

West Virginia EPI-LOG

Statewide Disease Facts and Comparison

2016 West Virginia Legislature tackles public health issues



The regular session of the 2016 West Virginia Legislature was full of legislation that impacted public health. Of the 2,237 bills introduced during the 60-day session, 290 (15.4%) had to do with healthcare or public health.¹ Legislation that was passed dealt with everything from consuming raw milk, to pharmacists giving naloxone to patients without a prescription, to treating sexually transmitted infections (STIs) differently within local health and other healthcare practices.

Of the completed legislation, the bill allowing raw milk consumption was one of the most heavily debated. The public appeared strongly divided on the issue. Raw milk is milk that has not been pasteurized or homogenized.² Proponents of the bill say raw milk is more natural and serves as a healthier alternative to milk that has

been pasteurized. Those opposed to consuming raw milk believe that pasteurization, or heating the milk to kill bacteria, is essential to the prevention of dangerous infectious diseases. Unpasteurized milk does have a higher risk of several serious diseases including campylobacter, listeria, salmonella and E. coli, including the highly pathogenic E. coli type H0157. All diseases spread through the consumption of raw milk are considered to be category 1 reportable diseases and must be reported to the local health department immediately upon diagnosis.

The raw milk legislation passed will allow West Virginia citizens to purchase a shared ownership of the milk producing animal from which they will be able to obtain and consume raw milk. However, they are not allowed to sell or distribute that milk to other individuals outside of the herd sharing agreement. Individuals who participate in such herd sharing agreements are required to formally acknowledge the multiple, severe health risks that occur with raw milk consumption. Raw milk legislation varies from state to state. The Center for Disease Control and Prevention (CDC) maintains information on raw milk at www.cdc.gov/foodsafety/rawmilk/raw-milkquestions-and-answers.html.

Legislation pertaining to opioid abuse was also introduced. In an effort to combat the high number of overdose related deaths in the State, bills loosening restrictions on naloxone were passed in both the 2015 and 2016 legislative sessions. Naloxone is an “opioid antagonist,” a medication that blocks or reverses the effects of opioid drugs. Symptoms of opioid overdose include extreme drowsiness, slowed breathing, loss of consciousness and even death. Naloxone is used to treat an opioid overdose in an emergency situation.³ In 2015, there was legislation to allow first responders such as police, firefighters, and emergency medical service providers to carry naloxone because they often respond to reports of drug overdoses. In 2016, West Virginia passed additional legislation to allow pharmacists and pharmacy interns to distribute naloxone to patients without a prescription from a healthcare provider. This allows for better access to naloxone for patients at risk for an opioid overdose, or their friends and family members.

The legislation mandates that pharmacists and pharmacy interns must provide anyone requesting naloxone with counselling and other information. For example, anyone administering naloxone should call 911 even if an overdose victim becomes conscious after receiving the drug. While the half-life of naloxone ranges from 30-81 minutes, many narcotic medications have a much longer half-life.⁴ This means that although a person who has overdosed is conscious following administration of naloxone, they are still at risk of going back into respiratory arrest from the overdose once the naloxone wears off. Counselling will also include how to safely deal with a patient after they have received naloxone. These patients can become combative due to the rapid reversal of the narcotic’s effects, sending them into immediate withdrawal. Pharmacists and pharmacy interns will also monitor the naloxone distribution through medical records.



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In response to funding cutbacks at the state and federal levels, legislation was passed in 2016 to allow local health departments to invoice for human immunodeficiency virus (HIV) and other STI counselling, testing and treatment. This will allow for such services to be more financially sustainable. Provisions within the legislation allow for an opt-out of billing insurance if the patient wishes to remain anonymous.⁵

Also passed during the legislative session was the Expedited Partner Therapy (EPT) bill. EPT is the clinical practice of treating the sexual partners of patients diagnosed with chlamydia or gonorrhea by providing a prescription or dispensing medications to the patient to take to his/her partner without the healthcare provider first examining the partner.⁶ The purpose of EPT is to decrease the rate of reinfection and transmission to other partners. Materials for patients and providers who utilize EPT in West Virginia are now available at www.dhhr.wv.gov/oeps/std-hiv-hep/stds_stis/Pages/Expedited-Partner-Therapy.aspx.

References:

¹ Healthcare Highlights: Volume 28, Issue 8, Stevens et al. | ² www.fda.gov/Food/ResourcesForYou | ³ www.drugs.com/naloxone.html

⁴ www.drugs.com/pro/narcan.html | ⁵ www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=SB404%20intr.htm&yr=2016&sesstype

⁶ www.cdc.gov/std/ept

More screening and better lifestyle choices key to beating colorectal cancer in West Virginia

Figure 1. Age-adjusted Incidence Rates of Colorectal Cancer, WV and US by Gender, 2004 - 2012

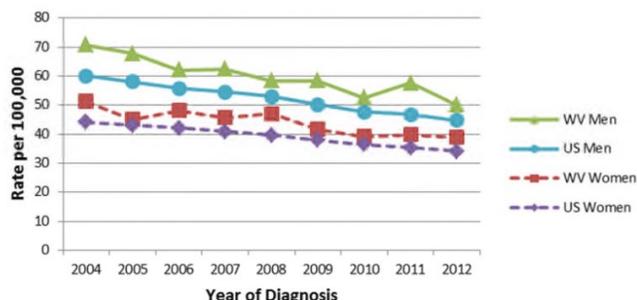


Figure 2: Age-adjusted Mortality Rates of Colorectal Cancer, West Virginia and US by Gender, 2004 - 2012

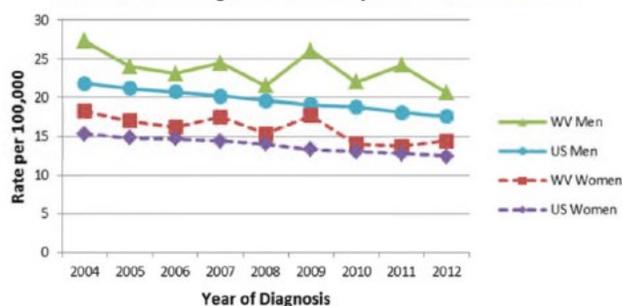
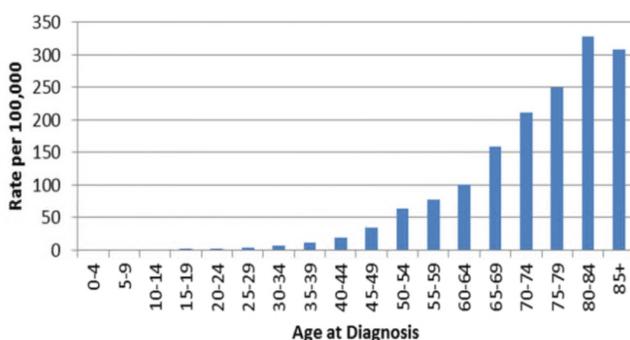


Figure 3: Age-specific Average Annual Colorectal Cancer Incidence Rates, West Virginia, 2009 - 2013



Colorectal cancer starts in either the colon or the rectum. It is one of the most common cancers diagnosed in West Virginia, following prostate and lung cancer in men and breast and lung cancer in women.

Although colorectal cancer rates are declining in West Virginia, incidence rates remain higher for West Virginia than for the United States as a whole (Figure 1).¹ Incidence rates by county are generally highest in central West Virginia and in the southern coalfields.

Colorectal cancer is a significant cause of cancer-related death in West Virginia, and is responsible for more deaths than any other cancer except lung cancer. West Virginia colorectal cancer mortality rates have also decreased in recent years, yet they remain significantly higher than the national mortality rate (Figure 2).

The risk of developing colorectal cancer is influenced by a number of factors (Table 1). These include non-modifiable factors such as inherited risks, race, and increasing age, especially for persons over the age of 50 (Figure 3), and modifiable risks such as smoking, lack of physical activity, and obesity. The most effective ways to reduce the risk of developing colorectal cancer are by reducing modifiable risk factors and getting screened for colon polyps (growths that can become cancerous).

Colorectal cancer typically arises from precancerous polyps in the colon or rectum. Some colorectal screening tests can prevent the occurrence of colorectal cancer by detecting and removing polyps before cancer develops. Colorectal screening tests can also find colorectal cancer at an early stage, when treatment is most effective. Research has shown that a large proportion of deaths from colorectal cancer could be prevented with the widespread use of screening.

The United States Preventive Services Task Force (USPSTF) released their updated screening recommendations in 2016.² The USPSTF recommends colorectal screening for all average risk

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adults between the ages of 50-75. There are many screening options available which include stool-based tests and direct visualization tests (e.g., colonoscopy). Despite solid evidence indicating colorectal cancer is highly preventable and treatable through screening, the rate of colorectal screening in West Virginia is well below the national average.

In West Virginia, less than half of colorectal cancers are diagnosed at an early stage (e.g., in situ or local) when the disease is most responsive to treatment and survival odds are greatest (Figure 4). Five-year survival estimates vary by stage. Approximately 90% of persons diagnosed at the local stage will survive at least five years. The five year survival rate drops to 71% when it is diagnosed at the regional stage, and drops further to 13% when it is diagnosed at the distant stage.

Given the high prevalence of colorectal cancer risk factors in West Virginia (older population, obesity, tobacco use, lack of physical activity), and low rates of colorectal screening in the State, it should be no surprise that West Virginia is among the highest in the nation in

Figure 5. Colorectal Cancer Stage at Diagnosis, West Virginia, 2009 - 2013

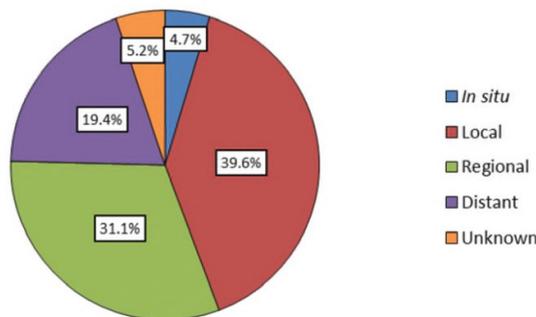
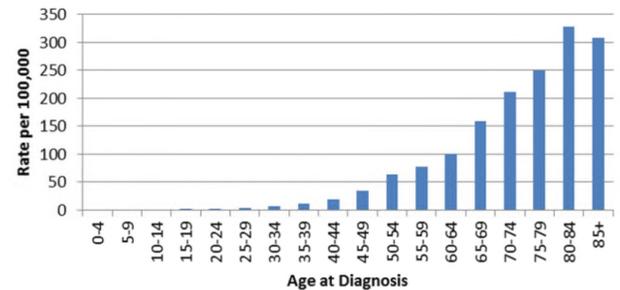


Table 1. Colorectal Cancer Risk Factors	
Nonmodifiable Risk Factor	Modifiable Risk Factor
• Increasing age (particularly after age 50)	• Obesity
• Personal history of colorectal cancer, colon polyps, or inflammatory bowel disease	• Physical inactivity
• Family history of colorectal cancer	• Smoking
• Inherited syndromes such as familial adenomatous polyposis or hereditary non-polyposis colon cancer	• Heavy alcohol use
• Race (African Americans have the highest incidence and mortality)	• A diet high in red meats and processed meats

Note: Some risk factors, called "nonmodifiable risk factors," cannot be changed. Some risk factors, called "modifiable risk factors," can be modified, controlled or treated. This list is not exhaustive.

Figure 4. Age-specific Average Annual Colorectal Cancer Incidence Rates, West Virginia, 2009 - 2013



colorectal cancer incidence and death rates. Although screening methods have been available for many years, screening rates remain low in West Virginia. Until colorectal cancer screening is better utilized, this beatable disease will continue to be a significant public health problem in our State.

References:

¹ United States Cancer Statistics Working Group. United States Cancer Statistics: 1999–2012 Incidence and Mortality Web-based Report. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute; 2015. Available at nccd.cdc.gov/uscs. |

² Final Update Summary: Colorectal Cancer: Screening. U.S. Preventive Services Task Force. June 2016. Available at w.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2.

Parents of public school students urged to keep vaccinations up to date

As the 2016-2017 public school year gets underway, primary care providers will be getting calls from parents whose children need vaccinations, either before enrolling in school for the first time, or entering 7th or 12th grade.

The West Virginia Division of Immunization Services (WVDIS) provides information about vaccine requirements for first time school enrollees at www.dhhr.wv.gov/oeps/immunization/requirements/Documents/NewSchoolEnterers.pdf, and the requirements for 7th and 12th grade students may be found at www.dhhr.wv.gov/oeps/immunization/requirements/Documents/SevenTwelve.pdf.

Although human papillomavirus (HPV) and meningococcal B vaccinations are not required for 7th and 12th grade students, these vaccines are still considered critically important for teens. The Centers for Disease Control and Prevention (CDC) recommends the anti-cancer HPV vaccine for boys and girls at age 11 or 12.

New data from the CDC shows that an average of 38,793 HPV-associated cancers (11.7 per 100,000 persons) were diagnosed annually in the United States from 2008 to 2012, including 23,000 (13.5 per 100,000) among females and 15,793 (9.7 per 100,000) among males. Among these cancers, CDC estimates that 30,700 (79%) can be attributed to HPV, and 28,500 of these are attributable to HPV types that are preventable with the 9-valent HPV vaccine. West Virginia currently has the highest rate of HPV-associated cancers among females in the United States at 17 per 100,000 persons.

Healthcare providers should enroll with the West Virginia Statewide Immunization Information System (WVSIS) to

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determine the vaccination histories of their patients, or to produce lists of patients by age group who have or have not received these vaccinations. The WVSIS also has helpful tools such as the vaccine forecasting report and a reminder/recall notice generator.

Healthcare providers who do not stock vaccines or are unable to provide the vaccinations needed for school entry may refer children to any West Virginia local health department for vaccinations by completing the Immunization Referral found at www.dhhr.wv.gov/oeps/immunization/providers/Documents/Section%206/VFCphysreform.pdf.

For more information, please visit the WVDIS online at www.dhhr.wv.gov/oeps/immunization/Pages/default.aspx or call (304) 558-2188.

West Virginia making progress against tuberculosis

Infection with *Mycobacterium tuberculosis* (TB) is classified into two categories: latent TB infection (LTBI) and active TB disease. People with active TB disease are typically very sick with symptoms like cough, fever, weight loss and night sweats. They can also infect others when their own TB bacteria are spread through the air by coughing, laughing or speaking. People with LTBI have been infected with TB bacteria, but the microbes are dormant in the body. These individuals do not have any symptoms and are not contagious. However, the bacteria can become active in the future and cause the person to become sick with active TB. This typically happens when the person's immune system becomes compromised for various reasons.

In 2015, there were 10 cases of active TB disease in West Virginia, a 23.1% decrease from 2014. Three of those persons were foreign-born and one was Hispanic. Rates of TB infection in many other parts of the world are much higher than in the United States. Typically, the most common risk factor among TB cases in West Virginia is being born in another country.

Among the ten active cases, six were male and four were female, none were admitted drug users and none admitted to alcohol abuse. At time of diagnosis, eight were alive and two were deceased. Seven were pulmonary cases, meaning the TB was in their lungs, and three were extrapulmonary cases (TB infection somewhere other than in the lungs). Of the eight cases that are currently living, four have completed treatment, and four are still being treated.

The ten cases were in Boone, Hancock, Harrison, Kanawha, Monongalia, Putnam, and Summers counties. Kanawha County had three cases and Putnam County had two; the other counties had one case each.

In West Virginia, employees of the Division of TB Elimination have worked hard over the last decade to significantly reduce the number of cases of active TB disease in the State. These efforts include aggressive treatment of cases and contacts as well as increased testing to identify and treat individuals with LTBI in order to keep them from developing active TB disease. As a result, the incidence rate of TB disease for West Virginia in 2015 was 0.54 per 100,000 persons, which was the lowest incidence rate for TB in the United States for 2015. Nationwide, there were 9,563 cases of active disease in 2015. The national incidence rate was 2.98 per 100,000 persons. The number of cases in the United States actually increased slightly (by about 150) for the first time since 1992.

Statewide, there were 13,880 people tested by the local health departments for TB in 2015. Of those tested, 146 (1.05%) were found to have LTBI. Most of these patients were treated in order to greatly reduce the possibility of developing active TB disease later in life. The incidence rate for LTBI in West Virginia for 2015 is 7.88 per 100,000 persons. Treatment for infected patients is aggressively promoted in this State, which may explain why we have the lowest incidence rate of TB disease in the nation.

Office of Epidemiology and Prevention Services

HIV/AIDS Surveillance & Prevention	(304) 558-2195
Cancer Epidemiology	(304) 356-4953
Infectious Disease Epidemiology	(304) 558-5359
Immunization Services	(304) 558-2188
Sexually Transmitted Diseases	(304) 558-2195
Hepatitis Prevention	(304) 558-2195
TB Elimination	(304) 558-3669
Epidemiologic Informatics and Evaluation	(877) 408-8930

The **West Virginia EPI-LOG** is published quarterly by the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Epidemiology and Prevention Services. Graphic layout by Chuck Anziulewicz. Please call (304) 558-5358 for additional information. To submit an article or idea, ask for editor Loretta Haddy.

Mid-year 2016 HIV and AIDS surveillance

West Virginia AIDS and HIV Infection Cases Diagnosed by Age Group, Gender, Race and Exposure Category Cumulative through June 30, 2016

Characteristic	HIV/AIDS ‡		HIV-NA ‡		AIDS ‡	
	No.	%	No.	%	No.	%
Age at Diagnosis §						
< 13 years	23	1	12	1	11	1
13 - 24 years	343	12	217	24	126	7
25 - 44 years	1,803	64	536	59	1,267	66
45 - 64 years	611	22	130	14	481	25
65 + years	45	2	8	1	37	2
Gender						
Males	2,286	81	683	76	1,603	83
Females	541	19	221	24	320	17
Race/Ethnicity						
White	2,099	74	621	69	1,478	77
Black	595	21	229	25	366	19
Other*	133	5	54	6	79	4
Exposure Category						
Male-to-male sex (MSM)	1,501	53	459	51	1,042	54
Injection drug use (IDU)	397	14	119	13	278	14
MSM/IDU	132	5	32	4	100	5
Heterosexual contact	401	14	144	16	257	13
Perinatal	26	1	13	1	13	1
Other/Unknown†	370	13	137	15	233	12
Total	2,827	100	904	100	1,923	100

Notes: These are HIV/AIDS case numbers reported to the West Virginia Department of Health and Human Resources as of June 30, 2016. No adjustments were made for reporting delays. AIDS data includes reports from April 1984 through June 30, 2016; HIV data includes reports from January 1989 through June 30, 2016. Federal prisoners have been excluded. Percentages may not add to 100% due to rounding.

‡ HIV/AIDS provides information on the person's earliest diagnosis of HIV or AIDS in West Virginia. HIV-NA provides information on individuals diagnosed with HIV but not AIDS in West Virginia. These individuals may have been diagnosed with AIDS in another state. Individuals with AIDS may or may not have been diagnosed with HIV in West Virginia.

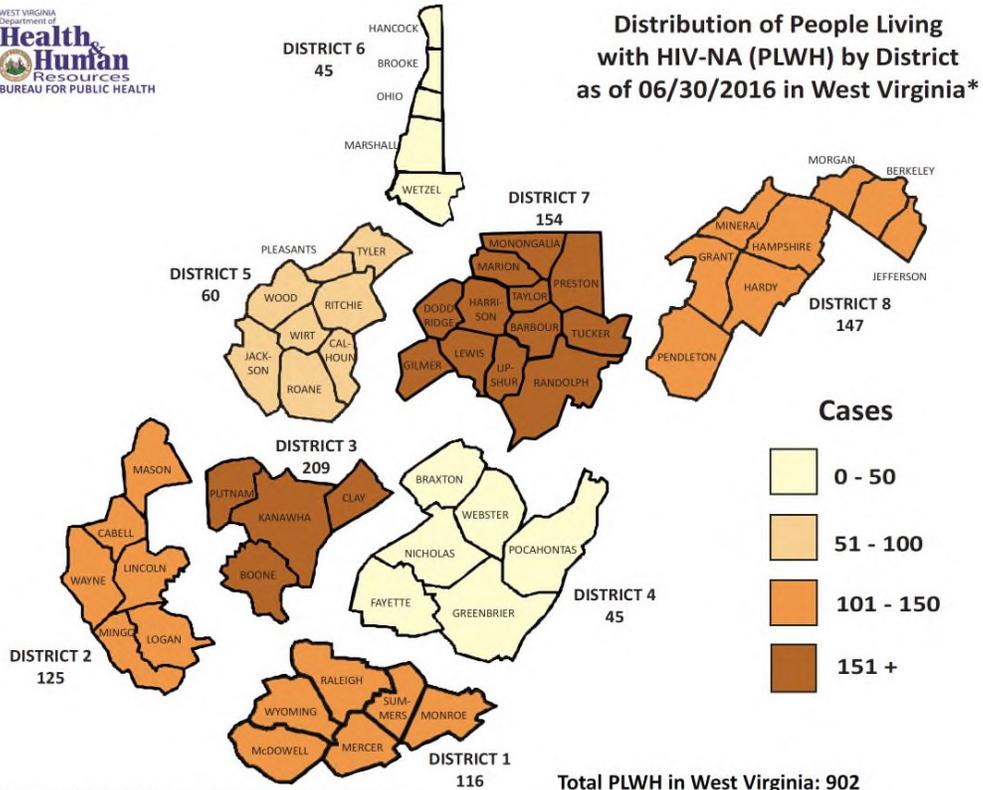
*Other race categories include Hispanic, Asian, Native Hawaiian, Pacific Islander, American Indian, Alaskan Native, Multiple Races, and Unknown race.

†Other/Unknown risk categories include hemophilia, blood transfusion, and risk not reported or identified.

§Total includes one person with unknown age at diagnosis.

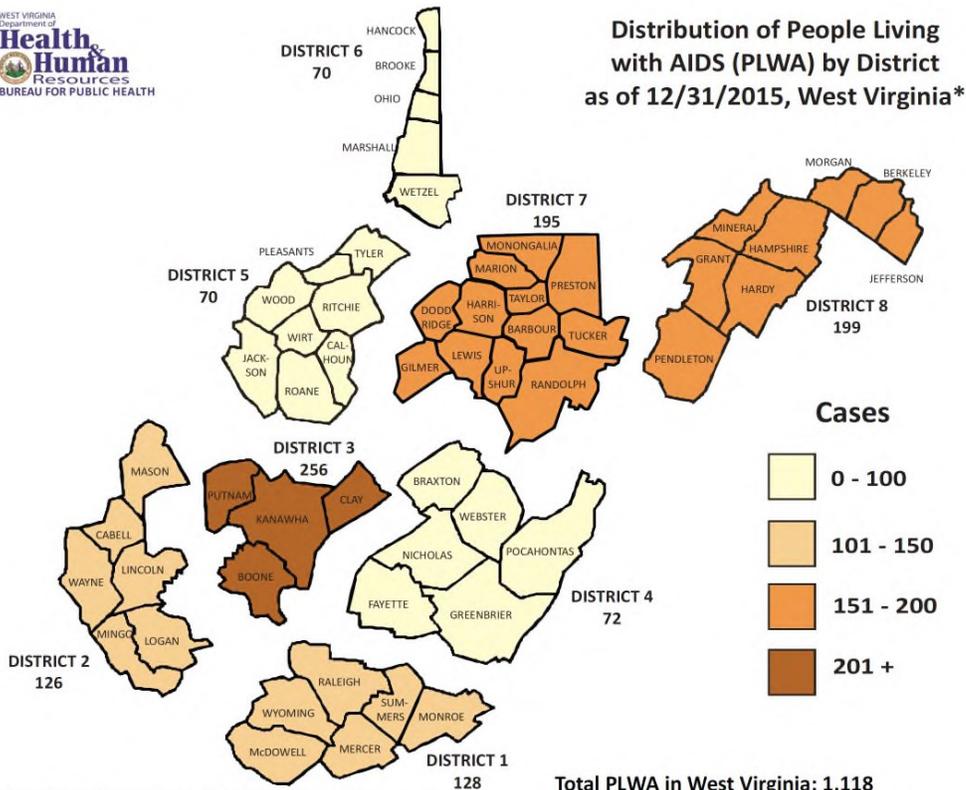
See *HIV and AIDS surveillance*, page 6

AIDS and HIV, continued from page 5



ata Source: West Virginia Department of Health and Human Resources Bureau of Public Health, Office of Epidemiology & Prevention Services,

Total PLWH in West Virginia: 902
* Excludes federal prisoners. There is 1 case with unknown district of residence.



ata Source: West Virginia Department of Health and Human Resources Bureau of Public Health, Office of Epidemiology & Prevention Services,

Total PLWA in West Virginia: 1,118
* Excludes federal prisoners. There are 2 cases with unknown district of residence.