

## Opium Epidemic and Washington State's Response

Washington State is currently experiencing an opioid abuse and overdose crisis involving prescription opioids and heroin. When opioid prescribing began decreasing between 2005-2010, the number of teens in Washington State reporting use of these medicines to "get high" also decreased. As pharmaceutical opioids became less available, some people with opioid use disorder switched to heroin because of its greater availability and lower cost. Heroin however, brings with it higher risks for overdose, infectious disease and, because it is illegal, incarceration.

- In Washington, about 600 individuals die each year from opioid overdose with an increasing proportion of those deaths involving heroin. In Grant County, there were 13 total known opioid related deaths from 2012-2014, but the number is likely higher.
- The largest increase in heroin overdose deaths from 2004 to 2014 occurred among people ages 15 to 34 years.
- According to a recent statewide survey of syringe exchange clients, 57% of those who inject heroin said they were "hooked on" prescription opiates before they began using heroin.

The WA State Interagency Opioid Working Plan outlines the goals, strategies and actions that are being implemented by a number of stakeholders across diverse professional disciplines and communities. The plan outlines both current efforts as well as new proposed actions to scale up response.

### WORKING PLAN OVERVIEW

The plan includes four priority goals with points on attaining the goals listed both in the picture at the bottom of the page and below:

1. Prevent opioid misuse and abuse.
  - Promote use of best practices among health care providers for prescribing opioids for acute and chronic pain.
2. Treat opioid abuse/dependence.
  - Make buprenorphine more accessible for people who have opiate-use disorders
  - Increase capacity of syringe exchange programs to effectively provide overdose prevention and engage clients in support services including housing.
3. Prevent deaths from overdose.
  - Educate individuals who use heroin and/or prescription opioids, on how to recognize

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### TO REPORT A NOTIFIABLE CONDITION:

PHONE

(509) 766-7960

FAX

(509) 764-2813

24 HOUR REPORTING LINE

(509) 398-2083

Communicable Disease Fax

(509) 764-2813

and appropriately respond to an overdose.

- Make system-level improvements to increase availability of naloxone.
- 4. Use data to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions.
  - Improve PMP (Prescription Monitoring Program) functionality to document and summarize patient/prescriber patterns to inform clinical decision making.
  - Utilize PMP for public health surveillance and evaluation.
  - Link PMP data to overdose death and hospitalization data to determine relationships

Additional resources and the full Washington State work plan can be found at:

[www.theathenaforum.org/sites/default/files/FINAL%20-%20Washington%20State%20Interagency%20Opioid%20Working%20Plan%20-%20March%202016.pdf](http://www.theathenaforum.org/sites/default/files/FINAL%20-%20Washington%20State%20Interagency%20Opioid%20Working%20Plan%20-%20March%202016.pdf)



## Lead Screening Guidelines

Washington State Department of Health (DOH) convened an expert panel last year (2015) to develop targeted childhood lead screening recommendations for clinicians in Washington State. Since the removal of lead from paint and gasoline in the 1970s, the prevalence and severity of elevated blood lead levels in children have been reduced. Legacy lead paint and plumbing remains in some homes and communities which continue to serve as sources of lead exposure.

There have been several news reports with concerns about lead in water supplies because of lead fixtures within the infrastructure of the water distribution system. Lead testing indicated elevated levels of lead in specific parts of the system. Even with Washington's robust surveillance and testing system in water there is still potential for lead to be leached into drinking water.

DOH partnered with the Office of the Superintendent of Public Instruction (OSPI) to communicate with schools in Washington due to the recent cases of elevated lead levels in the drinking water found in schools in Washington. Water does not seem to be an efficient route of exposure, but it is still an unnecessary exposure and there is no known safe level of exposure. Leaching can occur within the plumbing of a building regardless of the age of the building if the incoming water is corrosive enough. DOH has information about lead in schools available on their [www.doh.wa.gov/CommunityandEnvironment/DrinkingWater/Contaminants/LeadinSchools](http://www.doh.wa.gov/CommunityandEnvironment/DrinkingWater/Contaminants/LeadinSchools). Grant County schools who would like to consult about water testing should contact the Eastern Regional office of DOH.

Currently, housing age, as an indication of potential residential lead

hazards, is the most established risk factor for lead poisoning. Even relatively low levels of blood lead (<10 µg/dl) have been shown to have subtle effects on the developing central nervous system.

[Who to Test for Lead Poisoning](#)  
[Healthcare providers should assess all children for risk of lead poisoning at 12 and 24 months of age.](#) DOH recommends performing a blood lead test on children with the following risk factors:

- Lives in or regularly visits any house built before 1950 or before 1978 with recent or ongoing renovations or remodeling.
- From a low income family; income <130% of the poverty level (federal law mandates screening for all children covered by Medicaid).
- A sibling or frequent playmate with an elevated blood lead level.
- A recent immigrant, refugee, foreign adoptee, or child in foster care.
- Has a parent or caregiver who works professionally or recreationally with lead, (examples: remodeling and demolition; painting; works in or visits gun ranges; battery recycling; makes lead fishing weights or shotgun pellets; hobbies involving stained glass, pottery, soldering, or welding).
- Uses traditional, folk, or ethnic remedies or cosmetics (examples: Greta, Azarcon, Ghasard, Ba-baw-san, Sindoor and Kohl).

Healthcare providers should consider testing additional children per clinical judgment, including but not limited to:

- Children whose parents have concerns or request testing (including older children that have risk of exposure).
- Children living within a kilometer of an airport or lead emitting industry, or on former orchard

land.

- Children with pica behavior.
- Children with neurodevelopmental disabilities or conditions such as autism, ADHD, and learning delays.

Educating Parents for Prevention  
Healthcare providers are encouraged to educate parents who have children that are 6 months to 6 years old on the risk factors associated with lead exposure during routine check-ups. Prevention requires reducing environmental exposures from paint, dust, soil, and water. Efforts to increase awareness of lead hazards and nutritional interventions to increase iron and calcium, which can reduce lead absorption, are other successful prevention strategy. Other Common Sources of Lead  
Some candies imported from Mexico have been found to contain lead. Ingredients such as chili powder and tamarindo, are found to be the most common source of exposure. Lead has also been found in the ink of some imported candy wrappers as well as in non-regulated imported spices such as turmeric.

Lead Exposure Risk Mapping Tool  
Healthcare providers are encouraged to use the Department of Health Lead Exposure Risk Index [www.fortress.wa.gov/doh/wtn/WTNIBL](http://www.fortress.wa.gov/doh/wtn/WTNIBL) to better understand which areas in their community are at higher risk for lead exposure based on age of housing.

Additional Resources  
[www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionalsandFacilities/ProfessionalResources/BloodLeadTestingandReporting](http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionalsandFacilities/ProfessionalResources/BloodLeadTestingandReporting)  
[www.doh.wa.gov/Portals/1/Documents/Pubs/334-383.pdf](http://www.doh.wa.gov/Portals/1/Documents/Pubs/334-383.pdf)

Consultation  
Todd Phillips, Environmental Health Manager 509-766-7960 ext. 26

## Influenza in Washington

2016-2017 Flu Season Update:  
State summary: Currently, flu activity is low .

- As of the end of October, two lab-confirmed influenza deaths have been reported in WA (2016-2017 season).
- During week 41, 7 out of 103 specimens (6.8%) tested by the World Health Organization/ National Respiratory and Enteric Virus Surveillance System (WHO/ NREVSS) collaborating laboratories in Washington were positive for influenza: six influenza A not subtyped and one influenza B.
- During week 41, the proportion of outpatient visits for influenza-like illness was 0.7% below the seasonal baseline of 1.1%.

Antiviral Resistance Testing  
44 influenza A (H1N1) isolates collected in Washington during the 2015-2016 season had antiviral resistance testing performed at CDC, with one isolate resistant to oseltamivir and peramivir. 44 influenza A (H3N2) isolates and 94 influenza B isolates had antiviral resistance testing performed at CDC, with none found to be resistant. Nationally, less than one percent of influenza viruses tested have resistance to antivirals. No testing has occurred on specimens collected during the 2016-2017 influenza season. New recommendations for the 2016-2017 influenza season? On June 22, **2016, CDC’s Advisory Committee on Immunization Practices (ACIP)** voted that the live attenuated influenza vaccine (LAIV) should not be used

during the 2016-2017 flu season. ACIP continues to recommend annual flu vaccination for everyone 6 months and older. The final annual recommendations on the prevention and control of influenza vaccines will be published in a CDC Morbidity and Mortality Weekly Report (MMWR) in late summer or early fall.

The FDA licensed a new seasonal influenza vaccine containing adjuvant for adults 65 years of age and older. An adjuvant is an ingredient added to a vaccine to create a stronger immune response to vaccination available this year.

Resources:  
[www.doh.wa.gov/Portals/1/Documents/5100/420-100-FluUpdate.pdf](http://www.doh.wa.gov/Portals/1/Documents/5100/420-100-FluUpdate.pdf)

## Norovirus Prevention

Each year on average in the United States, norovirus:

- Causes 19-21 million cases of acute gastroenteritis.
- Leads to 1.7-1.9 million outpatient visits and 400,000 emergency department visits, primarily in young children.
- Contributes to about 56,000-71,000 hospitalizations and 570-800 deaths, mostly among young children and the elderly.

There can be 50% more norovirus illness in years when there is a new strain of the virus going around.

### Recommendations for Prevention

- Actively promote hand washing with soap and water after all patient care during an outbreak. Alcohol-based hand sanitizers can be used, but should not be a substitute for washing with soap and water.

- Use gowns and gloves when in contact with, or caring for patients who are symptomatic.
- When you are sick, do not prepare food or care for others who are sick.
- Routinely clean and disinfect high touch patient surfaces and equipment .
- Remove and wash contaminated clothing or linens thoroughly.

*Notify Grant County Health District as soon as symptoms appear in more than one patient in a facility.*

Over half of all norovirus outbreaks reported in the United States occur in long-term care facilities. The virus can be introduced into healthcare facilities by infected patients-who may or may not be showing symptoms-or by staff, visitors, or contaminated foods.

Outbreaks in these settings can be quite long, sometimes lasting months. Illness can be more severe, occasionally even fatal, in hospitalized or nursing home patients compared with otherwise healthy people.

Resources:  
[www.cdc.gov/HAI/organisms/norovirus.html](http://www.cdc.gov/HAI/organisms/norovirus.html)  
[www.cdc.gov/norovirus/trends-outbreaks.html](http://www.cdc.gov/norovirus/trends-outbreaks.html)

Setting of Norovirus Outbreaks Reported Through the National Outbreak Reporting System (NORS), 2009-2012

Exposure Setting	Number of Outbreaks	Percentage of Outbreaks
Healthcare facility	2189	62.7%
Restaurant or banquet facility	771	22.1%
School or day-care facility	214	6.1%
Private residence	69	1.9%
Other/multiple settings	251	7.2%



**Public Health**  
Prevent. Promote. Protect.

Grant County Health District

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**Grant County Notifiable Conditions**

	Jan-Oct	Jan-Oct
DISEASE/CONDITION	2016	2015
Botulism	<5	0
Blood Lead – Child	<5	<5
Campylobacter	20	22
Chlamydia	320	325
Cryptosporidium	0	0
Shiga toxin E. coli (STEC)	<5	6
Giardia	<5	<5
Gonorrhea	87	96
Hepatitis A	0	<5
Hepatitis B (chronic)	<5	<5
Hepatitis C (chronic)	49	39
Hantavirus	0	0
Herpes Simplex	28	16
HIV	0	0
Influenza Deaths	0	<5
Listeriosis	0	0
Malaria	0	0
Measles	0	0
Meningococcal	0	0
Mumps	0	0
Pertussis	<5	13
Rabies PEP	9	<5
Relap. Fever/Lyme	0	0
Rubella	0	0
Salmonella	<5	6
Shigella	<5	6
Syphilis	18	15
Tuberculosis	<5	0
Yersiniosis	0	0
West Nile Virus	0	0
Unexplained Death	0	0
Totals	549	561

GCHD has a new website!

**Grant County Health District's has a new website. This extensive redesign includes Healthcare provider specific content. The Healthcare section includes links to GCHD Provider Alerts, EPI-Updates, Notifiable Conditions forms, and other information designed with healthcare providers in mind.**  
[www.granthealth.org](http://www.granthealth.org)



*Always working for a safer & healthier Grant County*

