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New Changes to Los Angeles County Reportable Diseases

The Los Angeles County Department of Public Health has recently updated its list of local reportable diseases and conditions. These changes are consistent with those directed by the State of California.

While the majority of reporting requirements remain the same, there are several revisions.

Newly Reportable Diseases

Notably, the Reportable Diseases and Conditions list has been expanded to now include, or more clearly specify, the following diseases:

- Both human and animal cases of anthrax
- Both human and animal cases of brucellosis (except infections due to *Brucella canis*)
- Cyclosporiasis
- Hepatitis E
- Both human and animal cases of tularemia
- Both human and animal cases of the viral hemorrhagic fever diseases.

Diseases No Longer Reportable

Several diseases have been removed from the list:

- Colorado tick fever
- Kawasaki syndrome
- Rheumatic fever
- Water-associated diseases, such as swimmer's itch and hot tub rash.

Note, however, that outbreaks of any of these conditions remain reportable.

Other Changes

In addition to the changes outlined above, for clarity, the various hepatitis diseases have been extended by viral type. And typhus and typhus-like illnesses have been grouped under rickettsial diseases.

There have also been several revisions to the reporting of influenza: Avian

influenza has been removed, although all cases due to any novel influenza viral strains should be reported immediately to the Department of Public Health. While hospitalized influenza cases are no longer reportable, fatal cases of all ages should be reported within 7 working days to the Department of Public Health. This local reporting requirement differs from that of the state.

Safeguarding the Public's Health

Timely and accurate reporting of suspected or confirmed communicable diseases allows the Department of Public Health to investigate, identify, and interrupt the spread of many diseases before they affect others in the community.

Primary care physicians are often the first to recognize unusual occurrences or patterns of disease. Therefore, it is crucial to maintain a "high index of suspicion" for conditions of potential public health significance and to report them quickly.

Submitting Disease Reports

Disease reports can be submitted via several methods:

- Contact the Communicable Disease Reporting System (1-888-397-3993).
- Submit a Confidential Morbidity Report (CMR) Form www.publichealth.lacounty.gov/acd/reports/CMR-H-794.pdf.
- Log on to the Visual CMR online system (restricted to designated persons).

The latest Reportable Diseases and Conditions list is featured on page 2; it is also online and can be downloaded at www.publichealth.lacounty.gov/acd/reports/DiseaseList2011.pdf.





REPORTABLE DISEASES AND CONDITIONS

Title 17, California Code of Regulations (CCR), § 2500

It is the duty of every health care provider, knowing of or in attendance on a case or suspected case of any diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. "Health care provider" encompasses physicians (surgeons, osteopaths, oriental medicine practitioners), veterinarians, podiatrists, physician assistants, registered nurses (nurse practitioners, nurse midwives, school nurses), infection control professionals, medical examiners/coroners, dentists, and chiropractors, as well as any other person with knowledge of a case or suspected case.

Urgency Reporting Requirements

= Report immediately by telephone = Report within 1 working day of identification = Report within 7 calendar days from time of identification

REPORTABLE DISEASES

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> Acquired Immune Deficiency Syndrome (AIDS) ■ Amebiasis Anaplasmosis/Ehrlichiosis Anthrax, human or animal + Babesiosis Botulism: infant, foodborne, or wound Brucellosis, animal; except infection due to <i>Brucella canis</i> + Brucellosis, human + Campylobacteriosis Chancroid ■ Chickenpox (Varicella), only hospitalized and fatal cases, do not report cases of herpes zoster or shingles <i>Chlamydia trachomatis</i> infection, including lymphogranuloma venereum (LGV) ■ Cholera + Ciguatera Fish Poisoning Coccidioidomycosis Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE) Cryptosporidiosis Cyclosporiasis Cysticercosis or Taeniasis Dengue Diphtheria + Domoic Acid (Amnesic Shellfish) Poisoning Ehrlichiosis/Anaplasmosis Encephalitis, specify etiology: viral, bacterial, fungal or parasitic <i>Escherichia coli</i>, shiga toxin producing (STEC) including <i>E. coli</i> O157 + Foodborne Disease Foodborne Outbreak; 2 or more suspected cases from separate households with same assumed source Giardiasis Gonococcal Infection ■ <i>Haemophilus influenzae</i>, invasive disease only, less than 15 years of age Hantavirus Infection | <ul style="list-style-type: none"> Hemolytic Uremic Syndrome Hepatitis A, acute infection Hepatitis B, specify acute or chronic Hepatitis C, specify acute or chronic Hepatitis D (Delta), specify acute or chronic Hepatitis E, acute infection Human Immunodeficiency Virus (HIV) ■ (\$2641-2643) Influenza deaths, laboratory confirmed cases only, all ages ★ Influenza, novel strains, human Legionellosis Leprosy (Hansen's Disease) Leptospirosis Listeriosis + Lyme Disease Malaria + Measles (Rubeola) Meningitis, specify etiology: viral, bacterial, fungal, or parasitic Meningococcal Infection Mumps Paralytic Shellfish Poisoning Pelvic Inflammatory Disease (PID) ■ Pertussis (Whooping Cough) Plague, human or animal + Poliovirus Infection Psittacosis Q Fever Rabies, human or animal Relapsing Fever Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses Rocky Mountain Spotted Fever Rubella (German Measles) Rubella Syndrome, Congenital Salmonellosis, other than Typhoid Fever + SARS (Severe Acute Respiratory Syndrome) Scabies, atypical or crusted ★ Scombroid Fish Poisoning Shiga Toxin, detected in feces Shigellosis | <ul style="list-style-type: none"> Smallpox (Variola) <i>Staphylococcus aureus</i> Infection; deaths only or admission to an intensive care unit of a person who: has not had surgery or dialysis or been hospitalized, or resided in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture. Streptococcal Infection, outbreaks of any type Streptococcal Infection, individual case in a food handler or dairy worker Streptococcal Infection, Invasive Group A, including Streptococcal Toxic Shock Syndrome and Necrotizing Fasciitis; do not report individual cases of pharyngitis or scarlet fever. ★ <i>Streptococcus pneumoniae</i>, Invasive ★ Syphilis ■ Tetanus Toxic Shock Syndrome Trichinosis Tuberculosis + ■ Tularemia, animal Tularemia, human + Typhoid Fever, cases and carriers + <i>Vibrio</i> Infection + Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses) West Nile Virus (WNV) Infection Yellow Fever Yersiniosis <p> OCCURRENCE OF ANY UNUSUAL DISEASE</p> <p> OUTBREAKS OF ANY DISEASE, including diseases not listed above. Specify if occurring in an institution and/or the open community.</p> |
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Reportable Non-Communicable Diseases or Conditions

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> Alzheimer's Disease and Related Conditions (CCR § 2802, § 2806, § 2810) | <ul style="list-style-type: none"> Disorders Characterized by Lapses of Consciousness (CCR § 2806, § 2810) | <ul style="list-style-type: none"> Pesticide-Related Illnesses (Health and Safety Code §105200) |
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- ★ Reportable to the Los Angeles County Department of Public Health.
- + Bacterial isolates and malarial slides must be forwarded to Los Angeles County Public Health Laboratory for confirmation. Health care providers must still report all such cases separately. **Public Health Laboratory (562) 658-1300**
- For questions regarding the reporting of HIV/AIDS, STDs or TB, contact the respective program:

HIV Epidemiology Program
(213) 351-8516

www.publichealth.lacounty.gov/hiv/index.htm

STD Program
(213) 744-3070

www.publichealth.lacounty.gov/std/index.htm

TB Control Program
(213) 744-6271 (reporting); (213) 744-6160 (general)
www.publichealth.lacounty.gov/tb/index.htm

To report a case or outbreak of any disease, contact the Communicable Disease Reporting System

Tel: (888) 397-3993 • Fax: (888) 397-3778

Victim Identification in Health Care Settings

Susie Baldwin, MD, MPH

Human trafficking is modern-day slavery, a global industry that generates billions of dollars in international profits each year.¹ The United Nations defines human trafficking as

“the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.”²

In the United States, the Trafficking Victims Protection Act (TVPA) of 2000 and subsequent TVPA reauthorizations codify human trafficking as a federal crime, create protections for victims in the U.S., and strengthen the ability of the U.S. government to combat human trafficking internationally. In California, state laws criminalize human trafficking as a felony and assist survivors in rebuilding their lives.

Regardless of the form of their exploitation, people who are trafficked suffer intense abuse that often results in physical and mental illness.³ Because of the health risks inherent to the trafficking experience, encounters in health care settings may provide opportunities for victim identification.

A 2005 report by the Family Violence Prevention Fund reported that among a sample of 21 victims from San Francisco, Los Angeles, and Atlanta, 28% received medical care while under the control of their trafficker.⁴ The U.S. Department of Health and Human Services (HHS), the federal agency responsible for assisting trafficking victims, supports the notion that health care settings can serve as sites for identification and rescue of trafficking victims. In 2004, HHS initiated a campaign to increase awareness of human

trafficking among professionals, including health care workers, who may unknowingly interact with trafficking victims in the context of their daily work.⁵ HHS has since reported that law enforcement and service providers have identified health and dental clinic workers and emergency room personnel as sources of victim referrals.⁶

Health care settings can serve as sites for identification and rescue of trafficking victims.

A recently published study supports anecdotal reports that human trafficking victims in the U.S. interact with health care personnel, including providers of primary care, sexual and reproductive health care, dental care, and traditional or alternative remedies.⁷ In this exploratory study, six of 12 women interviewed reported having seen a doctor while they were under their trafficker’s control. Another victim actually worked in a health care facility.

As mandated reporters, clinicians in California must report suspected abuse of a minor as well as any instance in which a patient has a physical injury that the provider suspects was caused by “assaultive or abusive conduct.”^{8,9}

Potential Signs of a Trafficking Victim

There is no typical clinical presentation of a trafficking victim. These patients have many different backgrounds, experience myriad forms of labor violations and abuse, and present with a variety of symptoms and complaints. However, certain patient behaviors and accompanying trafficker

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Human Trafficking in the United States

Though concrete data regarding the extent of human trafficking are difficult to collect,¹⁰ the U.S. is known to be an international trafficking destination.¹¹ The State Department estimates that 14,000-17,500 women, men, and children are trafficked into the U.S. each year from dozens of countries.¹² In addition, many thousands of U.S. citizens, mostly women and children, are trafficked within U.S. borders for commercial sexual exploitation.

California is considered a top destination for traffickers because of the state’s extensive international border, its major harbors and airports, its powerful economy and industries, and its large immigrant population.¹³

Los Angeles is a known gateway through which international victims arrive in the U.S.¹⁴ However, many victims are

transported to other parts of the country; as of 2004, forced labor victims had been identified in at least 90 U.S. cities in 31 states.¹⁵

Trafficked people are typically absorbed into underground, unregulated sectors of the economy, where violations of wage, health, and safety laws routinely occur.¹⁵ Commonly, trafficking victims work as enslaved domestic servants or as forced laborers in the restaurant, agricultural, or manufacturing sectors. Trafficking victims are also coerced into prostitution, pornography, and other sectors of the commercial sex industry. Minors involved in commercial sex work are legally classified as victims of human trafficking, even if they do not consider themselves to have been coerced.

behaviors can alert health care professionals to a potential human trafficking case.

Aside from physical evidence of abuse, characteristics of patients that should trigger closer evaluation by health professionals include

- Delay in seeking care for illness or injury
- Limited English proficiency
- Fear, reticence, depression
- Overbearing or controlling companion
- Uninsured, cash payment for services
- High-risk youth (runaways, high-school dropouts, impoverished, unemployed, those who have spent time in juvenile justice or child welfare systems).

These individual warning signs describe thousands or, in some cases, millions of people who utilize health services in Los Angeles County. Rather than serving as a checklist to identify victims, warning signs should alert health care providers to investigate the patient's situation further.

Strategies to Improve Identification of Human Trafficking Victims in Health Care Settings

- Train health care personnel, including other physicians, nurses, dentists, medical assistants, technicians, and receptionists to increase awareness of trafficking and coercion.
- Mitigate language barriers; provide professional interpreters.
- Interview and/or examine all patients privately.
- Incorporate social, work, home situation, and domestic violence screening questions into the routine history.
- Carefully observe the body language and communication style of patients and those who accompany them.
- Learn about local resources to help with suspected trafficking cases (many U.S. metropolitan areas, including Los Angeles, have a Human Trafficking Task Force).
- Call for assistance 24/7 if you suspect trafficking.

The Coalition to Abolish Slavery and Trafficking
(888) KEY-2-FRE(EDOM)

National Human Trafficking Resource Center
(888) 3737-888

Los Angeles Police Department
Innocence Lost Task Force
Hotline for minor victims of sex trafficking
(800) 655-4095

By taking a more nuanced history about the presenting complaint and a brief social history assessing home and work environments, clinicians may be able to discern a potential trafficking victim.

A patient's body language, affect, and attitude all may convey her or his status as a victim. As with women who suffer intimate partner violence, the presence of an overbearing or controlling companion should trigger concern. To allow patients the opportunity to speak for themselves, clinic or hospital staff should interview and assess all patients privately at some point during their visit. This might require asking family members and other companions to leave the patient's room.

Discussing a Potential Trafficking Victim

Questioning of potential trafficking victims should be conducted sensitively and gently, in a manner that builds trust. Many factors prevent trafficked patients from disclosing their situation to health care providers. Victims do not self-identify as having been trafficked, and commonly they do not even recognize themselves as victims. Coercion and control by their "employer," social and cultural alienation, and pervasive fear and shame all impede victim identification.

Clinicians may miss important clues about trafficking victim patients because of their lack of awareness and training, and also lack of time. While validated screening questions for identifying trafficking victims do not yet exist, it is possible that simple questions can enable health care providers to better identify these patients. Here are a few:

"Are you safe in your home?"

This question can potentially serve to identify trafficking victims, as can routine social history questions.

"Do you owe your employer money?"

This question can identify cases of debt bondage and indentured servitude, which are key, illegal elements of human trafficking.

"Can you come and go as you please?"

"Where do you sleep and eat?"¹⁶

If the patient's circumstances seem suspicious, staff should contact a human trafficking hotline (see "Strategies" box) or law enforcement for guidance and assistance about how to proceed and how to report their concerns.

Language also poses a great barrier to identification of international trafficking victims in health care settings. Victims who receive health services commonly report that medical personnel communicate only with their trafficker, who serves as their interpreter. In Los Angeles County, where an estimated 150 languages are spoken and more than 2.5 million people have limited English proficiency (LEP), language barriers to health services present a tremendous challenge.¹⁷

Under federal and state laws, LEP persons have a right to language assistance in accessing health and social services

programs, including clinics, hospitals, and health plans. However, health care facilities typically lack the resources to make language services available to all of those who need them. Accordingly, in most clinical settings any bilingual person accompanying a patient may be engaged as their interpreter. This practice has dangerous implications for trafficking victims.

Conclusion

Although the prevalence of human trafficking victims in the general U.S. population is likely very low, increasing awareness of human trafficking may improve identification of victims in clinical settings, especially among high-risk youth and in immigrant communities. As more U.S. citizens and some legal immigrants acquire health insurance coverage through the implementation of the Patient Protection and Affordable Care Act, undocumented immigrants, recent immigrants, and other vulnerable, uninsured patients may increasingly concentrate in safety net hospitals and community health centers. Targeted efforts to increase awareness of human trafficking among health care providers in these settings could perhaps maximize the impact of educational interventions. However, because trafficking victims may visit a variety of medical settings, including small, private doctors' offices, increasing awareness of human trafficking among health care personnel in all types of settings remains a worthy goal.

In light of an expected increase in adoption of electronic medical records and incentives to screen patients for public insurance program eligibility, the implementation of health insurance reform may present new opportunities to screen for human trafficking. Focusing these efforts among immigrant or LEP patients, or those who pay cash for services, may facilitate identification of international trafficking victims.

Recognition and mitigation of the barriers to identification of trafficking victims, coupled with greater awareness of human trafficking among physicians and other health care professionals, should enable providers to more effectively assess risk among vulnerable patients in Los Angeles and could improve identification of victims. 

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Note: This article is adapted from Baldwin SB, Eisenman DP, Sayles JN, Chuang K, Ryan G. Identification of human trafficking victims in health care settings. *Health and Human Rights*. 2011;13:1-14. For the full article, go to www.hhrjournal.org/index.php/hhr/article/view/409/612.

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Improving Adolescent Immunization Rates

By Julia Heinzerling, MPH

The inaugural year of a new school immunization mandate in 2011 required students to provide proof that they had received a dose of tetanus, diphtheria, and acellular pertussis (Tdap) vaccine for school entry. This requirement increased Tdap coverage levels, called attention to the fact that other adolescent vaccination rates are low (Figure 1), and highlighted the importance of continued efforts to protect all adolescents from pertussis and other vaccine-preventable diseases. This article encourages providers to actively promote adolescent immunizations and implement office-based strategies to ensure that their adolescent patients receive recommended vaccines on time.

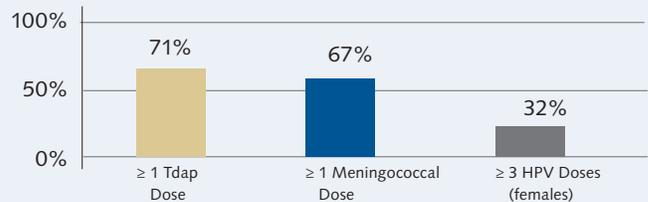
Adolescent Vaccines, Safety and Effectiveness

The Advisory Committee on Immunization Practices (ACIP) recommends that Tdap, meningococcal, and human papillomavirus (HPV) vaccines, as well as an annual influenza vaccine, be given at 11 and 12 years of age at a routine, comprehensive preventive care visit. On October 25, 2011, the ACIP expanded HPV recommendations to include routine vaccination of males against HPV. Boys should receive 3 doses of HPV4 vaccine, starting at 11 or 12 years of age and the vaccine can be given to males as early as 9 years of age. On-time vaccination is important because the immune response to HPV is stronger at 11-12 years of age than in later adolescence and HPV vaccine is most effective if received before exposure through sexual contact. Catch-up doses are recommended for males through 21 years of age and can be given through 26 years of age. Other vaccines are recommended for children who are at high risk for catching or spreading certain vaccine-preventable diseases or are missing doses due earlier in childhood. (Table 1)

Clinical trial and post-licensure studies show that adolescent immunizations are effective. HPV4 (Gardasil) and HPV2 (Cervarix) were found to be 97% and 93% effective, respectively, in preventing HPV 16 or 18-related cervical intraepithelial neoplasia (CIN) grade 2 or 3 and adenocarcinoma in situ (AIS).¹ Tdap's clinical efficacy is expected to be similar to DTaP's (80% -85%).¹ Finally, in serological studies, the two available meningococcal conjugate vaccines, Menveo and Menactra, achieved a titer level that predicts protection for more than 98% of vaccinees. Because vaccine studies suggest that protection may not last more than 5 years, a booster meningococcal conjugate vaccine dose is now recommended at 16 years of age for individuals vaccinated at 11-12 years of age.²

The most common reported reactions to adolescent vaccinations are local reactions such as pain, redness, and swelling at the injection site. Serious side effects are rare but episodes of syncope following vaccination have led to injuries in adolescents, some of which have required hospitalization. Though syncope is not common, as a precaution, the ACIP recommends that providers "strongly consider observing patients for 15 minutes after they are vaccinated" and if syncope develops manage them appropriately.³

Figure 1. Percent of 13- to 17-Year-Olds Vaccinated, 2010



Source: CDC National Immunization Survey - Teens

What Physicians Can Do to Improve Adolescent Immunization Rates

In 2010, only 71% of California's adolescents between 13 and 17 years of age had received a Tdap dose; 67% had received a meningococcal dose and 32% of females had received 3 HPV vaccine doses (Figure 1). This leaves a significant number of adolescents at risk of becoming infected with and spreading vaccine-preventable diseases.

The causes for low adolescent immunization coverage levels include a lack of effective adolescent-targeted disease prevention education, low use of preventive visits by adolescents, the high cost of adolescent vaccines, and a lack of a physician recommendation.^{4,5}

Administer vaccines on-time and provide catch-up doses.

- Administer immunizations at the earliest opportunity allowed under ACIP recommendations.
- Schedule a comprehensive preventive visit for all preteens at 11-12 years of age to provide recommended immunizations and discuss other preventive health recommendations such as physical activity, sexual health issues, and chemical dependence.
- Provide catch-up immunizations for all adolescent patients, when not contraindicated, during non-preventive care visits, including sports physicals and acute care visits.
- Administer all routinely recommended and catch-up vaccines simultaneously at one visit unless a particular vaccine is contraindicated at the time of the visit. If not administered at the same visit, live vaccine doses (MMR, intranasal flu, and varicella) should be separated by at least 28 days.

Use office-based systems to bring adolescents into your office and to reduce missed opportunities to vaccinate.

- Use the California Immunization Registry (CAIR) to track vaccine doses, decrease the likelihood that duplicate doses are administered, and identify clients who are missing recommended doses (800- 578-7889 or CAIRHelpDesk@cdph.ca.gov).
- Use chart stickers, preventive flow sheets, and EHR or registry prompts to reduce missed opportunities and remind clinicians and staff when vaccines are due for patients.

- Use letters, postcards, email, phone calls, automated messages, and text messages to notify parents when immunizations are due or overdue. CAIR can generate reminder/recall lists and postcards for patients who are missing recommended doses.
- To expand access and reduce out-of-pocket costs, consider walk-in visits, evening or weekend appointments, and participating in the VFC Program. For information about the VFC program, log on to www.eziz.org.

Ensure that your care team is familiar with laws impacting immunizations.

- On January 1, 2012, a new law went into effect in California that allows minors 12 years of age or older to consent to medical care related to the prevention of a sexually transmitted disease. This allows minors to consent to hepatitis B and HPV vaccination without parental permission.
- Students entering the 7th grade are required to show proof of a Tdap vaccine on or after their 7th birthday. The California State University (CSU) system requires students to provide proof of immunization against measles and rubella and both the CSU and University of California systems require first-time enrollees who are under age 19 show proof of 3 doses of hepatitis B vaccine.

Educate parents and adolescents about the importance of immunizations.

- Talk to all adolescent patients and their parents about immunizations. Inform them about vaccine risks and benefits and provide a Vaccine Information Statement (VIS), as required by law, for every vaccine provided.
- Download flyers, brochures and other educational materials at www.publichealth.lacounty.gov/hea/Materials_Review/2011.Sept.27_Print%20Materials%20Inventory.pdf.
- Educate parents and teens about the risks of skipping or delaying vaccine doses. Directly answer their questions and concerns about vaccine safety. Responses to common questions about vaccine safety are posted online at

www.publichealth.lacounty.gov/ip/HCPs.htm and www.immunizeca.org/resources/vaccine-safety.

- Use plain language, limit information to the most important messages and discuss the most important facts first. Communication and health literacy tips can be downloaded at www.ama-assn.org/resources/doc/ama-foundation/healthlitclinicians.pdf.
- Combine science-based facts with personal stories. Share why you and your family members stay up to date with vaccines. Refer patients to the www.shotbyshot.org website to learn about the impact of vaccine-preventable diseases on families in California.

Adolescent immunizations are safe, effective, and the best way to protect adolescents and their contacts from diseases that can be serious. Preteen Vaccine Week, which is celebrated February 12-18, 2012, presents the opportunity to increase awareness of adolescent immunizations in your practice and to implement the strategies described above to improve immunization rates throughout the year. For more information and resources, visit www.publichealth.lacounty.gov/ip. 

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Table 1. Summary of ACIP Adolescent Immunization Recommendations

Routine Immunizations	<ul style="list-style-type: none"> • Human papillomavirus* • Meningococcal conjugate, with booster dose at age 16 • Tetanus, diphtheria and acellular pertussis booster • Annual influenza immunizations
<i>Recommended for all adolescents at 11-12 years of age, with catch-up vaccines administered throughout adolescence</i>	* In October 2011, the ACIP voted to recommend routine vaccination of males with HPV vaccine.
Catch-up Immunizations	<ul style="list-style-type: none"> • Hepatitis B • Inactivated polio • Measles, mumps and rubella • Varicella
<i>Recommended for adolescents who are not fully immunized</i>	
High-risk Immunizations	<ul style="list-style-type: none"> • Hepatitis A • Pneumococcal disease
<i>Recommended for adolescents at high risk for disease and/or complications</i>	

For additional details, minimum intervals, and contraindications, visit www.cdc.gov/vaccines/recs/schedules/downloads/child/7-18yrs-schedule-pr.pdf

Rx for Prevention is published 10 times a year by the Los Angeles County Department of Public Health. If you would like to receive this newsletter by e-mail, go to www.publichealth.lacounty.gov and subscribe to the ListServ for *Rx for Prevention*.

Rx for Prevention

Promoting health through prevention in Los Angeles County

Upcoming Trainings

Immunization Training Resources for Clinicians

The Los Angeles County Department of Public Health Immunization Program, the California Department of Public Health, the CDC and other entities offer a variety of web-based and in-person immunization training programs for clinicians and staff. Some programs offer CMEs. Visit www.publichealth.lacounty.gov/ip/trainconf.htm.

Immunization Skills Training for Medical Assistants

The Immunization Skills Institute is a 4-hour course that trains medical assistants on safe, effective, and caring immunization skills. Visit www.publichealth.lacounty.gov/ip or call (213) 351-7800.



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Comments or Suggestions? If so, or if you would like to suggest a topic for a future issue, e-mail Dr. Jeffrey Gunzenhauser, co-editor, at jgunzenhauser@ph.lacounty.gov.

Index of Disease Reporting Forms

All case reporting forms from the LA County Department of Public Health are available by telephone or Internet.

Reportable Diseases & Conditions

Confidential Morbidity Report
Morbidity Unit (888) 397-3993
Acute Communicable Disease Control
(213) 240-7941
www.publichealth.lacounty.gov/acd/reports/CMR-H-794.pdf

Sexually Transmitted Disease Confidential Morbidity Report
(213) 744-3070

www.publichealth.lacounty.gov/std/providers.htm (web page)
www.publichealth.lacounty.gov/std/docs/STD_CMV.pdf (form)

Adult HIV/AIDS Case Report Form

For patients over 13 years of age at time of diagnosis
HIV Epidemiology Program
(213) 351-8196
www.publichealth.lacounty.gov/HIV/hivreporting.htm

Pediatric HIV/AIDS Case Report Form

For patients less than 13 years of age at time of diagnosis

Pediatric AIDS Surveillance Program
(213) 351-8153

Must first call program before reporting
www.publichealth.lacounty.gov/HIV/hivreporting.htm

Tuberculosis Suspects & Cases Confidential Morbidity Report

Tuberculosis Control (213) 744-6160
www.publichealth.lacounty.gov/tb/forms/cmrv.pdf

Lead Reporting

No reporting form. Reports are taken over the phone.
Lead Program (323) 869-7195

Animal Bite Report Form

Veterinary Public Health (877) 747-2243
www.publichealth.lacounty.gov/vet/biteintro.htm

Animal Diseases and Syndrome Report Form

Veterinary Public Health (877) 747-2243
www.publichealth.lacounty.gov/vet/disintro.htm

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