



Public Health Bulletin

A Publication of the Public Health Department, Jeff Hamm, Health Agency Director
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The Benefits of Public Health Efforts in Our County

Did You Miss Public Health Week April 4-10, 2011?

We're guessing not...because if you are alive, you reap the benefits of Public Health.

We hope that our readers appreciate the efforts of the San Luis Obispo County Public Health Department, but we wouldn't be surprised if you had difficulty answering the question, "What does Public Health do?"

Public Health is... vaccinations to prevent epidemics, vital records, food safety, prevention of HIV infections by education, learning to take care of a baby—before and after birth, restaurant hygiene reports, accurate lab test results used in science-based decisions, and messages to avoid alcohol during pregnancy, to eat healthy, and to start children on a proper diet and exercise to prevent obesity and its complications.

Public Health tracks down the cause of outbreaks such as salmonella in peanut butter, e coli O157 in spinach, unpasteurized fruit juices or raw milk. Public Health finds the source and designs solutions that protect people from similar events. Public Health investigates

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Penny Borenstein, M.D., M.P.H.



Advancing the Use of Targeted Tuberculosis Testing

Targeted testing for latent tuberculosis infection (LTBI) is an important tool in detecting and treating those at most risk of tuberculosis (TB) infection. More than a decade ago, the Centers for Disease Control and Prevention (CDC) and the American Thoracic Society (ATS) authored guidelines for testing those persons at high risk for progressing from LTBI to active TB (MMWR, 2000; 49:(No. RR-6). Uptake of these guidelines has been slow in coming in our county. There are likely several reasons, including exaggerated perceptions of the infectivity of Mycobacterium tuberculosis and outdated legal requirements for universal testing in some populations, despite an absence of epidemiologic data to support such practices.

The San Luis Obispo County Public Health Department has adopted targeted TB testing criteria based on the 2000 CDC/ATS

guidelines "Targeted Tuberculin Testing and Treatment of Latent TB Infection," with consideration given to local TB case reports since 2002. In addition, the Public Health Department utilizes two specific tests for detection of LTBI, as recommended by the CDC. These tests are described below.

TB testing of low-risk individuals is not recommended and may lead to false-positive results with subsequent unnecessary treatment, patient anxiety, and use of scarce resources. The lower the prevalence of a disease, the greater the likelihood of such false positive results. With this in mind, we would like to encourage providers to study and utilize these guidelines in their own practice.

The following persons or groups should be tested for LTBI since they are at increased risk for being recently infected with Mycobacterium tuberculosis (M. tb):

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Advancing the Use of Targeted Tuberculosis Testing (cont.)

- Close contact of a person with known or suspected active TB
- Persons who have immigrated within the last 5 years from areas of the world with high rates of TB (Africa, Asia, Latin America, Eastern Europe, Russia)
- Children and adolescents <18 years of age who were born in or resided for more than a week with friends or family members in areas of the world with high TB rates
- Groups with higher rates of TB than the rest of the U.S.-born local population - homeless persons¹, injection drug users, and persons with HIV infection
- Mycobacteriology laboratory workers

Persons with the following clinical conditions that increase the risk of progression from LTBI to TB disease should also be tested for LTBI:

- HIV infection
- Pulmonary fibrotic lesions on chest radiograph consistent with prior healed TB
- Diabetes mellitus (esp. insulin-dependent)
- Silicosis
- Chronic renal failure/hemodialysis
- Chronic immunosuppression
 - Transplant recipients
 - Prolonged corticosteroid therapy (>15 mg/day prednisone for > 1mo)
 - Other immunosuppressive therapy (e.g., anti-Tumor Necrosis Factor-alpha agents)
- Leukemia or lymphoma
- Malnutrition and clinical situations associated with rapid weight loss
 - Cancer of the head and neck or lung
 - Intestinal bypass or gastrectomy
 - Chronic malabsorption
 - Low body weight (>15% below ideal body weight)
- Injection drug use

¹ Due to the rarity of cases of active TB diagnosed in homeless persons in SLO County, screening prior to admittance to a homeless shelter may be limited to individuals who present with symptoms of active TB (e.g., recent unexplained weight loss, night sweats, productive cough, especially if bloody, or difficulty breathing).

Once a person has been identified as a candidate for targeted TB testing, the next decision is to determine which of the two widely accepted testing methodologies would yield the best information, tuberculin skin testing (TST) or an interferon gamma release assay (IGRA).

The SLO PHD has been transitioning most TB testing over the past year to an IGRA, specifically quantiferon-gold in tube (QFT-GIT). We find that the very high specificity of the test (near 99%), along with obviating a return visit by the patient to have a TST read, makes the QFT-GIT a superior choice. This approach is in accordance with CDC's recently published "Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium Tuberculosis Infection — United States" (MMWR, 2010; 59:(No. RR-5). In this article, CDC recommends that the following groups be preferentially tested with an IGRA – homeless, drug users and recipients of a BCG injection. The only circumstance in which a TST is preferable to an IGRA is in children under five years of age.

If you do identify a patient in your practice with LTBI, we would like you to treat the patient in your practice. The Public Health Department can answer any questions you have regarding recommended treatment, but should be a provider of last resort, when the patient has no regular clinical provider. This ensures that the PHD saves its resources for those patients who truly have no other recourse, and allows patients with regular private providers to receive comprehensive, continuing care for any co-morbidities that exist.

If you have any questions, call Christine Gaiger, PHN, TB Control Program Manager, at 781-5577, or me.

The Benefits of Public Health in Our County (cont.)

and identifies new diseases when the usual causes are ruled out, e.g., Legionnaires disease, West Nile Virus, SARS, hantavirus and many others.

Public Health answers questions such as: “Is the disease rate increasing?,” “What medicine should be used?” and “Where can I find someone who knows about this illness?”

Public Health messages can be deceptively simple: “Wash your hands,” “Cover your cough,” “Buckle up,” “Stop smoking,” “Eat right and get exercise,” “Recycle,” “Drive safely,” “Work safely,” “Play safely,” and “Cook your burger thoroughly.”

Public Health is your ally against the spread of TB, HIV and hepatitis, antibiotic resistant microbes, tobacco and illegal drug use, obesity, dead batteries in landfills, and advises the public against swimming in risky waters or preparing a salad on a cutting board also used to prepare raw chicken.

Look around you and you’ll see public health at work.

Visit the Updated SLO Public Health Laboratory Web Site

The SLO Public Health Laboratory web site—updated in numerous categories—went live on February 28. Please browse the site and bookmark the URL:

www.slocounty.ca.gov/health/healthtesting/laboratory.htm

Influenza Virus Surveillance

Influenza virus infections continue in California. The SLO Public Health Laboratory has detected all three strains included in this season’s vaccine - 2009 Pandemic H1N1 A, seasonal H3N2 A and B.

Important issues:

- A properly collected specimen (a nasal wash, or if not possible to collect a nasal wash, a throat swab) collected in a M4 viral transport medium is still the only transport medium specimen we can accept for the CDC–developed reverse transcription PCR assay; saline is NOT acceptable as it has not been validated by the CDC.
- The “Influenza Requisition” used in 2009-2010 season is NOT required, but can be used as well as a regular requisition for test ordering.
- There is still no charge for specimens submitted from a patient who is rapid flu-test positive.
- Selected specimens are being referred to the State Laboratory (Viral and Rickettsial Disease Laboratory, VRDL) for culture and enhanced characterization of viral culture isolates.

CDPH would like to thank all of you who are participating in the enhanced surveillance for severely ill cases (i.e., those that require intensive care or who die) aged 0-64 years with laboratory-confirmed influenza. Unfortunately, many reported cases have had respiratory specimens discarded before confirmatory testing is done. Often when the initial diagnosis in the hospital is made by non-molecular rapid tests, the subtype is never identified.

CDPH and the SLO PHD strongly encourage confirmatory influenza testing by PCR and sub-typing for these severely ill cases. Local health department laboratories need to work closely with hospitals to obtain prompt notification of these cases and to obtain any residual respiratory specimens for further confirmation and characterization. This information is critical to statewide surveillance of subtypes.

New 2011 Immunization Schedules for Children and Adults

Make sure your office has the most current versions. Copies are available from the State Immunization Program site www.eziz.org. This site also has Vaccine Information Statements, online recertification, interactive training modules, and information on storage and handling of vaccines, plus much more.

Immunization Assessment of Children Enrolled in Child Care Centers

The 2010 data for children under 5 years of age enrolled in child care in SLO County is shown below. Pre-school children in SLO County are less up-to-date with recommended vaccinations than in the rest of California, with the exception of Head Start enrollees. This finding is due to a higher percentage of vaccine waivers for Personal Belief Exemption (PBE) from families in our county. State average for PBE is 2.44%, SLO County is 4.09%.

Child Care Centers Up to Date Immunizations – SLO County 2010

	Total		Public		Private		Headstart	
	Children		Children		Children		Children	
2010 – SLO	3,009	89.83%	603	88.56%	1,942	88.41 %	464	97.41 %
2010 - State	489,082	90.69%	105,343	92.87%	266,043	88.29 %	71,854	96.67 %

State Releases New Confidential Morbidity Report Forms

When a disease that is reportable under section 2500 of the California Code of Regulations (CCR) is reported to the Public Health Department, the form to use is the Confidential Morbidity Report, or CMR. Recently, the California Department of Public Health (CDPH) revised the CMR, and broke it up into three different forms. For most diseases, the form stays much the same. The major difference is that now providers reporting a loss of consciousness or seizure to the DMV will use one version of the CMR, and providers reporting tuberculosis will use another.

These forms are on the SLO County web site at: www.slocounty.ca.gov/health/publichealth/phforms.htm

We would like to take this opportunity to urge you to look at the revised forms, and review the reportable diseases on the form to ensure you are reporting all diseases mandated by the CCR and Health and Safety Code. Please let us know if you have any questions by phoning 781-5500.

Valley Fever Testing and Reporting

Coccidioides infections, or Coccidioidomycoses, have continued to increase in the past several months, reflected in both case reports and actual fungal isolates referred to the San Luis Obispo Public Health Laboratory for confirmation. SLO Public Health Laboratory (PHL) isolates positive for Coccidioides has doubled between 2009 and 2010, and so too has there been a large increase in the number of confidential morbidity reports (CMRs) for Coccidioidomycoses in the same period.

Passive surveillance may only result in reports of half or less than the actual number of cases diagnosed in the medical community, thus the true number of cases may actually be two or three times higher than reports received. The surge in cases is following a well-documented pattern of a wet winter with abundant rainfall followed by a surge in cases several months later.

The SLO PHL can culture for Coccidioides from sputum, aspirates, biopsies and can perform a DNA hybridization probe test to conclusively identify a white, cottony mold as Coccidioides.

Recommended Use of Meningococcal Conjugate Vaccines

Advisory Committee on Immunization Practices (ACIP), 2010 Excerpts from MMWR January 28, 2011/60(03):72-76

On October 27, 2010, the Advisory Committee on Immunization Practices (ACIP) approved updated recommendations for the use of quadrivalent (serogroups A, C, Y, and W-135) meningococcal conjugate vaccines (Menveo, Novartis and Menactra, Sanofi Pasteur) in adolescents and persons at high risk for meningococcal disease. These recommendations supplement the previous ACIP recommendations for meningococcal vaccination. The changes are based on findings of the Meningococcal Vaccines Work Group of ACIP which reviewed available data on immunogenicity in high-risk groups, bactericidal antibody persistence after immunization, current epidemiology, vaccine effectiveness (VE), and cost-effectiveness of different strategies for vaccination of adolescents.

The updated guidelines for use of meningococcal conjugate vaccines fall into two categories as follows:

Recommendation for Routine Vaccination of Persons Aged 11 through 18 Years

- Routine vaccination at age 11 or 12 years, with a booster dose at age 16 years.
- For adolescents who receive the first dose at age 13 through 15 years, a one-time booster dose should be administered, preferably at age 16 through 18 years, before the peak in increased risk.
- Persons who receive their first dose of meningococcal conjugate vaccine at or after age 16 years do not need a booster dose. Routine vaccination of healthy persons who are not at increased risk for exposure to *N. meningitidis* is not recommended after age 21 years.

Recommendation for Persons Aged 2 through 54 Years with Reduced Immune Response

- Persons with persistent complement component deficiencies or asplenia should receive a 2-dose primary series administered 2 months apart and then receive a booster dose every 5 years.

Adolescents aged 11 through 18 years with HIV infection should be routinely vaccinated with a 2-dose primary series. Other persons with HIV who are vaccinated should receive a 2-dose primary series administered 2 months apart.

All other persons at increased risk for meningococcal disease (e.g., microbiologists or travelers to an epidemic or highly endemic country) should receive a single dose.

No data are available on the interchangeability of vaccine products. Whenever feasible, the same brand of vaccine should be used for all doses of the vaccination series. If vaccination providers do not know or have available the type of vaccine product previously administered, any product should be used to continue or complete the series. Persons with complement component deficiency, asplenia, or HIV infection who have previously received a single dose of meningococcal conjugate vaccine should receive their booster dose at the earliest opportunity.

The Vaccines for Children (VFC) program now covers the booster dose. The full report is available at MMWR, January 28, 2011; 60(03):72-76

Tdap Vaccination for Parents and Teens

The Public Health Department is celebrating National Infant Immunization Week April 23 - April 30, 2011, and Toddler Immunization Month May 2011. Remember that all family members and caregivers of infants should get a Tdap vaccine (tetanus, diphtheria, and acellular pertussis) to protect the baby before and immediately following birth. Ten infants died in California last year from pertussis (whooping cough) after disease transmission from siblings or parents. In addition, proof of Tdap vaccine will be required for 7th-12th grade school attendance as of July 1, 2011. For more information visit www.ShotsForSchool.org

Appointments are available at local Public Health Department clinics in Paso Robles 237-3050, SLO 781-5500, or Grover Beach 473-7050. Cost is \$25 for the visit and vaccine, or based upon ability to pay.

**California Department of Public Health (CDPH), Immunization Branch
Local Health Departments ~ CDPH Approved Clinics
Vaccine Eligibility Guidelines Effective January 2011**

Vaccine	Eligibility Criteria
DTaP/DT	<ul style="list-style-type: none"> • Children under age 7 years.
Hepatitis A	<ul style="list-style-type: none"> • Children ages 1 through 18 years. • High risk adults via Adult Hepatitis Vaccine Project.
Hepatitis B	<ul style="list-style-type: none"> • Children through age 18 years. • Adults only if household or sexual contact of HbsAg+ pregnant woman.
Hib	<ul style="list-style-type: none"> • Children through age 4 years. • Older children with high risk conditions as recommended by ACIP.
HPV	<ul style="list-style-type: none"> • Adolescents 9-18 years.
Influenza	<ul style="list-style-type: none"> • Refer to current year CDPH Influenza Guidelines.
Meningococcal Conjugate Vaccine	<ul style="list-style-type: none"> • Adolescents ages 11 through 18 years. • Ages 2-10 with high risk conditions as recommended by ACIP.
MMR	<ul style="list-style-type: none"> • 1st dose – Children aged 1 year and older, and adults¹. • 2nd dose – Children ages 1 through 18 years. • 2nd dose – Adults 19 years and older and born in 1957 or later ONLY if they are: College/university students, or health care workers. In an area with a current measles, rubella, or mumps outbreak AND the local health officer decides that a 2nd dose of MMR is needed as a part of outbreak control.
Pneumococcal Conjugate Vaccine	<ul style="list-style-type: none"> • Children under 5 years of age and children 5 years through 18 years with high-risk conditions as recommended by ACIP.
Polio (IPV)	<ul style="list-style-type: none"> • Children through 18 years of age. • Adults 19 years and older in high-risk situations as recommended by ACIP.
Rotavirus	<ul style="list-style-type: none"> • Infants 6 weeks through 8 months of age.
Td	<ul style="list-style-type: none"> • Clients over 7 years of age only when Tdap is not indicated.
Tdap	<ul style="list-style-type: none"> • Clients over 7 years of age.
Varicella	<ul style="list-style-type: none"> • Susceptible children ages 1 year through 18 years.

¹ No strict upper age limit, though most persons born before 1957 are already immune to these diseases and don't need MMR.

Health departments and a limited number of CDPH approved clinics receive vaccine from a combination of funding sources. This allows them to administer vaccine to all clients who fall within the above criteria, despite pay source. When the health department or CDPH approved clinic has the capacity to bill insurance and an insured client presents for vaccination, privately purchased vaccines should be administered and the insurance company billed (including Healthy Families). If the health department or CDPH approved clinic does not have the capacity to bill, the patient should be immunized and referred back to their medical home for future immunizations. For further guidance regarding immunization services to privately insured children including those with Healthy Families coverage, see "Policy for Provision of State Funded Vaccine to Privately Insured Patients by Local Health Department Jurisdictions" document. Funds for the purchase of adult vaccines are limited and therefore the CDPH, Immunization Branch is unable to make all vaccines available to adults. In local health department settings, CDPH provided vaccines are intended for clients only and not health department staff. Finally, state provided vaccine should not be used in travel clinic settings.

National Expert Coming to SLO in May to Speak About Creating Health and Sustainability in Communities

Everyone knows that overweight and obesity are major health issues in our nation. Over the past three decades, childhood obesity rates in America have tripled and recent data finds that 42% of San Luis Obispo County adults are overweight, which costs our county over \$454 million in direct health care costs and lost productivity annually. Many people understand that the way towns and cities are planned and developed can lead to negative effects such as traffic congestion, loss of economic vitality and costly infrastructure. What may be surprising is how past patterns of growth can negatively affect our health. In the last ten years, mounting evidence has demonstrated that the way communities grow has contributed to the rising incidence of chronic diseases such as diabetes, obesity and asthma. Children are particularly vulnerable.

To find out more about what can be done, you are invited to attend a free presentation by Dr. Richard Jackson, MD, MPH, on May 18 from 3 to 5 p.m. in the Spanos Theater at Cal Poly. Dr. Jackson's message is titled "Confronting the Crisis, Crash and Collapse: Creating Co-Beneficial Solutions for Healthy Communities, Economic Growth, and Sustainable Resources."

Dr. Jackson is the chair of Environmental Health Sciences at the UCLA School of Public Health. In addition to holding many appointments within the state of California, he gained national prominence when he worked for the CDC and addressed the environmental impacts on health related to urban design, architecture and mobility. Dr. Jackson recently served on the Board of Directors of the American Institute of Architects, and he has also chaired the American Academy of Pediatrics Committee on Environmental Health. He has a three-part PBS special, "Designing Healthy Communities," which will be aired in the spring, along with a companion book which will be released at the same time. For more information, please contact Kathleen Karle, Public Health Division Manager, at 781-4929.

The Importance of Good Oral Health during Pregnancy

Good oral health has the potential to improve the health and well-being of women during pregnancy and contributes to improving the oral health and well-being of their children. The reasons women do not receive oral health care during pregnancy are many, but prime among these are misconceptions among patients and providers (both perinatal and dental) about the importance and safety of such care. In addition, many women face barriers to care because they lack insurance coverage for dental care or they are unable to identify providers willing to accept public insurance coverage, such as MediCal (CenCal).

Why is oral health for pregnant women so important? Cavities, dental decay, caries. Regardless of what you have heard it called, dental caries is the infection of the teeth that causes cavities. The infection (bacteria) is contagious and is generally passed from caregiver, usually the mother, to the baby before the first tooth even erupts into the mouth at around 9 months of age. Dental decay remains the most common chronic childhood illness, even more common than asthma.

The silver lining regarding dental decay? Effective primary and secondary prevention measures, such as optimally fluoridated drinking water, xylitol gum, fluoride varnish and dental sealants exist so children today do not have to experience cavities like their parents.

New Oral Health Program Manager Hired

San Luis Obispo Public Health recently hired Theresa Anselmo, MPH, BSDH, RDH, to be the Oral Health Program Manager and to help coordinate oral health efforts within the county. Theresa comes to us with a wealth of experience, and was most recently the Dental Director for the State of Colorado. For more information about local oral health efforts and the work of the SLO Oral Health Coalition, call Theresa at 781-5503.

Content of this article was taken from Oral Health During Pregnancy and Early Childhood: Evidence Based Guidelines for Health Professionals, California Dental Association Foundation, 2010. View the guidelines online at www.cdafoundation.org/learn/perinatal_oral_health.

San Luis Obispo County Reported Cases of Selected Communicable Diseases - Spring 2011

Disease	1st Quarter	Total	1st Quarter	Total
	2010	2010	2011	2011
AIDS/HIV	Not available	3/19	4/1	4/1
Campylobacteriosis	20	98	21	21
Chlamydial Infections	179	694	221	221
Coccidioidomycosis	25	102	21	21
Cryptosporidiosis	2	24	2	2
E. Coli	0	13	2	2
Giardiasis	1	9	6	6
Gonorrhea	3	28	17	17
Hepatitis A	0	1	0	0
Hepatitis B (Chronic)	7	36	18	18
Hepatitis C (Community)	54	274	122	122
Hepatitis C (Correctional)	125	582	120	120
Lyme Disease	0	0	0	0
Measles (Rubeola)	0	0	0	0
Meningitis (Bacterial)	1	4	1	1
Meningitis (Viral)	6	35	8	8
MRSA	0	0	0	0
Pertussis	0	382	10	10
Rubella	0	0	0	0
Salmonellosis	7	35	1	1
Shigellosis	0	5	0	0
Syphilis (Primary/Secondary)	0	0	0	0
Tuberculosis	0	4	2	2

Case counts reflect those reported diseases that meet case definitions as established by the California Department of Public Health. Cases reported by health care providers that do not meet the case definitions are not included in case counts. All cases are for San Luis Obispo County residents only. Persons who do not list San Luis Obispo County as their primary residence and are reported as having a communicable disease are reported in their primary county of residence.



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