



**Mark Your Calendars:**

**Georgia Pediatric Nurses and Practice Managers  
Fall Meeting  
October 16, 2015  
Cobb Energy Centre, Atlanta**

**Pediatrics on the Parkway  
Georgia Chapter, AAP  
Fall Meeting  
November 5-7, 2015  
Cobb Galleria Centre, Atlanta**

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**Not enough signatures: Vaccine opponents fall short in ballot effort**

September 30, 2015, Reporting from Sacramento  
L.A. Times  
Patrick McGreevy

Opponents of a **new child vaccination law** in California have reported that they turned in some 228,000 signatures on petitions for a referendum to overturn the measure, far short of the number needed to qualify it for next year's ballot.

Referendum supporters needed the signatures of 365,880 registered voters by Monday to place the measure before state voters in November 2016.

The referendum was intended to overturn a law signed by Gov. Jerry Brown in June eliminating personal-belief exemptions that allowed some parents to avoid having their children vaccinated before they entered kindergarten.

The failure of the referendum drive was welcomed by Sen. Richard Pan (D-Sacramento), the author of the bill. "The people of California know that vaccines work and most Californians support requiring vaccination for children to attend public school," he said. "The misguided effort to repeal SB 277, my law to boost vaccination rates, appears to have fallen short. That would be good news for public health and particularly California's children." Added Assembly woman Lorena Gonzalez (D-San Diego), who supported the bill, "California kids and public health win!" she said on Twitter.

Leaders of the referendum drive reported their signature counts when they turned in petitions to local elections authorities across the state, who are doing their own counts to be completed by Oct. 8.

The petitions must contain a statewide total of at least 365,880 signatures before the counties will perform random signature checks to determine whether a sufficient number are those of registered voters.

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Interviews with county elections officials found that several, including those in Mendocino and Colusa counties, received petitions Tuesday, past the deadline for them to be included. Some counties, including Inyo and Lassen, reported that no signatures were turned in.

**Old-school and current vaccines have no link to autism (again), study says**

Shannon Kroner, a leader of the referendum drive from Woodland Hills, declined to comment on the low count, saying she would wait for the official tally by the counties.

Los Angeles County officials did their own count and said they received 43,168 signatures for the referendum, which is the largest number of any county, according to tallies provided to other counties.

“Clearly, there is a very large number of people in L.A. County who are not in favor of this unconstitutional vaccine law that strips away a parent's rights to make medical decisions and segregates children,” said Kroner, a parent and educational therapist.

The California secretary of state's office is expected to begin **posting** a running tally of counties' signature counts as they are reported, beginning Wednesday afternoon.

### **Three videos added to IAC's *MCV4: You're Not Done If You Give Just One; Give 2 Doses to Strengthen Protection* initiative**

The Immunization Action Coalition, in collaboration with Sanofi Pasteur, recently launched a new initiative titled *MCV4: You're Not Done If You Give Just One; Give 2 Doses to Strengthen Protection*. This initiative was developed to raise awareness about the extremely low immunization rates for meningococcal conjugate vaccine (MCV4) booster doses, help health care providers know their second dose MCV4 coverage rate, and supply tools for providers to increase rates and help close the MCV4 booster gap.

The initiative's website, [www.give2mcv4.org](http://www.give2mcv4.org), offers important resources for health care providers, including fact sheets, talking points, an overview of adolescent immunization recommendations, Q&As, and other great materials. A new 3-part video series was just added to the website, providing vital information about meningococcal disease and the importance of the booster dose of MCV4 at 16 years of age. The series features Tina Tan, MD, a pediatric infectious disease specialist in Chicago, and Thomas Kuhls, MD, a pediatrician in private practice in Norman, Oklahoma, discussing why a booster dose of MCV4 is important.

The videos can be accessed from the home page of the [www.give2mcv4.org](http://www.give2mcv4.org) website.

CDC recommends that a child receive one dose of MCV4 vaccine at age 11 or 12 years, followed by a second (or booster) vaccination at age 16, as the protection provided by the first dose wanes within five years in many teens. This means teens might have decreased protection from ages 16–21 years, when they are at greatest risk of meningococcal disease. Recent data published by CDC from its National Immunization Survey-Teen report found that only 28.5 percent of adolescents who were age 17 years at the time of the interview had received the recommended second dose of MCV4.

Be sure to visit the initiative website, [www.give2mcv4.org](http://www.give2mcv4.org), and download and use the free, helpful materials available there!

## New Guidelines Call for Kids, Health Care Workers to Get Flu Shots

Pediatric group pushes seasonal vaccine as essential for these groups

MONDAY, Sept. 7, 2015 (HealthDay News) -- All eligible children and health care workers should get flu shots, according to new policy statements from the American Academy of Pediatrics (AAP).

"Parents must consider flu vaccine an essential vaccine for their children," Dr. Wendy Sue Swanson, an AAP spokeswoman, said in a news release from the pediatric group.

"Now is the time to call your pediatrician and make an appointment, or find out when flu clinics start. Flu vaccine is a critically important, every-year vaccine that can protect your child from very serious illness and death due to a virus that is so often common in our communities, and so common in childhood," said Swanson. She is executive director of Digital Health at Seattle Children's Hospital in Washington.

In previous years, about 90 percent of children in the United States who died from the flu were unvaccinated. During last year's flu season, 145 children in the United States died from the flu, and many of them had no other health problems.

Dr. Henry Bernstein, author of both policy statements, said, "Flu vaccine is the best way we have to protect children against this virus.

"The flu virus is unpredictable. We cannot always anticipate how severely it will affect different groups of people. Being immunized with the flu vaccine every year significantly reduces the risk of your child being hospitalized due to flu, and it protects other vulnerable members of your family and community," said Bernstein, who is professor of pediatrics at Hofstra North Shore-LIJ School of Medicine in Hempstead, N.Y.

The AAP recommends that annual flu shots should be given to all people 6 months of age and older. Children aged 6 months to 8 years require two doses this flu season if they have received less than two doses of flu vaccine before July 2015.

Flu shots are recommended for all people who have contact with children younger than 5 years of age and children with high-risk conditions. Pregnant women are at high risk for flu-related complications and can safely receive flu vaccination at any time during pregnancy. Getting a flu shot during pregnancy also protects infants for the first 6 months of life, the statements said.

The AAP also noted that many people at high risk for flu and related complications require regular medical care, meaning they have frequent, close contact with health care workers. By getting flu shots, health care workers reduce the risk they pose to these vulnerable patients.

"Employees of health care institutions have an ethical and professional obligation to act in the best interest of their patients' health," Bernstein said. "For the prevention and control of influenza, we must continue to put the health and safety of the patient first."

In the 2013-14 flu season, 75 percent of U.S. health care workers received flu vaccinations, well below the Healthy People 2020 target of 90 percent. Voluntary programs are less effective than mandatory programs, which can achieve health care worker vaccination rates higher than 94 percent, according to the AAP, which repeated its call for mandatory vaccination for health workers nationwide.

The policy statements were published online Sept. 7 in the journal *Pediatrics*.

### More information

The U.S. Centers for Disease Control and Prevention has more about [seasonal flu vaccination](#).

SOURCE: American Academy of Pediatrics, news release, Aug. 7, 2015

[Medscape Medical News](#)

## Annual Influenza Vaccinations Help the Elderly

Lara C. Pullen, PhD

August 31, 2015

In years when the seasonal influenza vaccine is well-matched to the circulating strain, elderly patients have a lower incidence of pneumonia and influenza (P&I) hospitalizations and mortality.

Aurora Pop-Vicas, MD, from Brown University in Providence, Rhode Island, and colleagues published the results of their retrospective cohort study [online](#) August 17 in the *Journal of the American Geriatrics Society*. The investigators tested the effect of vaccination in a population with uniformly high vaccination rates: more than 1 million Medicare New Hampshire nursing home residents between 2000 and 2009.

Taking advantage of the random disease variation that occurs over multiple influenza seasons, the investigators were able to compare vaccine effectiveness in the years the vaccine was well matched with vaccine effectiveness in the years it was not.

The study showed that the better the match between the influenza vaccine and the circulating strain of virus, the fewer nursing home residents were hospitalized or died.

The investigators report that average weekly all-cause mortality varied from 3.74 to 4.13 per 1000 New Hampshire residents per week. Hospitalizations for P&I varied from 2.05 to 2.43. The researchers' model estimated that a 50 percentage point increase in the A/H3N2 match rate was associated with a 2.0% reduced rate of long-stay resident deaths and a 4.2% reduced rate of P&I hospitalizations.

The authors note that these rates were similar to the pattern of P&I mortality reduction in 122 Centers for Disease Control and Prevention sentinel cities.

The study was not designed to account for the known contribution of vaccinated healthcare workers to reductions in influenza-associated disease.

The investigators designed the study to provide an answer to a frequently asked question: Does influenza vaccination help the elderly? Although annual influenza vaccination is standard care in nursing homes, some public health officials question whether the vaccination is beneficial in a frail, elderly population that tends to have poorer vaccine responsiveness.

The authors conclude from their results that influenza vaccination is an important primary prevention strategy in elderly adults. Moreover, they suggest that the effectiveness of seasonal influenza vaccines in healthier older individuals may be underestimated.

*The authors have disclosed no relevant financial relationships.*

*J Am Geriat Soc.* Published online August 17, 2015. [Abstract](#)

## **CDC publishes updated ACIP recommendations regarding the intervals between PCV13 and PPSV23 vaccines for use in immunocompetent adults age 65 years and older**

In the [September 4 issue of \*MMWR\*](#) (pages 944–947), CDC published [Intervals Between PCV13 and PPSV23 Vaccines: Recommendations of the Advisory Committee on Immunization Practices \(ACIP\)](#).

On June 25, 2015, ACIP changed the recommended interval between PCV13 followed by PPSV23 (PCV13–PPSV23 sequence) from 6–12 months to  $\geq 1$  year for immunocompetent adults aged  $\geq 65$  years. Recommended intervals for all other age and risk groups remain unchanged. The report outlines the rationale for this change and summarizes the evidence considered by ACIP to make this recommendation. The "Summary" section is reprinted below in its entirety.

### **Summary**

#### *What is currently recommended?*

*The Advisory Committee on Immunization Practices (ACIP) currently recommends that both 13-valent pneumococcal conjugate vaccine (PCV13) and 23-valent pneumococcal polysaccharide vaccine (PPSV23) be given to all immunocompetent adults aged  $\geq 65$  years. ACIP recommends that PCV13 be given first followed by PPSV23 6–12 months later. ACIP also recommends that adults aged  $\geq 65$  years who already received a dose of PPSV23, should also receive a dose of PCV13  $\geq 1$  year after the dose of PPSV23. Among persons aged  $\geq 2$  years with medical indications to receive both PCV13 and PPSV23 in a series, including adults aged  $\geq 65$  years with immunocompromising conditions, functional or anatomic asplenia, cochlear implants, or cerebrospinal fluid leaks, a dose of PPSV23 should be given  $\geq 8$  weeks after a dose of PCV13.*

#### *Why are the recommendations being modified now?*

*To simplify the recommendations for PCV13 and PPSV23 use among immunocompetent adults aged  $\geq 65$  years, ACIP recommended harmonization of recommended intervals between PCV13 and PPSV23 regardless of the order in which the two vaccines are given.*

#### *What are the new recommendations?*

*ACIP recommends that both PCV13 and PPSV23 be given in series to adults aged  $\geq 65$  years. A dose of PCV13 should be given first followed by a dose of PPSV23 at least 1 year later to immunocompetent adults aged  $\geq 65$  years. The two vaccines should not be co-administered. If a dose of PPSV23 is inadvertently given earlier than the recommended interval, the dose need not be repeated.*

[Read the full-text article](#) to access the complete recommendations; a [PDF version of the entire issue](#) is also available.

## **Take a STAND™: Use Standing Orders to Improve Adult Immunization Rates**

NFID is a supporting organization for a new national program being conducted for a limited time by the Immunization Action Coalition (IAC). The free program is designed to improve adult immunization rates by increasing the use of standing orders in medical practices. Program elements include a 1/2 day workshop that will be presented in 22 cities across the US starting in October 2015 and continuing through June 2016. Physicians, clinic managers, nurse practitioners, physician assistants, and nurses in medical practices that serve adults are encouraged to attend. The March 17, 2016 workshop will be held in conjunction with the NFID Spring 2015 [Clinical Vaccinology Course](#) in Phoenix, AZ.

[Learn more about the program and register online](#)

### **Question of the Week**

**IAC Express Issue Issue 1205: September 15, 2015**

**I have never seen a case of hepatitis A in my pediatric population, even before hepatitis A vaccine was licensed. Is this vaccine necessary among pediatric patients?**

One reason you may not have seen hepatitis A in your pediatric patients is because the likelihood of having symptoms with hepatitis A infection is related to age. In children younger than age 6 years, 70 percent of infections are asymptomatic. When illness does occur in young children, it is typically not accompanied by jaundice. In older children and adults, infection typically is symptomatic, with jaundice occurring in more than 70 percent of patients. However, in 2000, children age 0 through 9 years had the highest rate of acute hepatitis A (6.56 per 100,000 persons). Rates were particularly high in states west of the Mississippi. In 2006, hepatitis A was recommended as a routine vaccine for all children. Since that time, hepatitis A has become very rare in pediatric patients. In 2013, there were 0.14 cases of acute hepatitis A per 100,000 children age 0 through 9 years of age. This dramatic decline is the result of the hepatitis A vaccination program.

### **Question of the Week**

**IAC Express Issue Issue 1206: September 22, 2015**

**The Advisory Committee on Immunization Practices now designates a vaccine recommendation as either "A" or "B." My interpretation is that an A recommendation means the vaccine is routinely recommended for all children in an age or risk group, and a B recommendation is for permissive use (at the clinician's discretion). Does the Affordable Care Act (ACA) require health plans (non-grandfathered) to provide benefit coverage on permissive B recommended vaccines?**

Your understanding of A and B recommendations is correct. ACA requires coverage of vaccines with both A and B recommendations. The Vaccines for Children program also includes vaccines with a B recommendation.