

THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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Summer Months Peak Injury Fatalities Among Children in Los Angeles County

National and local data confirm the summer months increase the risk of childhood injury, likely due to increased exposure to outdoor activities such as swimming, biking, playing outdoors and traveling more often in motor vehicles.

During the summer months, children are drawn to the beach, lakes, pool, backyards, parks and other places for activities from summer fun to summer work. However, during the summer, children spend more of their time outdoors often with inadequate supervision, increasing their risk of injury and even death.

A national study on the seasonality of unintentional childhood injury¹ found that 42% of all unintentional injury related deaths and 39.9% of all unintentional injury related hospitalizations among children ages 14 and under occurred during the summer months (see Figure 1). The study also found that 66.1% of drowning fatalities, 52.5% of bicycle-related fatalities, 49.2% of fall-related fatalities, 40.8% of pedestrian-related fatalities, and 40.3% of motor vehicle occupant fatalities occurred during the summer (see Figure 2).

A national study on the seasonality of unintentional childhood injury found that 42% of all unintentional injury related deaths and 39.9% of all unintentional injury related hospitalizations among children ages 14 and under occurred during the summer months.

Figure 1: Percent of unintentional injury deaths and hospitalizations among children 14 and under during summer months in the U.S. and Los Angeles County

	National	Los Angeles County
Deaths	42	50.9
Hospitalizations	39.9	40

Reference

1. Kane BE, Mickalide AD, Paul HA. *Trauma Season: A National Study of the Seasonality of Unintentional Childhood Injury*. Washington, D.C.: National SAFE KIDS Campaign, 2001 May.

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Reporting Dead Birds Aids West Nile Virus Surveillance Efforts

The public is encouraged to report dead birds, which may provide valuable information about the spread of WNV in Los Angeles County and also can allow for the targeting of mosquito abatement efforts to prevent disease.

To report dead birds or other animals with encephalitis (e.g., horses) contact:

Los Angeles County Department of Health Services, Veterinary Public Health Program
Toll free hotline: 1-877-747-2243

OR

California Department of Health Services, Toll free hotline: 1-877-WNV-BIRD (877-968-2473)

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ANTIBIOTIC RESISTANCE INFORMATION CORNER

Trends in Antimicrobial Drug Development: Implications for the Future

Spellberg B, Powers JH, Miller LG, Edwards JE. *Clin Infect Dis.* 2004;38:1279-1286*

It is especially important that doctors assist public health efforts by prescribing judiciously and educating patients on the appropriate use of antibiotics since drug companies are cutting back on the development of new antibiotics.

The emergence of multidrug resistance and consequential limited antibiotic choices illustrate the need to expand research and development for new antibacterial agents. However, pharmaceutical and biotechnology companies have shifted research efforts away from antibacterial agents for several reasons; for instance, medications used for chronic conditions are more profitable. An evaluation of the U. S. Food and Drug Administration's (FDA) databases confirms this declining trend in the development of new antibacterial agents. FDA approval of new antibacterial agents has decreased by 56% over the past 20 years (1998-2002 vs. 1983-1987). And the prospects of future development of new antibiotics are bleak — only 6 of 506 drugs currently in development by the major drug companies are antibacterial agents.

The authors recommend several strategies to increase the research and development of new antibacterial agents including:

- establishing partnerships between research and development programs and government, academia and industry
- streamlining efforts in the drug approval process that do not compromise safety and efficacy standards
- creating government contracts to develop antibacterials to meet specific national needs, and
- creating legislation to provide economic incentives.

* Article available online at: www.journals.uchicago.edu/CID/journal/issues/v38n9/33161/33161.html

Clinical practice guidelines and other resources are available online at:

- Infectious Diseases Society of America - www.idsociety.org
- Clinical Practice Guidelines - www.journals.uchicago.edu/IDSA/guidelines/
- California Medical Association (CMA) Foundation - www.aware.md/resource/index.asp
- Clinical Practice Guidelines Compendium (Pediatric and Adult) - www.aware.md/clinical/clinical_guide.asp
- Centers for Disease Control and Prevention - www.cdc.gov/drugresistance/community/
- Los Angeles County Department of Health Services Acute Communicable Disease Control Program - www.lapublichealth.org/acd/antibio.htm

What Every Health Care Provider Should Know: *Screening Children for Lead Poisoning*

Background

Lead poisoning continues to be one of the major environmental health threats to children in Los Angeles County. Lead is found in lead-based paint, lead-contaminated house dust and soil, as well as imported items such as candy, home remedies, folk medicines and ceramic ware.

Lead intoxication can affect a child's neuro-developmental processing. Most lead-poisoned children do not have any obvious symptoms; however, numerous studies indicate that elevated blood lead levels (EBLLs) are associated with adverse outcomes on measures of intellectual functioning and social-behavior. Early childhood lead exposure has been linked to a drop in IQ scores, short attention span, and the increasing presence of certain types of behavioral problems pertinent to the diagnosis of attention deficit disorder. Therefore, "elevated blood lead levels should be viewed as a risk factor for neuro-developmental problems, not a diagnosis."

The national blood lead level of concern, designated by U.S. Centers for Disease Control and Prevention (CDC) is 10 micrograms/dL; nonetheless, studies have shown that exposure to even lower levels of lead can also be harmful.

Since 1991, more than 12,000 children in the county (under six years of age) have been identified with elevated blood lead levels. For most of these children, the source of lead has been lead-based paint found in older homes; older homes comprise a large percentage of the housing stock in Los Angeles County.

Until now, the true incidence of lead poisoning in the county has been unknown because the majority of low blood lead level tests are not reported to the health department. Last year, a new law went into effect (Senate Bill 460) requiring laboratories to report the results of all blood lead tests. However, it is important that providers continue to screen children using the screening guidelines and recommendations suggested by state and local public health officials.

The Role of the Primary-Care Providers

The California Code Regulations (Title 17, Division 1, Chapter 9 Screening for Childhood Lead

Early childhood lead exposure has been linked to a drop in IQ scores, short attention span, and the increasing presence of certain types of behavioral problems pertinent to the diagnosis of attention deficit disorder.

Poisoning) requires pediatric and family practice health care providers to screen children receiving services from any publicly (federal and state) funded programs children for lead exposure. Such publicly funded programs include Medi-Cal, Child Health and Disability Prevention Program (CHDP), Healthy Families, and Women and Infants and Children (WIC). A health care provider who fails to comply with this standard of care may be subject to the disciplinary provision (Article 12 of Chapter 5 of Division 2 of the Business and Professions Code).

It is recommended that primary care providers use a blood lead test to screen children at ages 12 and 24 months, and to screen children between 24-72 months who were not previously tested or who missed the 24 month test. Children who may or may not be recipients of publicly funded health services should not be excluded if they have not been tested for lead in the past or have been recently exposed.

If a child does not receive public assistance, two risk assessment questions should be asked by providers:

Does your child live in or spend a lot of time in a place built before 1978 that:

1. Has peeling or chipped paint or
2. Has been recently renovated?

If the response to either question is "Yes" or "Don't Know" a blood lead screening test should be ordered.

Choice of Sample Collection Method

Providers may choose to have blood samples collected by the venous method or the capillary method. A venous blood draw is considered the method of choice for many providers because of the high level of reliability and accuracy and a smaller chance for specimen contamination. The capillary draw is an alternate method of blood lead screening if a missed opportunity to screen a child exists, but must be performed

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Screening Children for Lead Poisoning (from page 3)

according to the CDC and state Fingerstick protocol. The testing may take place in the office by trained staff or by an off-site phlebotomist in a CHDP-approved or state certified proficiency lab.

Role of the health department's Childhood Lead Poisoning Prevention Program (CLPPP)

CLPPP is responsible for facilitating case management recommendations at the local level and establishing basic targeted screening recommendations based on assessment of local data such as:

- lead exposure and screening capacity
- housing data
- demographic characteristics,
- and the presence of other sources of lead.

In addition, CLPPP is responsible for quality assurance activities, which includes monitoring provider screening practices and the number of false positive reported.

Quality Assurance

In 2003, the CLPPP began reviewing false-positive results by conducting telephone and on-site surveys related to screening practice and sampling collection. Providers are contacted if the survey results indicate the following:

- A discrepancy existing between the number of children (under the age of six years) seen by the provider each month and the number of children screened for lead.
- Provider was unaware of the CDC protocol for collecting capillary blood lead samples
- Provider stated that their contracted lab collected the blood lead sample.

The Fingerstick Training is offered monthly. The Summer 2004 schedule is as follows:

Date	Time
June 17, 2004	1-4pm
July 14, 2004	1-4pm
August 4, 2004	1-4pm

Providers who wish to register certified medical assistants and licensed nursing staff for one of the training sessions or to obtain more information may contact: Kathleen Lang, Assistant Program Specialist, Childhood Lead Poisoning Prevention Program, 5555 Ferguson Drive Ste., 210-02, City of Commerce, CA 90022 or 323-869-7171.

Provider Outreach Education

Each child that experiences a false positive result is subject to a case review by both the public health nurse (PHN) and the provider training/education coordinator. The coordinator contacts the provider to inform them of the false positive value and to review the method used to collect blood lead samples. The coordinator discusses and develops a plan of action with the provider to minimize future occurrence of false positive results. If the samples are collected in the provider's office, an invitation is extended to the provider to send their staff to our monthly fingerstick training to learn how to perform the correct technique for collecting a capillary sampling. The following are examples of reasons for false positive results, although no single set of reasons applies to all situations:


- Specimen contamination
- Faulty equipment
- Flawed methodology
- Clerical error

Provider Outreach Training

A "Lead Awareness and Fingerstick" training session is offered to new and existing providers as requested by both CHDP and CLPPP.

Following the completion of the training the provider is contacted in order to inform them of screening updates from the state and of newly identified sources of lead poisoning for evaluation purposes.

The goal of the training is to:

- Inform the provider of their screening responsibilities according to state mandates
- Educate the provider and staff of the primary and secondary sources of lead
- Train the provider and staff on the recommended CDC technique for collecting a capillary blood lead sample
- Inform provider and staff of proper follow-up protocol for managing and treating elevated blood lead levels
- Eliminate the occurrence of false positive results
- Provide the provider with lead awareness materials that will facilitate anticipatory guidance to the family 

Gains in Children's Health Insurance Coverage may be threatened by proposed caps to public programs

Nearly nine in ten County children (ages 0-17 years) have some form of health insurance coverage (89.7%), according to a report just released by the Los Angeles County Department of Health Services. New findings from the 2002-03 Los Angeles County Health Survey show that since 1997, there has been a 45% decrease in the rate of uninsured and a 40% increase in the rate of children covered by Medi-Cal and Healthy Families-public coverage for low-income children. However, the rate of children covered by private health insurance, primarily employer-based coverage, is similar to that observed for 1997, suggesting a reversal from the modest gains in employer-based coverage observed in 1999.


"We are pleased with the upward trend in health insurance coverage among children, but further progress towards universal insurance coverage is needed," said Dr. Jonathan Fielding, Director of Public Health. "We are concerned that these gains will be jeopardized by the state's fiscal crisis and resulting proposed changes to public insurance programs in the Governor's budget."

Since the growth in coverage has been in Medi-Cal and Healthy Families rather than private coverage, proposed budget cuts threaten the significant progress in coverage rates. For example, the Legislative Analyst's Office budget analysis estimated that the proposed Healthy Families cap would result in 159,000 children on the waiting list by the end of 2004-05, with waits as long as six months.

Although the number of insured children has increased, 276,000 children remain uninsured. Furthermore, inequities persist, with Latino children nearly four times, and Asian/Pacific Islander children nearly three times as likely to be uninsured compared to white and African-American children.

In Los Angeles County, the percentage uninsured was higher among children aged 6 to 17 years (12%) than those five years of age and younger (6%). The percentage uninsured was also higher among Latino (14%) and Asian/Pacific Islander (10%) children than among white (4%) and African-American (3%) children. In addition 17% of children living in households with incomes below the federal poverty level (FPL) were uninsured compared to only 1% among those with incomes above 300% FPL.

Findings from the survey also revealed that uninsured children were more than four times as likely not to have a regular source of health care than children covered by private and other forms of public insurance (e.g., Medi-Cal or Healthy Families). Furthermore, parents of uninsured children were more than three times as likely to report difficulty obtaining needed medical care for their child in the past 12 months compared to parents of children with private and other forms of public insurance.

For a copy of the complete study on child insurance, visit: lapublichealth.org/ha. 

Breastfeeding Practices in the County: Rates increase, but most women stop too early

More mothers in the county are initiating breastfeeding (82%) compared to findings in a previous survey (79% in 1999) according to findings from the 2002-03 Los Angeles County Health Survey. The new data shows that African-American (63%) and Asian/Pacific Islander (78%) women have lower breastfeeding initiation rates compared to Latinas (83%) and White women (90%).

However, breastfeeding rates decline steadily over the infant's first year for all major racial/ethnic groups, with only one-half of all mothers still breastfeeding their infants at six months, and less than one-third at 13 months.

Extensive research demonstrates the positive impact of breastfeeding on the health and development of infants and children. Breastfed infants have enhanced immune response and reduced risk for chronic illnesses such as asthma, diabetes and inflammatory bowel disease. Breastfeeding may also have a protective effect against childhood obesity. Breastfeeding also improves a mother's health by minimizing postpartum bleeding, reducing the risk of ovarian cancer and breast cancer and facilitating bonding between mother and infant.

Exclusive breastfeeding yields even more pronounced

Health survey background: The Los Angeles County Health Survey is a periodic, population-based telephone survey that collects information on socio-demographic characteristics, health status, health behaviors and access to health services among adults and children in the county. The 2002-03 survey collected information on a random sample of more than 8,000 adults and nearly 6,000 children with interviews offered in six languages.

health benefits and the American Academy of Pediatrics recommends that infants be exclusively breastfed for the first six months of life and be breastfed for 12 months or longer with the addition of appropriate foods.

The health department recommends the promotion of exclusive breastfeeding during pre-natal care and the education and support immediately after the child's birth to influence early decisions about breastfeeding and increase the likelihood of success.

For a copy of the full report, visit: www.lapublichealth.org/ha. 

A Community-Based Directly Administered Antiretroviral Therapy Program

Adherence to complex highly-active antiretroviral therapy (HAART) regimens is one of the most daunting challenges that an HIV-infected person faces. Data suggest that $\geq 95\%$ adherence to HAART is needed for effective viral suppression.⁽¹⁻³⁾ The Los Angeles County Department of Health Services (DHS) HIV Epidemiology Program is in the fourth year of a CDC-funded randomized intervention trial to test 3 adherence support programs for HAART. One of the adherence models is a community-based directly administered antiretroviral therapy program (DAART) in which trained community workers observe ingestion of one of two daily HAART doses, 5 days per week and question the patient about the second dose, enabling intense adherence monitoring and real-time intervention. Between 11/01 and 11/03, 67 patients were enrolled into the DAART program from 3 public county HIV clinics. Among the DAART patients, 69% were Latino, 21% were African American, 9% were white; 61% were Spanish-speaking and 63% had annual incomes $< \$10,000$. Data on viral load suppression, adherence and cost effectiveness outcomes for the DAART program and a case-management adherence support program will be available in 2005. Recommended key components of a successful DAART intervention include: flexibility in work schedule for community workers; effective

communication between DAART program staff and the patient's health care providers; effective communication between DAART program staff and the pharmacy that conducts the unit dose packaging; capacity to refer patients to needed social support services; and integration of DAART program staff with HIV clinic staff. For more detailed information on the DHS DAART program, readers can access a recent article in *Clinical Infectious Diseases* at:

<http://lapublichealth.org/wwwfiles/ph/hae/hiv/ciddaart.pdf> 

References

1. Bartlett JA. Addressing the challenges of adherence. *J Acquir Immune Defic Syndr* 2002;29:S2-10.
2. Mannheimer S, Friedland G, Matts J, et al. The consistency of adherence to antiretroviral therapy predicts biologic outcomes for human immunodeficiency virus-infected persons in clinical trials. *Clin Infect Dis* 2002;34:1115-
3. Tuldra A, Fumaz C, Ferrer MJ et al. Prospective randomized two-arm controlled study to determine the efficacy of a specific intervention to improve long-term adherence to highly active antiretroviral therapy. *J Acquir Immune Defic Syndr* 2000;25:221-8/

Smoking Rate Drops in L.A. County for the First Time in 5 Years Nearly 3 in 4 smokers are trying to quit or cut back

Not only are there fewer adults who are smoking, but nearly three out of every four smokers are trying to quit or have cut back, according to recent data out of the county health department. Approximately 15.6% adults in Los Angeles County smoke cigarettes, according to new findings from the 2002-03 Los Angeles County Health Survey. The overall rate of smoking is lower now than was found in two previous surveys (1997 and 1999) both of which estimated the percentage of adult smokers at 18%.

Although these percentage differences may seem small, the study's findings mean that approximately 175,000 fewer adults are smoking than if the rate of smoking had remained the same as in previous years.


Not only are smoking rates lower than those measured statewide for more than 20 years, but 71% of smokers have cut down and/or quit successfully for one or more days in the past year. The most common methods used to quit smoking were "cold turkey" (74%), nicotine substitute (18%), and self-help materials (14%).

"We are pleased by the appearance of a downward trend in smoking, but we still have work to do to get more people to quit for good," said Dr. Jonathan Fielding, Director of Public Health and Health Officer.

Overall, 20% of men smoke compared to 11% of women. However, lower rates among women are primarily due to lower smoking rates among Asians/Pacific Islander women (7%) and Latinas (7%), while African-American women (19%) and White women (16%) smoke in rates comparable to men. In addition, the study noted that 39% of smokers who are white smoke heavily--a pack or more per day--which was true for 20% of African-American and 12% of Latino smokers.

Only half of smokers reported that their doctor advised them to quit.

"Clearly, physician counseling and smoking cessation are among the most effective and life saving of the preventive services doctors can provide" said Dr. Fielding. "We want to work to assure that more patients hear that message and receive appropriate support from their primary care physicians."

A complete copy of this study can be found at www.lapublichealth.org/ha 

Summer Safety (from page 1)

In Los Angeles County a similar pattern exists with 51% of all unintentional injury related deaths and 40% of all unintentional injury related hospitalizations among children ages 14 and under (see Figure 1). Additional unintentional injury trends in the county show 72% of drowning fatalities, 56% of bicycle-related fatalities, 41% of pedestrian-related fatalities, and 38% of motor vehicle occupant fatalities occur during summer among children of this age group (See Figure 2). ¶

Figure 2: Percent of unintentional injury deaths among children 14 and under by injury mechanism during summer months in the U.S. and Los Angeles County

	National	L.A. County
Drowning	66.1	72
Bicycle	52.5	56
Fall	49.2	*
Pedestrian	40.8	41
Motor Vehicle Occupant	40.3	38

Only "1" annual fatality reported and occurred in summer.

WATER SAFETY

Nine out of ten children who have drowned, were being supervised by an adult.¹ These adults were distracted as they were eating, talking, or reading while watching children in the pool. This is why "active" supervision is important, where the adult keep their eyes on the children and water at all times. Studies show that 69% of children who were found in a pool or spa were not expected to be at or in the pool or spa.² Further, 65% of these incidents occurred in a pool owned by the child's family and 33% occurs in a pool owned by a friend or relative. For these reasons other layers of protection are necessary in case of a laps in supervision or of a fail in one layer. These include:

- Isolation barrier fencing
- Self-closing and self-latching gates
- Lifesaving equipment at the pool or spa area
- Emergency phone in the pool or spa area
- Learn cardiopulmonary resuscitation (CPR)
- Swim lessons for children 5 years and older

RIDING SAFETY

California law requires that children under the age of eighteen wear approved safety helmets when riding bicycles, scooters, skateboards and skates. In addition to helmets, elbow and knee pads, and wrist guards for those riding skateboards and in-line and roller skate are recommended. For those riding scooters in addition to the helmet it is recommended the rider also wear elbow and knee pads for protection.

MOTOR VEHICLE SAFETY

California Child Passenger Safety Law requires³ children to be properly secured in a child seat or booster seat until they are at least 6-years old or weighing at least 60-pound and Children under 16-years of age but at least 6-years old or 60-pounds to ride in: a). Child restraint system (car seat, booster, harness, or other product certified to meet Federal Safety Standards), or b). Properly fitted safety belt (lap belt touching the thighs and shoulder belt on child's shoulder, not under their arm or behind their back).

PLAYGROUND SAFETY

Because many injuries are associated with inadequate supervision on playgrounds, parents should become proactive in playground supervision. Although all adults and parents are not expected to be trained inspectors of playgrounds, they should visually inspect the equipment for potential safety problems and make sure that children do not play on any unsafe equipment. ¶

References

1. A National SAFE KIDS study.
2. How to plan for the unexpected: preventing child drownings, Publication No. 359, U.S. Consumer Product Safety Commission, Washington DC 20207
3. California Child Passenger Safety Seat Law (California Vehicle Code, Sections 27360-27365)

For questions regarding West Nile Virus prevention, surveillance activities, and for test interpretation, call:

Acute Communicable Disease Control

213- 240-7941 (business hours, 8:00am - 5:00pm)

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COUNTY OF LOS ANGELES
 DEPARTMENT OF HEALTH SERVICES
Public Health

313 North Figueroa Street, Room 212
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Selected Reportable Diseases (Cases)¹ - January 2004

Disease	THIS PERIOD Jan 2004	SAME PERIOD LAST YEAR Jan 2003	YEAR END TOTALS				
			2003	2002	2001	2000	1999
AIDS ¹	185	100	2,590	1,719	1,719	1,637	1,850
Amebiasis	6	12	121	102	102	109	134
Campylobacteriosis	79	97	1,093	1,067	1,067	1,273	1,089
Chlamydial Infections	3,209	3,310	36,585	35,688	34,680	30,546	27,595
Encephalitis	8	3	41	61	61	49	39
Gonorrhea	686	694	8014	7,800	7,540	7,199	6,061
Hepatitis Type A	31	34	376	438	438	839	1,120
Hepatitis Type B, Acute	8	4	56	29	29	65	61
Hepatitis Type C, Acute	1	0	0	3	3	28	21
Measles	0	0	0	0	0	5	1
Meningitis, viral/aseptic	41	41	899	466	466	491	390
Meningococcal Infections	6	4	34	46	46	53	49
Mumps	0	0	10	16	16	29	24
Non-gonococcal Urethritis (NGU)	131	144	1,393	1,256	1,256	1,575	1,744
Pertussis	20	12	128	170	170	102	238
Rubella	0	0	0	0	0	3	0
Salmonellosis	76	91	996	956	956	990	1,101
Shigellosis	29	105	671	974	974	849	669
Syphilis, primary & secondary	35	40	448	364	355	136	88
Syphilis, early latent (<1 yr.)	27	40	377	353	348	200	328
Tuberculosis	3	15	949	1,021	1,021	1,065	1,170
Typhoid fever, Acute	1	15	16	33	33	21	16

1. Case totals are provisional and may vary following periodic updates of the database.

Data provided by DHS Public Health programs: Acute Communicable Disease Control, HIV/Epidemiology, Sexually Transmitted Diseases, and Tuberculosis Control.