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Pertussis Cases Continue to Rise: Steps for Preventing its Spread

Recently, the number of pertussis (whooping cough) cases and deaths in California and Los Angeles County has increased. In California, the number of cases reported as of August 2010 was seven times greater than during the same period in 2009. In LA County this year, there have been more confirmed and probable pertussis cases reported than for the entire year of 2009, and 4 infants have died.

The continuing increase in cases requires vigilance and action on the part of all physicians. To prevent further spread of this serious and deadly disease, medical practices should implement the following steps...

1. Be vigilant: Consider pertussis and treat suspect cases with an appropriate antibiotic.

Consider pertussis when an infant presents with respiratory difficulty, a cough, cold-like symptoms, and/or a respiratory illness of unknown cause.

Young infants often do not exhibit the whoop, and patients may seem asymptomatic between paroxysms. Observe infants while awake and consider parental reports of symptoms.

During periods of increased transmission, promptly treat all suspect pertussis cases with an antibiotic that is effective in eradicating pertussis from the airway (usually a macrolide antibiotic).

2. Promote pertussis vaccination: Vaccination is the best defense against pertussis.

Vaccinate all eligible patients with DTaP vaccine, as recommended by the Advisory Committee on Immunization Practices (ACIP):

- ACIP recommends routine administration of DTaP vaccine to children at 2, 4, 6 and 15-18 months of age, with

a booster dose between 4 and 6 years of age.

Vaccinate all eligible patients with Tdap vaccine:

- ACIP recommends routine administration of Tdap vaccine for pre-teens between 11 and 12 years of age, and adolescents and adults under 65 years of age who have not received a Tdap dose.
- During this period of increased cases, the California Department of Public Health recommends an expanded Tdap vaccination schedule, which includes vaccination of all ACIP-recommended groups, persons 7-10 years of age who have not completed the primary DTaP series, and persons 65 years of age and older who have not received a previous Tdap dose.
- Priority groups are pregnant and postpartum women, health care providers, and any individual in close contact with infants, including parents, siblings, grandparents, and child care providers.

3. Educate staff and patients about pertussis.

Distribute and post staff and patient education materials about pertussis. Log on to www.eziz.org/resources/materials_pertussis.html.

4. Report all suspected pertussis cases to Public Health.

Report all suspect cases of pertussis to the Department of Public Health within 1 working day of identification. Call (888) 397-3993, or send a fax to (888) 397-3778.

With the help of physicians, preventing the spread of pertussis is possible. Visit www.publichealth.lacounty.gov/ip for links to educational materials and additional information. 



ACIP Expands Age Groups for Seasonal Flu Vaccination

Willie Watts-Troutman, RN, PHN, APS

Earlier this year, the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP) revised its recommendation regarding the annual influenza vaccination. It now recommends that all persons 6 months of age and older be vaccinated against the influenza virus. This expands ACIP's previous recommendation, and now includes all adults aged 19 through 49 years. This revision is supported by evidence that annual influenza vaccination is a safe and effective preventive health action with potential benefit for all age groups.

A universal vaccination recommendation for all persons aged 6 months and older eliminates the need to determine whether each person has an indication for vaccination and emphasizes the importance of preventing influenza among person of all ages. In addition, expansion of vaccination recommendations to all adults removes potential barriers to receipt of influenza vaccine, including lack of awareness about vaccine indications among persons at higher risk for influenza complications and their close contacts.

Summary of Flu Vaccination Recommendations, 2010-2011

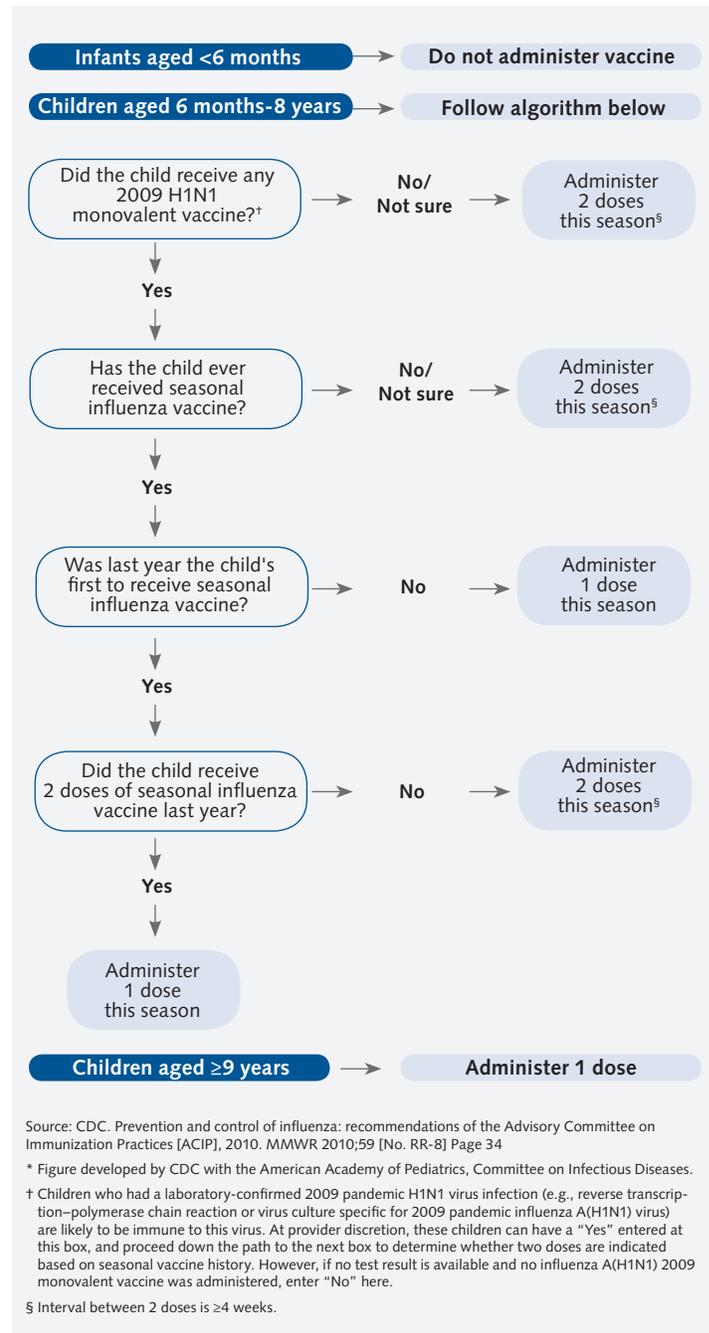
For this flu season, ACIP has released the following guidance:

- All persons aged 6 months and older should be vaccinated annually, including all adults 19 years of age and older.
- Protection of persons at higher risk for flu-related complications should continue to be a focus of vaccination efforts as providers and programs transition to routine vaccination of all persons aged ≥ 6 months. High-risk groups for flu vaccination include the following:
 - All children 6 months of age through 18 years
 - Pregnant and postpartum women
 - Immunocompromised persons and persons with chronic medical conditions
 - Children and adolescents receiving long-term aspirin therapy
 - Health care personnel
 - American Indians/Alaska Natives
 - Morbidly obese (body-mass index ≥ 40)
 - Residents at nursing home and other chronic care facilities
 - Household contacts and caregivers of
 - + persons with medical conditions that put them at higher risk for severe flu complications
 - + children aged < 5 years
 - + adults aged ≥ 50 years, with particular emphasis on vaccinating contacts of children aged < 6 months.

2010-2011 Vaccine Virus Strains

The 2010-11 flu vaccines will protect against the two common subtypes of influenza A and a common Type B virus. The specific vaccine strains are A/California/7/2009 (H1N1)-like (the

Figure 1. Flowsheet for Determining the Number of Vaccine Doses Recommended for Children, 2010–2011*



same strain that caused so much illness last year), A/Perth/16/2009 (H3N2)-like, and B/Brisbane/60/2008-like.

Number of Flu Doses Recommended for Children Aged 6 Months Through 8 Years, for 2010-2011

To assure the best protection, it is recommended that any child 6 months through 8 years of age receive 2 doses of flu

vaccine during the 2010-2011 season unless it is determined that the child received...

- at least one dose of H1N1 vaccine in 2009-10 and
- seasonal flu vaccine before 2009-10 or 2 doses of seasonal vaccine in 2009-10.

The minimum interval between doses is 4 weeks. All other children aged 6 months through 8 years should receive 1 dose of seasonal influenza vaccine. (Figure 1)

Newly Approved Vaccines

A newly approved inactivated trivalent vaccine containing 60 mcg of hemagglutinin antigen per influenza vaccine virus strain (Fluzone High-Dose [Sanofi Pasteur]) is an alternative inactivated vaccine for persons aged ≥65 years. Persons aged ≥65 years can be administered any of the standard-dose TIV

preparations or Fluzone High-Dose. Persons aged <65 years who receive inactivated influenza vaccine should be administered a standard-dose TIV preparation.

Previously approved inactivated influenza vaccines that were approved for expanded age indications in 2009 include Fluarix (GlaxoSmithKline), which is now approved for use in persons aged ≥3 years, and Afluria (CSL Biotherapies), which this year, with rare exception, is limited to use in persons 9 years of age and older. A new inactivated influenza vaccine, Agriflu (Novartis), has been approved for persons aged ≥18 years.

Contraindications and Precautions

Trivalent Inactivated Vaccine (TIV)

TIV is contraindicated for individuals who have anaphylactic hypersensitivity to eggs or other components of the vac-

continued on page 4 >

Table 1. Influenza Vaccines for Different Age Groups - United States, 2010–2011 Season*

Vaccine	Trade name	Manufacturer	Presentation	Mercury content (mcg Hg/0.5 mL dose)	Age group	No. of doses	Route
TIV [†]	Fluzone	Sanofi Pasteur	0.25 mL prefilled syringe	0.0	6-35 mos	1 or 2 [§]	Intramuscular [¶]
			0.5 mL prefilled syringe	0.0	≥36 mos	1 or 2 [§]	Intramuscular [¶]
			0.5 mL vial	0.0	≥36 mos	1 or 2 [§]	Intramuscular [¶]
			5.0 mL multidose vial	25.0	≥6 mos	1 or 2 [§]	Intramuscular [¶]
TIV	Fluvirin	Novartis Vaccines	5.0 mL multidose vial	24.5	≥4 yrs	1 or 2 [§]	Intramuscular [¶]
			0.5 mL prefilled syringe	<1.0			
TIV	Agriflu	Novartis Vaccines	0.5 mL prefilled syringe	0.0	≥18 yrs	1	Intramuscular [¶]
TIV	Fluarix	GlaxoSmithKline	0.5 mL prefilled syringe	0.0	≥3 yrs	1 or 2 [§]	Intramuscular [¶]
TIV	FluLaval	GlaxoSmithKline	5.0 mL multidose vial	25.0	≥18 yrs	1	Intramuscular [¶]
TIV	Afluria	CSL Biotherapies	0.5 mL prefilled syringe	0.0	≥6 mos**	1 or 2 [§]	Intramuscular [¶]
			5.0 mL multidose vial	25.0			
TIV High Dose ^{††}	Fluzone High-Dose	Sanofi Pasteur	0.5 mL prefilled syringe	0.0	≥65 yrs	1	Intramuscular [¶]
LAIV ^{§§}	FluMist ^{¶¶}	MedImmune	0.2 mL sprayer, divided dose	0.0	2-49 yrs	1 or 2 [§]	Intranasal

* Immunization providers should check Food and Drug Administration-approved prescribing information for 2010-11 influenza vaccines for the most updated information.

† Trivalent inactivated vaccine.

§ Children aged 6 months-8 years who have never received a seasonal TIV before or who did not receive at least 1 dose of an influenza A (H1N1) 2009 monovalent vaccine should receive 2 doses, spaced ≥4 weeks apart. Those children aged 6 months-8 years who were vaccinated for the first time in the 2009-10 season with the seasonal 2009-10 seasonal vaccine but who received only 1 dose should receive 2 doses of the 2010-11 influenza vaccine formula, spaced ≥4 weeks apart.

¶ For adults and older children, the recommended site of vaccination is the deltoid muscle. The preferred site for infants and young children is the anterolateral aspect of the thigh.

** This year, ACIP voted to limit use of this vaccine to persons 9 years of age and older with rare exceptions for persons 5-8 years of age with high risk of complications, if no other vaccine is available.

†† Trivalent inactivated vaccine high dose. A 0.5-mL dose contains 60 mcg each of A/California/7/2009 (H1N1)-like, A/Perth/16/2009 (H3N2)-like, and B/Brisbane/60/2008-like antigens.

§§ Live attenuated influenza vaccine.

¶¶ FluMist is shipped refrigerated and stored in the refrigerator at 36°F-46°F (2°C-8°C) after arrival in the vaccination clinic. The dose is 0.2 mL divided equally between each nostril. Health-care providers should consult the medical record, when available, to identify children aged 2-4 years with asthma or recurrent wheezing that might indicate asthma. In addition, to identify children who might be at greater risk for asthma and possibly at increased risk for wheezing after receiving LAIV, parents or caregivers of children aged 2-4 years should be asked: "In the past 12 months, has a health care provider ever told you that your child had wheezing or asthma?" Children whose parents or caregivers answer Yes to this question and children who have asthma or who had a wheezing episode noted in the medical record within the past 12 months should not receive FluMist.

Resources for Patients and Health Care Personnel

- Educational materials are posted at www.cdc.gov/flu, www.flu.gov, www.eziz.org, and www.publichealth.lacounty.gov.
- For 2010-2011 influenza information and vaccine-preventable disease updates, contact the Immunization Program at (213) 351-7800 or visit www.publichealth.lacounty.gov/ip.

cine, unless they have been desensitized. Vaccination should usually be delayed for persons with moderate to severe acute febrile illness, as well as those with severe acute illness, with or without fever. Guillain-Barré syndrome within 6 weeks of a previous dose of influenza is a precaution for TIV.

Live Attenuated Influenza Vaccine (LAIV)

LAIV is contraindicated for the following groups:

- Individuals who have anaphylactic hypersensitivity to eggs or other components of the vaccine, unless they have been desensitized.
- Children <2 years of age
- Individuals >50 years of age
- Pregnant women
- Individuals with asthma and children between 2 and 4 years of age whose parents/caregivers have been told by a health care provider that their child had wheezing or asthma during the preceding 12 months and/or whose medical records indicate a wheezing episode in the preceding 12 months
- Adults and children with chronic pulmonary, cardiovascular (except isolated hypertension), renal, hepatic, neurological/neuromuscular, hematologic, or metabolic disorders
- Adults and children with immunosuppression, including immunosuppression caused by medication or HIV
- Individuals 6 months through 18 years of age receiving aspirin or other salicylates.

Vaccination should usually be delayed for persons with moderate to severe acute febrile illness, as well as those with severe acute illness, with or without fever. Guillain-Barré syndrome within 6 weeks of a previous dose of influenza is a precaution for LAIV. LAIV should not be given to close contacts of immunosuppressed individuals who require a protected environment.

Other Vaccines to Consider this Flu Season

Take advantage of flu vaccination visits as an opportunity to vaccinate against pneumococcal disease and pertussis.

Pneumococcal Polysaccharide Vaccine (PPSV)

During the recent pandemic H1N1 influenza outbreak, most of the deaths occurred among persons with chronic health conditions—the same conditions that qualify individuals for receipt of pneumococcal vaccine. The following individuals should receive 1 dose of PPSV:

- All persons 65 years of age and older, including persons who

were vaccinated at age <65 years if it has been >5 years since that vaccination and they have not already received 2 lifetime doses of vaccine.

- Persons aged 2 years and older who are immunocompromised and persons who have a chronic medical condition.
- Persons aged 19-64 years who have asthma and/or who smoke cigarettes. Please provide smoking cessation counseling to smokers.

Tetanus, Diphtheria, Acellular Pertussis Vaccine (Tdap)

The following groups should receive 1 dose of Tdap vaccine if they have not previously received a Tdap dose.

- Persons 10-64 years of age
- Children 7-9 years of age who have not completed their primary DTaP series or require wound management (Recommended Off-Label Use)
- Persons 65 years and older if they are in close contact with an infant (Recommended Off-Label Use)
- Priority groups for Tdap vaccination are women of child-bearing age; close contacts of infants, including caregivers; patients with wounds; and health care personnel.

Use Every Visit as an Opportunity to Vaccinate

This flu season, the expanded flu recommendations give physicians a chance to protect more people from the flu than ever before. Take advantage of every visit as a chance to vaccinate patients, especially pregnant women, children over 6 months of age, individuals with chronic medical conditions and all healthy adults. Finally, stay healthy, avoid missing work, set an example, and protect patients by encouraging all providers and staff in the medical practice to receive a flu vaccine. 

Willie Watts-Troutman, RN, PHN, APS, is adult immunization coordinator, Immunization Program, Los Angeles County Department of Public Health.

REFERENCE

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Reducing Patients' Use of Cell Phones and Texting While Driving

Steven Teutsch, MD, MPH

Carrie A. Brumfield, MBA, MPH

Driver distraction contributed to 21% of all car accidents in 2008, resulting in nearly 6,000 fatalities and approximately 515,000 injuries nationally. The actual numbers are undoubtedly greater since distractions are under-reported.¹

Driver distraction involves performing tasks other than driving that take the driver's eyes and attention off the road. The Federal Motor Carrier Safety Administration conducted a study comparing 35 tasks that resulted in commercial driver distraction and found that those who texted while driving were 23 times more likely to be in a serious crash than those who were not distracted, the highest odds ratio of all tasks evaluated. Safety critical events occurred more often with complex tasks (e.g., texting, reading a map, rummaging through a bag), than with moderately complex tasks (e.g., reaching for an object, talking on a hand-held phone, personal grooming) or simple tasks (e.g., adjusting instruments or drinking coffee).

Individuals who text while driving avert their eyes from the road for an average of 4.6 seconds, or the equivalent distance of a football field when traveling at 55 mph.

While texting confers the highest risk of a vehicular crash and should be the primary focus of educational efforts, all types of driver distraction and inattention—including talking

Ways to Engage Patients in Distracted Driving Conversations

1. Add distracted driving-related questions to patient intake forms.
2. Hang posters in the waiting room and patient rooms.
3. Have brochures available for patients to read.
4. Add a question to annual patient review about distracted driving.

on a hand-held phone or reading a map—lead to greater risk of crashes and should be included in patient counseling.

The most important and consistent lesson from current research is that when drivers take their eyes off of the road, they are more likely to be involved in a collision. Individuals who text while driving avert their eyes from the road for an average of 4.6 seconds, or the equivalent distance of a football field when traveling at 55 mph, which results in the high odds ratio (23.3) for crashes that occur while texting. Although texting carries one of the highest risks, it is only one of many tasks that lead to driver distraction.

Other important sources of driver distraction are writing, reading a map, personal grooming, reading, and even emotional conversations. Since many of these tasks are not amenable to legislation, patients should be counseled of the risks associated with all such activities.

To date, six states, including California, prohibit all drivers from using hand-held cell telephones, and 21 states have banned writing, reading, or sending text communication while driving.² California implemented its hand-held phone ban in July 2008 and its texting ban on January 1, 2009.

One factor in the modest impact of the laws may be law enforcement's ability to enforce them. Currently, 15 states

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The "Just Drive" Campaign

The Los Angeles County Department of Public Health has created a distracted driving campaign titled, "Just Drive," to educate patients and other county residents about the perils of performing other tasks while driving. The campaign includes a variety of materials that can be used by doctors to enhance their patients' awareness of this danger.

Electronic posters can be printed out and hung in offices and flyers can be handed out to patients. Download these resources at www.publichealth.lacounty.gov/ivpp/JustDrive.



Tips for Counseling Patients on Distracted Driving

1. Share distracted driving statistics.
2. Ask patient why he or she is engaging in the behavior.
3. Ask patient if he or she is willing to reduce distractions.
4. Identify practical solutions with patient.

(including California), the District of Columbia, and Guam³ allow for primary enforcement of cell phone laws, though the level of enforcement has not been well-studied. Primary enforcement means that cars can be stopped for failing to obey the cell phone and texting law, and does not need to be limited to those who have been stopped for other reasons (secondary enforcement). This was an important feature of effective seat belt laws, which were relatively ineffectual until primary enforcement laws were passed and there was a pattern of enforcement that changed norms about their use.

What Can the Physician Do?

While enforcement of cell phone bans must be robust, physician counseling can play an important role in changing driver

behavior and social norms. Counseling, particularly of adolescents and young drivers who are at the highest risk, should address the range of distractions that occur when driving.

In addition to counseling patients on limiting driving distractions, physicians can utilize less time-consuming strategies to encourage safer driving habits. Providing resources (see “Just Drive” box) through brochures, posters, and other campaign materials exposes your patients to distracted driving risks while minimizing costs for the practice. **Rx**

Steven Teutsch, MD, MPH, is chief science officer, and **Carrie A. Brumfield, MBA, MPH**, is executive assistant for the chief deputy director, Los Angeles County Department of Public Health.

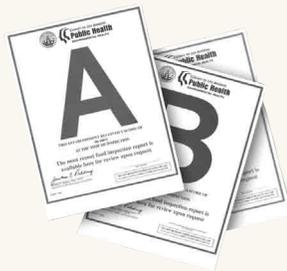
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1. National Highway Traffic Safety Administration. An examination of driver distraction as recorded in NHSTA databases. Traffic Safety Facts. DOT HS 811216.
2. Governors Highway Safety Association. Cell phone and texting laws. April 2010. http://www.ghsa.org/html/stateinfo/laws/cellphone_laws.html.
3. Governors Highway Safety Association. Cell phone and texting laws. April 2010. http://www.ghsa.org/html/stateinfo/laws/cellphone_laws.html.

Findings from Food Safety Quiz Reveal Improvement Needed in Home Kitchen Food Practices

In 1998, the Los Angeles County Department of Public Health began posting letter grades publicly for restaurant kitchens in the county. Restaurant kitchens were graded on several dimensions of food handling and preparation practices recommended by the California Code and USDA food safety principles. By the end of the year, the program was credited with helping to decrease the number of hospitalizations for foodborne infections from nontyphoidal *Salmonella*, *Campylobacter*, and *Escherichia coli* by 13.1%. However, this decline stalled after 2002, suggesting that other sources of infection may still pose significant risks to consumers, including the food distribution chain and private kitchens.

To educate the public about safer food hygiene practices at home, in 2006, the department unveiled its Home Kitchen Self-Inspection Program. Through this web-based, voluntary program, consumers take a Food Safety Quiz, which consists



of 57 questions related to their food handling and preparation practices at home. This free, interactive tool calculates a grade, similar to that used in the restaurant inspections, and offers feedback to help participants learn practical strategies for maintaining safe food hygiene practices in their own kitchens.

Based on data from the program's initial two years, approximately 13,000 participants completed the online Food Safety Quiz. Of these, 34% received an A rating (90%-100% correct answers), 27% a B (80%-89%), and 25% a C (70%-79%). The remaining 14% scored lower than the 70% required to receive a letter grade.

The Home Kitchen Self-Inspection Program was recently featured in the September 3, 2010 (Vol. 59, No. 34), issue of *Morbidity and Mortality Weekly Report*.

In discussions with patients about effective ways to prevent gastroenteritis caused by foodborne pathogens, physicians may find the online Food Safety Quiz a useful educational tool and can direct their patients to this self-assessment resource. It can be accessed at www.publichealth.lacounty.gov/eh/home_kitchen_self_inspection.htm. **Rx**

Disaster Healthcare Volunteers Preregistration Is Crucial to Rapid Deployment

Millicent Wilson, MD

Sandra Shields, LMFT, CTS

Jee Kim, MPH

We know that a major disaster will hit Los Angeles County. The question is not if, but when. The events of 9/11 and Hurricane Katrina point to the need for organized systems to recruit and mobilize qualified medical volunteers. To meet the increased need for health care personnel following disasters, Los Angeles County launched the Los Angeles County Disaster Healthcare Volunteer (DHV) program, formerly known as the ESAR-VHP/MRC.

The program is part of a federally mandated, state and nationwide effort to recruit and register health care volunteers in advance of the next disaster.

The goals of the LA County DHV program are simple: identify health care providers and volunteers; preregister them; prequalify them in terms of practice validation, licensure, and credentialing; and streamline their identification at disaster sites. All of these actions will help accelerate the deployment process in the event of a disaster.

The DHV is a collaborative effort led by Los Angeles County's Department of Health Services Emergency Medical Services Agency and the Department of Public Health. It consists of the Los Angeles County Surge Unit, as well as three Medical Reserve Corps, or MRCs (MRC-Los Angeles, the Beach Cities Health District MRC, and the Long Beach MRC). Volunteers are given a choice of units when they register.

Health Care Professionals Are Needed

Developing and implementing such a volunteer system in a county as large as Los Angeles presents many challenges. In a large scale anthrax attack, for example, the county would need as many as 43,000 volunteers to support mass medication efforts and about 4,000 medical volunteers for the surge-capacity staffing at area hospitals.

Although the U.S. Census lists 300,000 health care providers in the county, it would be difficult to mobilize a group that size to respond rapidly without preregistration.

As recent disasters demonstrate, doctors are eager, willing, and able to volunteer in an emergency. And they will be greatly needed to meet the extraordinary demands of a large-scale emergency or natural disaster. Hospitals and other health care providers will depend on the services that health care volunteers can provide.

It is understood that the first duty of physicians and health care providers is to their own hospitals. If a doctor registers with the DHV program and is asked to deploy, he or she may accept, decline, or ask to be rescheduled. Registering as a LA County Disaster Healthcare Volunteer will not detract in any way from a doctor's obligation to his or her own facility.

In addition to doctors, the following health care profes-



How to Register

Sign up now to be added to the roster of LA County Disaster Healthcare Volunteers. The process is quick and easy:

- Log on to www.lacountydhv.org.
- Click on "Sign Up Now." Create a Username and Password and complete the registration.

Applicants will receive a follow-up e-mail from the DHV registration system.



sionals are also being sought for the LA County Disaster Healthcare Volunteers program: physician assistants, nurses, licensed mental health professionals, dentists, paramedics, respiratory care practitioners, pharmacists, radiologists, certified nurse assistants, physical therapists, podiatrists, occupational therapists, optometrists, and phlebotomists.

Consider registering for the program now so that you can more quickly assist those in need in the event of a disaster. 

Millicent Wilson, MD, is disaster training specialist, and **Sandra Shields, LMFT, CTS**, is senior disaster services analyst, Emergency Medical Services Agency, Los Angeles County Department of Health Services. **Jee Kim, MPH**, is volunteer coordinator, Emergency Preparedness and Response Program, Los Angeles County Department of Public Health.

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Rx for Prevention

Promoting health through prevention in Los Angeles County

Upcoming Training

Healthy Aging for Women + Women & Health Care Reform

Physicians and other health care providers and leaders are invited to two free community dialogues on women's health. *Healthy Aging for Women* will focus on preparing our communities for the upcoming increase in the population of aging women in LA. *Women & Health Care Reform* will look at prioritizing and protecting women's health as Los Angeles begins to implement health care reform.

Hosted by the Office of Women's Health, LA County Department of Public Health, and 30 collaborating organizations

- October 5, 2010 | 8:30 am-5 pm
- The California Endowment

For a registration form, e-mail cortal@ph.lacounty.gov.

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Index of Disease Reporting Forms

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

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

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

Confidential Morbidity Report of Tuberculosis (TB) Suspects & Cases
Tuberculosis Control (213) 744-6160
www.publichealth.lacounty.gov/tb/forms/cmr.pdf

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

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/H1911A.pdf (form)

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