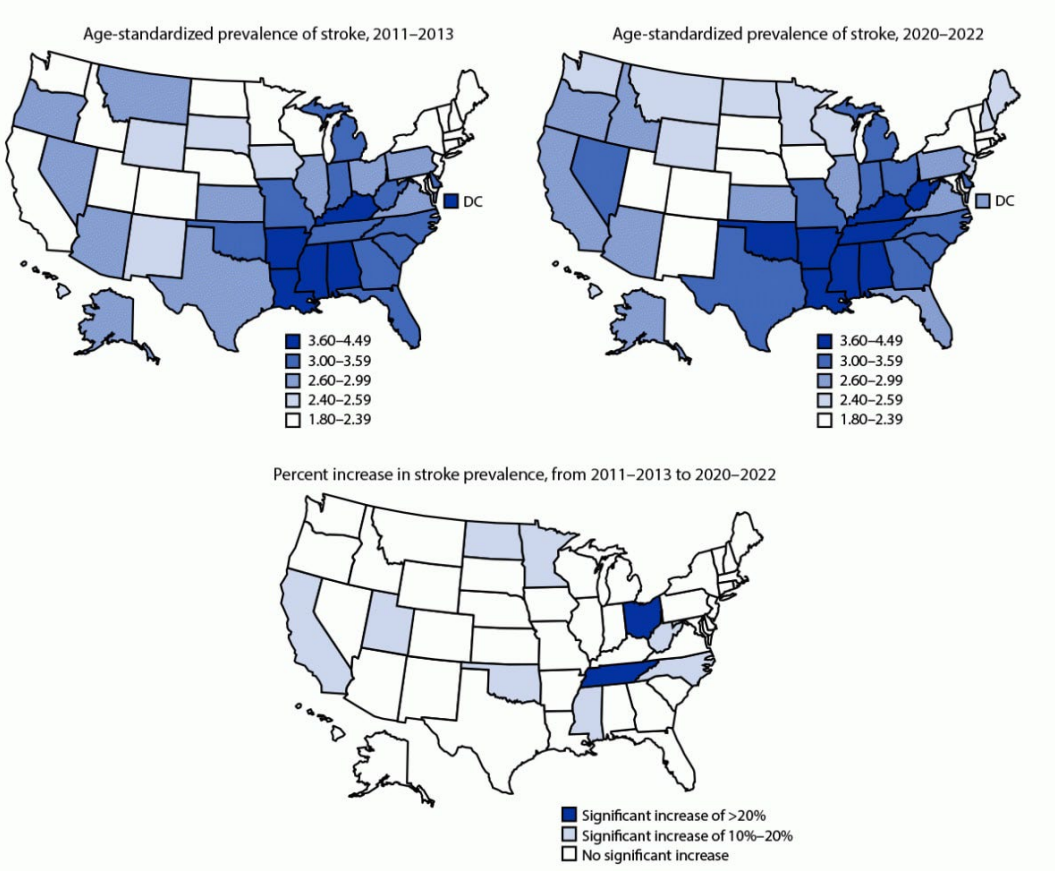
- During 2010–2022, preventable premature deaths from heart disease increased most in noncore (+9.5%) and micropolitan counties (+9.1%) and decreased most in large central metropolitan counties (–10.2%).
- The gap between the most rural and most urban counties for preventable premature deaths increased during 2010–2022 for four causes of death (cancer, heart disease, chronic lower respiratory disease, and stroke) and decreased for unintentional injury.



Indiana Department of Health

[Preventable Premature Deaths from the Five Leading Causes of Death in Nonmetropolitan and Metropolitan Counties, United States, 2010–2022 | MMWR (cdc.gov)]

Prevalence of Stroke



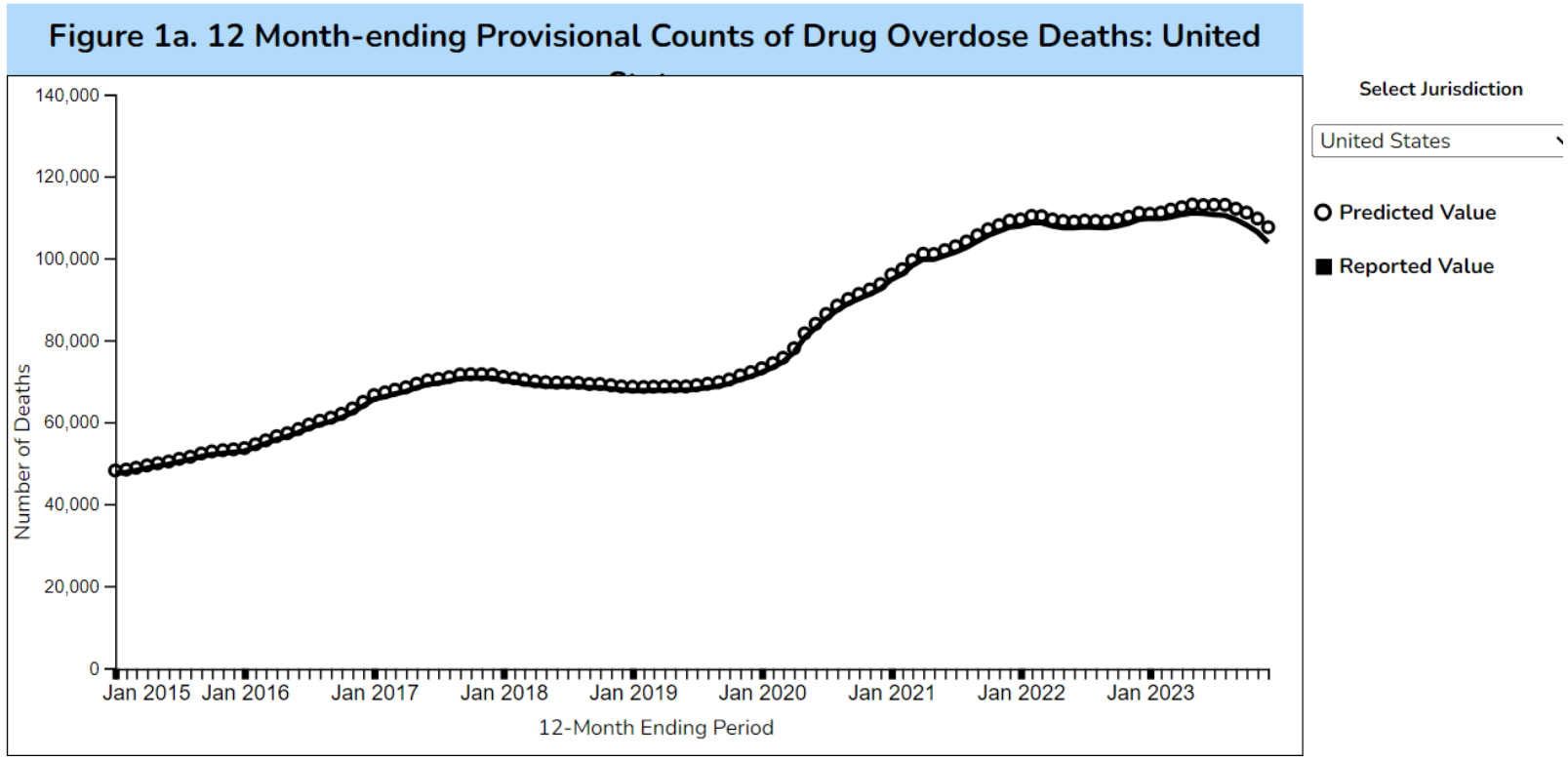
- During 2006–2010, stroke prevalence decreased by 3.7%.
- From 2011–2013 to 2020–2022, U.S. stroke prevalence increased by 7.8%.
    - Stroke prevalence decreased in the District of Columbia and increased in 10 states.
    - It was up in IN by 8.3%

Indiana Department of Health

[Prevalence of Stroke — Behavioral Risk Factor Surveillance System, United States, 2011–2022 | MMWR (cdc.gov)]

Provisional Drug Overdose Death Counts

Based on data available for analysis on: May 5, 2024



Indiana Department of Health

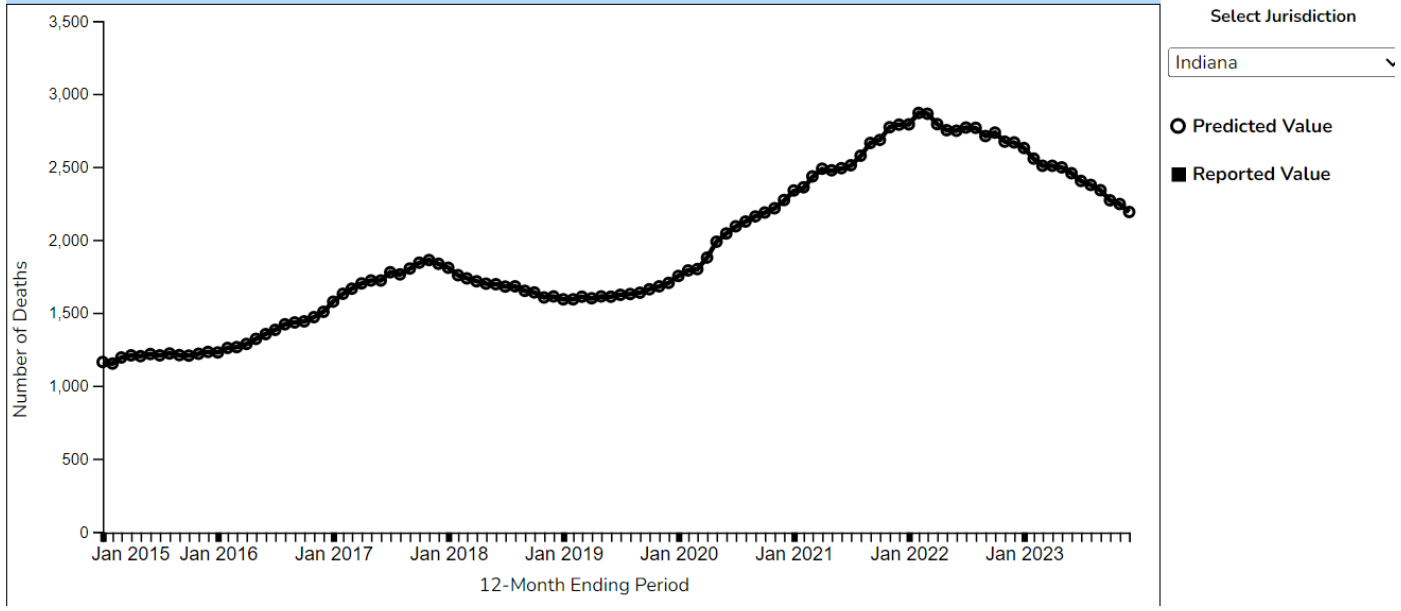
[Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov)]

Provisional Drug Overdose Death Counts

12 Month-ending Provisional Number and Percent Change of Drug Overdose Deaths

Based on data available for analysis on: May 5, 2024

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: Indiana



Indiana Department of Health

[Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov)]

Provisional Drug Overdose Death Counts

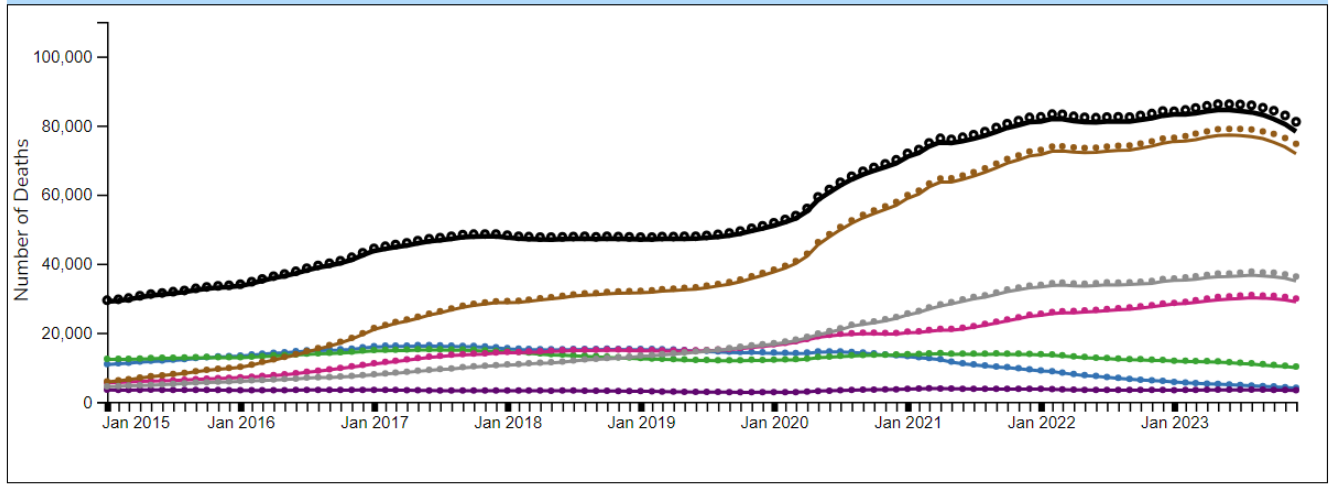
Based on data available for analysis on: May 5, 2024

*After opening the **drug class dropdown**, click the top of the dropdown menu again to make the checkboxes disappear.*

Select Jurisdiction: United States

Select specific drugs or drug classes: Select drug class

Figure 2. 12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class: United States



Legend for Drug or Drug Class

- Cocaine (T40.5)
- Heroin (T40.1)
- Methadone (T40.3)
- Natural & semi-synthetic opioids (T40.2)
- Opioids (T40.0-T40.4,T40.6)
- Psychostimulants with abuse potential (T43.6)
- Synthetic opioids, excl. methadone (T40.4)

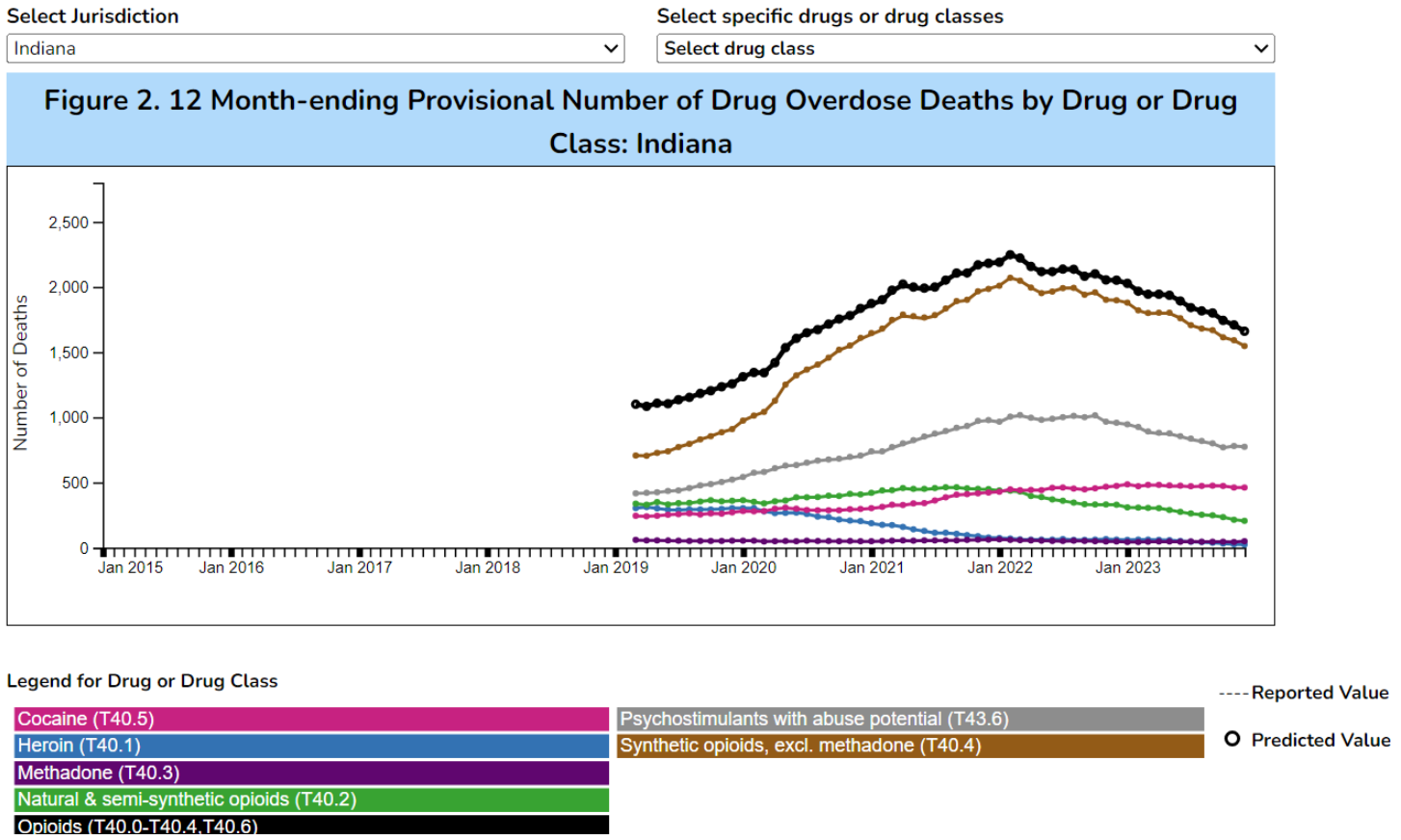
---- Reported Value

O Predicted Value

Indiana Department of Health

[Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov)]

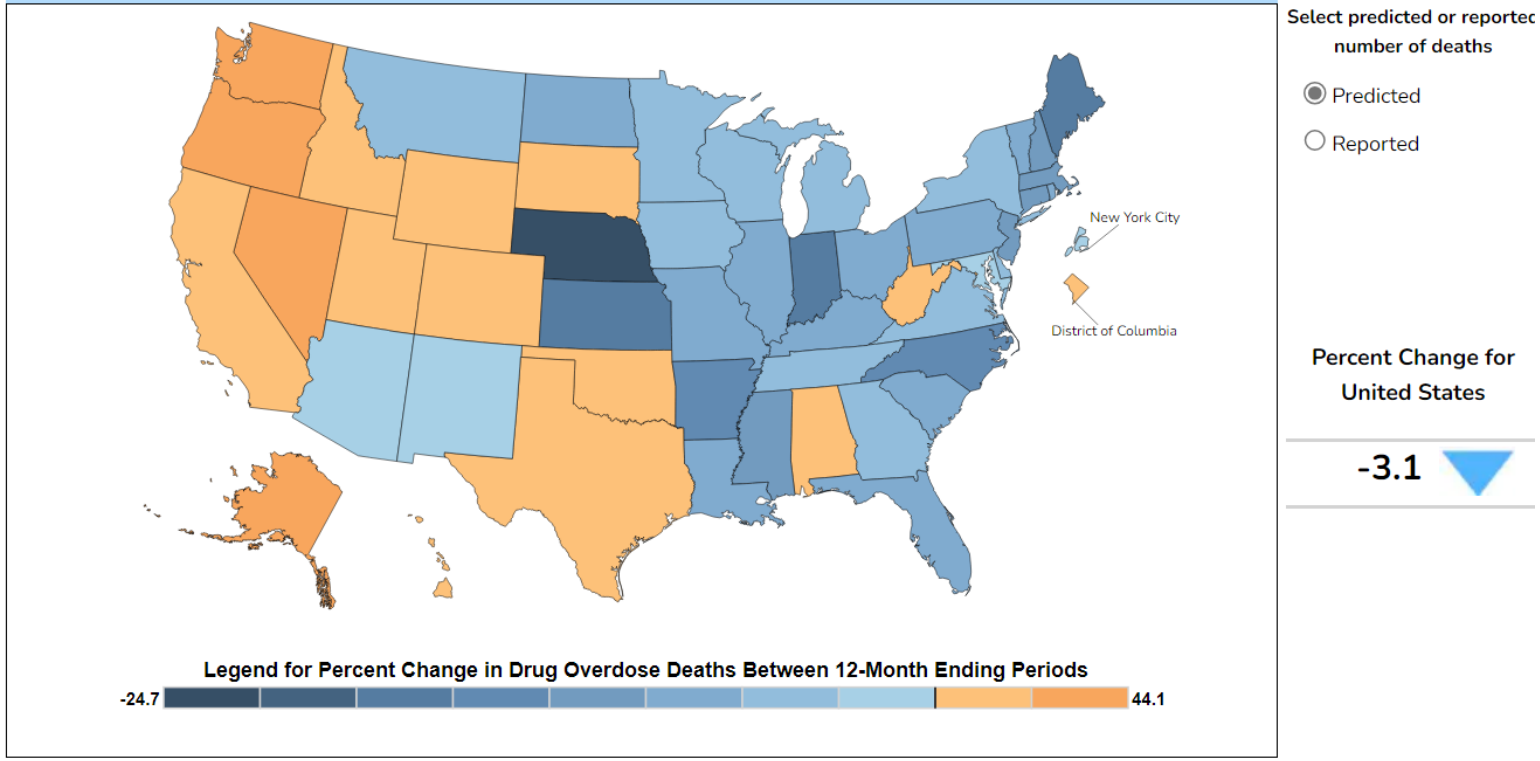
Provisional Drug Overdose Death Counts



Indiana Department of Health

Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov)

Figure 1b. Percent Change in Predicted 12 Month-ending Count of Drug Overdose Deaths, by Jurisdiction: December 2022 to December 2023



NOTES: *Reported* provisional counts for 12-month ending periods are the number of deaths received and processed for the 12-month period ending in the month indicated. Drug overdose deaths are often initially reported with no cause of death (pending investigation), because they require lengthy investigation, including toxicology testing. Reported provisional counts may not include all deaths that occurred during a given time period. Therefore, they should not be considered comparable with final data and are subject to change. *Predicted* provisional counts represent estimates of the number of deaths adjusted for incomplete reporting (see **Technical Notes**). Deaths are classified by the reporting jurisdiction in which the death occurred. Percent change refers to the relative difference between the reported or predicted provisional numbers of deaths due to drug overdose occurring in the 12-month period ending in the month indicated compared with the 12-month period ending in the same month of the previous year. Drug overdose deaths are identified using ICD–10 underlying cause-of-death codes: X40–X44, X60–X64, X85, and Y10–Y14.

Products - Vital Statistics Rapid Release - Provisional Drug Overdose Data (cdc.gov)

Ways to connect with us

- Access our webpage with resources for clinicians
- Please let us know what topics you'd like us to cover: Email svuppalanchi@health.in.gov or Gcrowder@health.in.gov
- Sign up for IHAN– Indiana Health Alert Network https://ihan-in.org
- Health: Long Term Care/Nursing Homes: Newsletters
- MARK YOUR CALENDARS - Clinician webinars for 2024: June 28, July 26, Aug. 23, Sept. 27, Oct. 25, Nov. 22, Dec. 27

For more information

The supplemental information section covers other topics to refer to on your own:

- Pivya (pivmecillinam) tablets for the treatment of female adults with uncomplicated urinary tract infections (UTIs) caused by susceptible isolates of Escherichia coli, Proteus mirabilis and Staphylococcus saprophyticus.
- Increasing Numbers of Nontoxigenic C. diphtheriae cases
- Additional Related Recalls of Saline and Sterile Water Medical Products Associated with Nurse Assist
- Multistate Outbreak of E. coli Infections Linked to Organic Walnuts
- Shiga Toxin–Producing Escherichia coli O157:H7 Illness Outbreak Associated with Untreated, Pressurized, Municipal Irrigation Water — Utah, 2023
- Prevalence of Positive Childhood Experiences Among Adults — Behavioral Risk Factor Surveillance System, Four States, 2015–2021
- Outbreak of Human Trichinellosis due to consumption of undercooked meat — Arizona, Minnesota, and South Dakota, 2022
- ED Visits for Pedestrians Injured in Motor Vehicle Traffic Crashes

Questions?

CONTACTS:

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Next call: Noon, June 28

Supplemental information

Indiana Department of Health

Pivya (pivmecillinam)

- On April 24, 2024, the U.S. Food and Drug Administration approved Pivya (pivmecillinam) tablets for the treatment of **female adults** with **uncomplicated urinary tract infections** (UTIs) caused by **susceptible isolates of *Escherichia coli, Proteus mirabilis and Staphylococcus saprophyticus*.**
- The primary measure of efficacy for the three trials was the composite response rate, which included clinical cure (resolution of the UTI symptoms and no new symptoms) and microbiological response. The composite response rate was assessed approximately 8 to 14 days after patients were enrolled into the studies.
  - In the clinical trial comparing Pivya to placebo, 62% of the 137 subjects who received Pivya achieved the composite response compared to 10% of the 134 who received placebo.
  - In the clinical trial comparing Pivya to another oral antibacterial drug, 72% of the 127 subjects who received Pivya achieved composite response compared to 76% of the 132 who received the comparator drug.
  - In the clinical trial comparing Pivya to ibuprofen, 66% of the 105 subjects who received Pivya achieved composite response compared to 22% of the 119 who received ibuprofen.
- Most common side effects of Pivya included nausea and diarrhea.

FDA Approves New Treatment for Uncomplicated Urinary Tract Infections | FDA

Pivya (pivmecillinam)

- PIVYA (pivmecillinam) is a prodrug of mecillinam (the active antibacterial agent)
- The recommended dosage of PIVYA is one 185 mg tablet orally 3 times a day for 3 to 7 days as clinically indicated. Administer PIVYA with or without food
- **Warnings and Precautions** : Hypersensitivity reactions, severe cutaneous adverse reactions, carnitine depletion, Clostridioides difficile-associated diarrhea and interference with a newborn screening test for isovaleric acidemia, a rare metabolic disorder.
- Avoid concurrent treatment with valproic acid, valproate, or other pivalate-generating drugs. Clearance of methotrexate from the body can be reduced by concurrent use of drugs in the penicillin class, including PIVYA.
- PIVYA is contraindicated in:
  - patients with primary or secondary carnitine deficiency resulting from inherited disorders of mitochondrial fatty acid oxidation and carnitine metabolism, and other inborn errors of metabolism (e.g., methylmalonic aciduria, or propionic acidemia)
  - patients suffering from porphyria as pivmecillinam has been associated with acute attacks of porphyria [see Warnings and Precautions

https://www.accessdata.fda.gov/drugsatfda_docs/label/2024/216483s000lbl.pdf

Corynebacterium diphtheriae

- Corynebacterium diphtheriae infections can be caused by toxigenic and nontoxigenic strains.
  - Diphtheria toxoid–containing vaccines (DTaP, Tdap, Td) only protect against toxigenic strains.
  - Nontoxigenic C. diphtheriae infections are most frequently associated with cutaneous disease and are not vaccine preventable.

Notes from the Field: Increase in Nontoxigenic Corynebacterium diphtheriae — Washington, 2018–2023 | MMWR (cdc.gov)

Increasing Numbers of Nontoxigenic *C. diphtheriae* cases

Beginning in 2000, Washington mandated submission of all C. diphtheriae isolates to Washington State Public Health Laboratories (WSPHL).

- Presentation of illness was consistent with infections caused by other organisms and recognized as *C. diphtheriae* only when cultures resulted.
- The number of reported nontoxigenic C. diphtheriae isolates in Washington has increased approximately tenfold, from 17 during 2012–2017 to 179 during 2018–2023
- 78% isolates were found in cutaneous wound culture
- 74% of patients were initially evaluated in an emergency department
- Severe disease can manifest as endocarditis (4% of cases) and bacteremia (12% of cases)
- 8% patients died soon after detection of nontoxigenic *C. diphtheriae* infection; causes of death varied and were affected by factors that included underlying medical conditions, infections, experience of homelessness, and substance use.
- Unstable housing and recent illicit substance use were prevalent among patients.

Notes from the Field: Increase in Nontoxigenic Corynebacterium diphtheriae — Washington, 2018–2023 | MMWR (cdc.gov)

Additional Related Recalls of Saline and Sterile Water Medical Products Associated with Nurse Assist

Update: April 15, 2024

In direct response to the Nurse Assist, LLC recall on November 6, 2023, distributors of Nurse Assist water-based medical products and manufacturers of kits and trays that contain Nurse Assist recalled products initiated voluntary recalls.

The list of additional recalls and affected products can be accessed here.

The FDA is receiving reports of adverse events associated with use of Nurse Assist products and is further evaluating this information.

Multistate Outbreak of E. coli Infections Linked to Organic Walnuts

As of April 30, 2024 report:

- 12 E. coli infection cases from 2 states.
- 7 hospitalized, 2 with HUS, No deaths
- Almost all sick people purchased organic walnuts from bulk bins in food co-ops or natural food stores in California and Washington. FDA determined that Gibson Farms, Inc supplied these walnuts and Gibson Farms, Inc has recalled these products. Distributed to natural food and co-op stores in AK, AR, AZ, CA, CO, HI, ID, KS, LA, MT, NE, NM, NV, OR, SD, TX, UT, WA and WY. Lot codes 3325-043 and 3341-501. These walnuts have expiration dates between May 21, 2025, and June 7, 2025.
- Some stores may repackage bulk walnut halves and pieces into plastic clamshells or bags.

CDC warns of E. coli outbreak linked to organic walnuts sold in bulk | CDC Online Newsroom | CDC

Shiga Toxin–Producing Escherichia coli O157:H7 Illness Outbreak Associated with Untreated, Pressurized, Municipal Irrigation Water – Utah, 2023

In 2023, at least 13 children in Utah became ill during an outbreak of Shiga toxin–producing Escherichia coli O157:H7 associated with untreated, pressurized, municipal irrigation water.

- Seven children were hospitalized, including two with hemolytic uremic syndrome.
- Nearly all children (12 of 13) reported using this untreated water for unintended purposes, including recreation and drinking.

Educating residents of communities with these irrigation systems about the risks of playing in or drinking untreated water and improving management and operations risk mitigation of these untreated water systems could help prevent the occurrence of waterborne illness outbreaks.

Prevalence of Positive Childhood Experiences Among Adults — Behavioral Risk Factor Surveillance System, Four States, 2015–2021

- Positive childhood experiences (PCEs) promote optimal health and mitigate the effects of adverse childhood experiences, but PCE prevalence in the United States is not well-known.
- Using Behavioral Risk Factor Surveillance System data, this study describes the prevalence of individual and cumulative PCEs among adults residing in four states: Kansas (2020), Montana (2019), South Carolina (2020), and Wisconsin (2015). Cumulative PCE scores were calculated by summing affirmative responses to seven questions. Subscores were created for family-related (three questions) and community-related (four questions) PCEs.
- The prevalence of individual PCEs varied from 59.5% (enjoyed participating in community traditions) to 90.5% (adult in respondents' household made them feel safe), and differed significantly by race and ethnicity, age, and sexual orientation.
  - Fewer non-Hispanic Black or African American (49.2%), non-Hispanic Alaska Native or American Indian (37.7%), and Hispanic or Latino respondents (38.9%) reported 6–7 PCEs than did non-Hispanic White respondents (55.2%).
  - Gay or lesbian, and bisexual respondents were less likely than were straight respondents to report 6–7 PCEs (38.1% and 27.4% versus 54.7%, respectively). A PCE score of 6–7 was more frequent among persons with higher income and education.
- Improved understanding of the relationship of PCEs to adult health and well-being and variation among population subgroups might help reduce health inequities.

Prevalence of Positive Childhood Experiences Among Adults — Behavioral Risk Factor Surveillance System, Four States, 2015–2021 | MMWR (cdc.gov)

Outbreak of Human Trichinellosis — Arizona, Minnesota, and South Dakota, 2022

- Human trichinellosis cases in the United States are rare and are usually acquired through consumption of wild game.
- Among eight persons who shared a meal that included the meat of a black bear harvested in Canada and frozen for 45 days, six trichinellosis cases were identified. The meat was grilled with vegetables and served rare; two cases occurred in persons who ate only the vegetables. Motile freeze-resistant Trichinella nativa larvae were identified in remaining meat frozen for >15 weeks.
- Cooking meat to an internal temperature of ≥165°F (≥74°C) is necessary to kill Trichinella spp. parasites. Trichinella-infected meat can cross-contaminate other foods, and raw meat should be kept and prepared separate from other foods to prevent cross-contamination.

ED Visits for Pedestrians Injured in Motor Vehicle Traffic Crashes — United States, January 2021–December 2023

- Traffic-related pedestrian injuries are preventable but are increasing in the United States. In 2021, approximately 7,000 pedestrians died in motor vehicle crashes, representing a 40-year high
- During January 2021–December 2023, the proportion of all emergency department visits for pedestrian injury was highest among six racial and ethnic minority groups, persons aged 15–34 years, and males and during September–November
- Timely pedestrian injury data can help collaborating federal, state, and local partners rapidly monitor trends, identify disparities, and implement strategies supporting the Safe System approach, a framework designed to protect all road users

Emergency Department Visits for Pedestrians Injured in Motor Vehicle Traffic Crashes — United States, January 2021–December 2023 | MMWR (cdc.gov)

ED Visits for Pedestrians Injured in Motor Vehicle Traffic Crashes — United States, January 2021–December 2023

TABLE. Emergency department visits for pedestrian injury* per 100,000 total visits and visit ratios, by selected characteristics — National Syndromic Surveillance Program,† United States, January 2021–December 2023

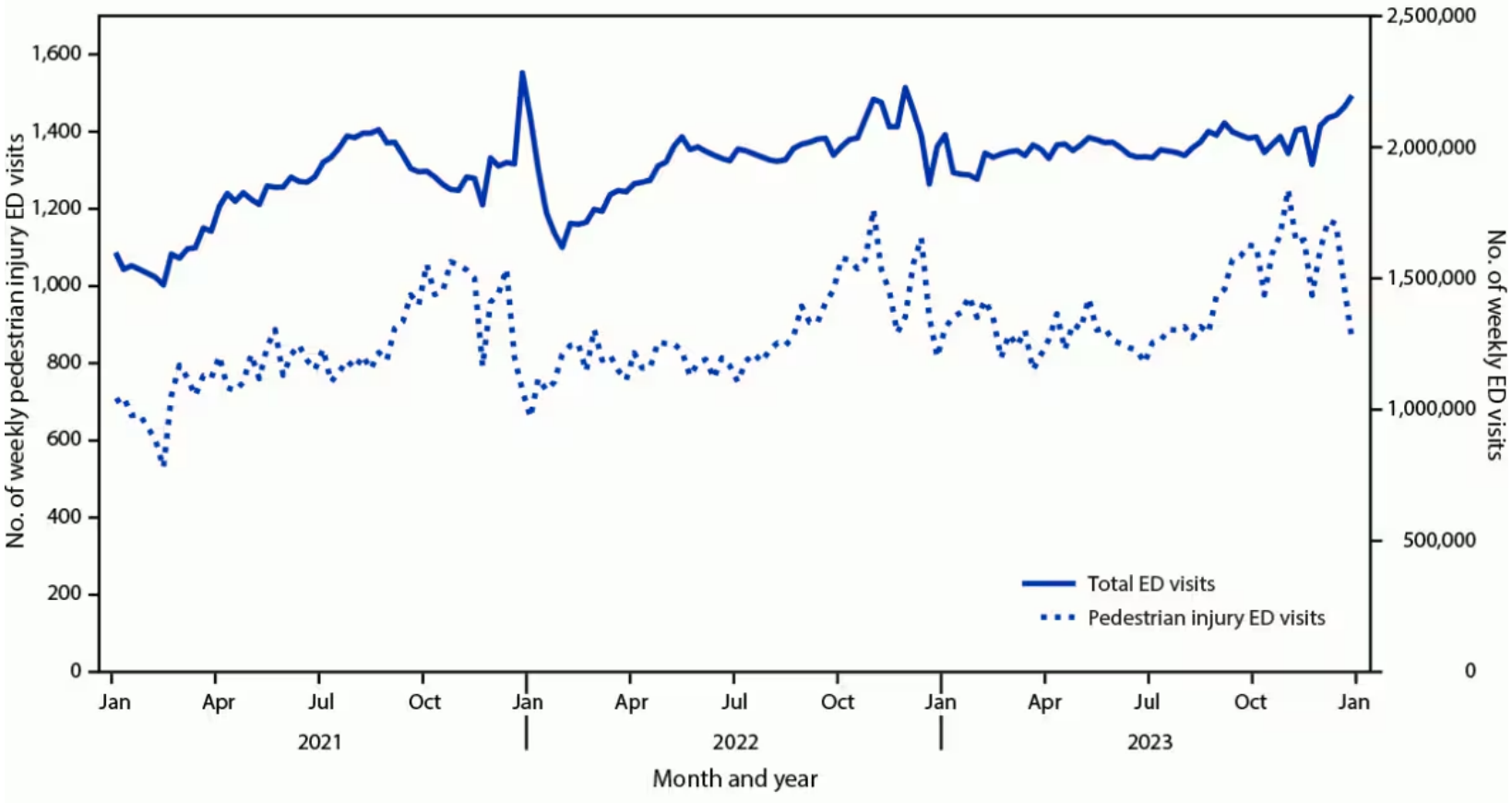
Return

Characteristic§	Visit proportion¶	Visit ratio** (95% CI)
Overall	**45.62**	—
Race and ethnicity††		
American Indian or Alaska Native	68.24	2.13 (2.07–2.19)
Asian	71.51	2.23 (2.19–2.27)
Black or African American	61.88	1.93 (1.91–1.95)
Native Hawaiian or Pacific Islander	49.09	1.53 (1.41–1.66)
White	32.06	Ref
Hispanic or Latino	54.37	1.70 (1.68–1.71)
Multiracial or another race	79.21	2.47 (2.44–2.50)
Age group, yrs		
0–14	29.50	1.25 (1.23–1.28)
15–24	66.67	2.83 (2.79–2.88)
25–34	61.46	2.61 (2.57–2.65)
35–64	51.38	2.18 (2.15–2.22)
≥65	23.53	Ref
Sex		
Female	31.93	Ref
Male	61.57	1.93 (1.91–1.94)

Indiana Department of Health

Emergency Department Visits for Pedestrians Injured in Motor Vehicle Traffic Crashes — United States, January 2021–December 2023 | MMWR (cdc.gov)

ED Visits for Pedestrians Injured in Motor Vehicle Traffic Crashes — United States, January 2021–December 2023



Indiana Department of Health

Emergency Department Visits for Pedestrians Injured in Motor Vehicle Traffic Crashes — United States, January 2021–December 2023 | MMWR (cdc.gov)