San Luis Obispo County Health Agency Spring 2012

Public Health Bulletin

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Health Officer Notes

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

Springtime Celebrations for a Healthy SLO

Springtime is the season that inspires new beginnings and fresh starts, which makes it the perfect time to inspire healthier living, and the month of April has San Luis Obispo County blossoming with healthy inspiration.

The Public Health Department is participating in two nationwide campaigns in April to make our residents aware of the abundance and variety of local programs and services available to help us all live healthier

April 2-8 is National Public Health Week, and this year's theme is A Healthier America Begins Today. April is also the time to celebrate Healthy Counties, Healthy Families, which is the theme for this year's National County Government Month.

Public and private organizations alike do a great job in our county in providing health care services, preventing disease, promoting healthy living, and offering an abundance of opportunities to be active and eat fresh, healthy food. Most residents, however, are not aware of all the resources available that may provide just the inspiration and support needed to make healthy lifestyle choices for ourselves and our families. To support our residents in making healthier choices and to help them access the variety of resources available, the Public Health Department has created the Gateway to Health. (continued on page 2)

Public Health Department newsletters can also be accessed online at the Public Health Department Web site: www.slopublichealth.org (click on Public Health Bulletins at the bottom of the home page).

Springtime Celebrations for a Healthy SLO (continued)

Located on the Public Health home page, the Gateway to Health assembles and categorizes all these resources into one convenient location. Visitors to the Gateway to Health will find brief descriptions and direct links to local programs, services, and events from County government together with community-based organizations.

The Public Health Department is also celebrating National Public Health Week on our Facebook page. We'll be posting useful tips and interesting facts all week long, and don't forget these opportunities for healthy fun in April:

SAN LUIS OBISPO MARATHON + HALF 2012
Benefiting The Leukemia & Lymphoma Society

Benefiting the Leukemia & Lymphoma Society Team in Training and Special Olympics of San Luis Obispo County

let's move SLO

Take the Let's Move SLO Challenge!

Sponsored by HEAL-SLO

Healthy Eating
Active Living
Happy Kids

An interactive program for the whole family!

Sponsored by HEAL-SLO

Medical Reserve Corps Needs Volunteer Health Care Pros

The San Luis Obispo County Medical Reserve Corps (SLOMRC) is now under the administration of the San Luis Obispo County Public Health Department. Previously, the program was administered by the San Luis Obispo County Chapter of the American Red Cross. Despite the change in administration, SLOMRC will continue to operate in coordination with the Red Cross to serve our community needs.

SLOMRC consists of volunteer health care professionals and auxiliary staff who are trained to respond and assist local emergency responders and public health professionals in public health emergencies. The group is a valuable resource during public health emergencies because volunteers are trained and organized to assist the community in a variety of medical capacities. SLOMRC fulfills staffing needs critical to a large-scale emergency response and offers ongoing training and networking opportunities for members.

If you are interested in volunteering through the Medical Reserve Corps, visit www.slopublichealth.org/MRC for more information or contact MRC Coordinator Elizabeth Merson at slomrc@aol.com or (805) 295-8672.

County Designates Its First Trauma Center

The County recently designated Sierra Vista Regional Medical Center as a level III trauma center, and on March 1, 2012 the countywide trauma system went live. A trauma system requires the coordinated efforts of all emergency medical services (EMS) to ensure severely injured patients get the right care, at the right place, at the right time.

Before Sierra Vista's designation, the nearest trauma center was Cottage Hospital in Santa Barbara, leaving San Luis Obispo County as one of only a few counties in the state without a trauma center.

Trauma center designation criteria, established in state regulations and local policy, sets strict requirements for staffing, specialist availability, response times, training, quality improvement and community education. Additionally, trauma centers have organized trauma teams that respond promptly to trauma alerts, and include specific personnel, services, and equipment necessary to provide optimal care for severely injured patients.

Trauma center designation includes levels I - IV and level I and II pediatric specific trauma centers. Level I and II trauma centers have similar personnel, services, and resource requirements with the greatest difference being that a level I is a research and teaching hospital. Level III and IV trauma centers generally provide initial stabilization of trauma patients with the greatest difference being surgical capabilities at the level III facilities.

Continuous oversight and evaluation of the trauma system will be performed by the Trauma System Work Group of the County's Emergency Medical Services Agency. The Trauma System Work Group is comprised of representatives of the trauma center, non-trauma center hospitals, EMS providers, law enforcement, and consumers.

New, Simpler Option Available for Treating Latent TB Infection

As many of our local providers are aware, the SLO Public Health Department no longer manages all cases of latent tuberculosis infection, or LTBI. But there is good news. Another treatment regimen for LTBI is now available. In the December 9, 2011 issue of the MMWR Weekly Report, the Centers for Disease Control and Prevention (CDC) introduced new recommendations for a 12-dose regimen that simplifies and shortens TB treatment from 270 daily doses over nine months to once-weekly doses over three months. Since approximately 40% of LTBI patients fail to complete the standard self-supervised therapy regimen within one year, experts are hoping the shorter 12-dose regimen will result in improved completion rates.

The CDC's new recommendations are based on results from three randomized control trials that found "a combination of isoniazid (INH) and rifapentine (RPT) given in 12 once-weekly doses under direct observation to be as effective in preventing TB as the 270-dose INH regimen self-administered daily over nine months."

This 12-dose regimen, however, is not recommended for everyone. Certain groups of people, including young children, pregnant women or women who expect to become pregnant during treatment, and HIV-infected people taking antiretroviral therapy, should be treated with other existing LTBI treatment regimens. In all cases, because missed doses or altered dosing intervals or amounts could jeopardize efficacy, directly observed therapy (DOT) is recommended. Physicians considering the 12-dose regimen for their patients should consult the CDC recommendations discussed in the December 2011 MMWR.

More than 11 million people in the United States have LTBI, according to the CDC. Without treatment, approximately 5–10% of persons with LTBI will progress to TB disease at some point in their lifetime. Identifying and treating those at highest risk for TB will help move toward elimination of the disease.

Statewide LBTI data from the California Department of Public Health (CDPH) shows that in 2009 there were 3,251 reported contacts of known cases (one of the highest risk groups for progression to TB active disease) diagnosed with LTBI. Only 2,041 (63%) started treatment and 1,208 (37%) patients completed their treatment regimen. [County data on treatment of contacts is not reliable given the low frequency of active disease and that LTBI is not reportable.] State data demonstrates that we collectively need to do a better job of getting LTBI patients in treatment and keeping them on their treatment regimen.

Our recommendation for LTBI patients to be treated by a primary care provider has the potential for better compliance due to established relationships. Also patients may receive comprehensive care for any co-morbidities. Managing treatment of TB patients is often challenging, but the 12-dose option is an opportunity for our local physicians to improve patient compliance. Given the newness of private provider treatment of LTBI in general, and this alternate regimen in particular, we welcome requests for consultation in treating your LTBI patients. SLO PHD continues to provide treatment to LTBI patients when the patient has no regular clinical provider or for complicated cases. We appreciate the ongoing collaboration with our local physicians in fighting this disease and hope that you will call Christine Gaiger, PHN, TB Control Program Manager, at 781-5577 with your questions or comments.

The CDC, MMWR article, Recommendations for Use of an Isoniazid–Rifapentine Regimen with Direct Observation to Treat Latent Mycobacterium Tuberculosis Infection, MMWR 2011;60:1650–1653, is available at: www.cdc.gov/mmwr/preview/mmwrhtml/mm6048a3.htm?s_cid=mm6048a3_w.

Public Health Lab Introduces New Pneumonia Diagnosis Tests

Overheard in a hospital waiting room: "Your daughter is in the ICU with severe pneumonia. We know it is not flu—the test came back negative."
"But what is it?"
"We don't know—probably another virus"

That kind of dialogue occurs more frequently than you might imagine, even when the "flu season" is in high gear. Often one hears people say they had "the flu" after a mild illness lasting a couple of days. Others refer to gastrointestinal illness as the "stomach flu" or "flu bug", a wholly inaccurate descriptor. This perception that the "flu" is not so bad may lead to people forgoing the preventable influenza vaccination.

In fact, influenza virus infections are not a trivial matter, and what people attribute to influenza virus is often something else entirely. Influenza virus infection can be devastating with many days in bed and weeks of recovery, and may be life-threatening - especially to the elderly. Infection with influenza virus, coincident with aspirin treatment in children, can lead to Reye's Syndrome, a rare potentially fatal disease that causes numerous detrimental effects to many organs.

Influenza virus infections can be diagnosed by an advanced assay performed at the SLO Public Health Laboratory using a technique called polymerase chain reaction or PCR, a method that allows multiplication of small bits of target DNA to the point of detection. A negative finding however is not the end of the road for diagnosis. There are many viruses that can cause severe respiratory illness or pneumonia. While influenza virus kills many thousands of unvaccinated susceptible individuals every year, other viruses - parainfluenza, respiratory syncytial virus (RSV), human metapneumovirus, enterovirus, rhinovirus, and adenovirus - can also make people ill to the point of requiring hospital care, and at times, the Intensive Care Unit.

The SLO Public Health Laboratory can now diagnose this diverse array of viruses using the Respiratory Virus PCR Panel (RVP). Offered in a validation study to hospital and community physicians, the RVP can determine the cause of serious illness. This complex test can also subtype influenza and RSV A and B strains. RSV in particular can cause very serious illness in infants, as well as in older adults.

In another group of patients an abnormal chest x-ray may be the first clue to other types of infectious lung diseases. Tuberculosis (TB) may be the first disease to come to the clinician's mind, and the SLO Public Health Laboratory can help diagnose TB with an array of available tests. But here on the Central Coast—and throughout California's San Joaquin Valley and parts of the desert southwestern United States, another illness must be considered: Coccidioidomycosis (Cocci) or Valley Fever. The disease is usually mild, with flu-like symptoms and rash. On occasion, those particularly susceptible may develop complications such as severe pneumonia or disseminated disease with skin ulcers, abscesses, bone lesions, severe joint pain, heart inflammation, urinary tract problems, meningitis, or even death. In some studies, as many as 30% of people hospitalized with community-acquired pneumonia in this area of the U.S. were shown to have Valley Fever. Fungal spores of Coccidioides immitis and C. posadasii reside in the soil and with soil disturbance, such as with construction, farming, or earthquakes, can be aerosolized and then inhaled to cause lung infection.

The SLO Public Health Laboratory is introducing Coccidioides PCR—also in a validation study- to allow diagnosis of the agent of Valley Fever. While culture can detect the invading fungus, it may take days for a result. The new PCR test can be performed in hours, shortening the time to begin effective treatment.

The Public Health Lab is offering these new tests for use by the medical community which promises to remove some of the guesswork in diagnosing pneumonia. www.cdc.gov/mmwr/preview/mmwrhtml/mm6048a3.htm?s_cid=mm6048a3_w.

Immunization Update

The Preteen Vaccine Week

The San Luis Obispo County Public Health Department and local health care providers participated in the 2012 Preteen Vaccination Week, celebrated February 12 - 18. The goal of 2012's Preteen Vaccine Week was to raise awareness about California's new Tdap requirement for incoming 7th grade students, immunization recommendations for 11- and 12-year-olds, and to promote the preteen doctor visit.

ACIP currently recommends that 11- and 12-year-olds receive these vaccines:

- Tdap (tetanus, diphtheria, whooping cough): For the 2012-13 school year and beyond, all students entering 7th grade will need proof of a Tdap booster shot before starting school
- Meningococcal
- Annual flu vaccine
- HPV (human papillomavirus) 3-shot series
- A total of 2 vaccines against chickenpox (varicella)

Expanded Indications for MCV4

In addition to a routine dose at 11-12 years old and a booster dose for adolescents at age 16 years, ACIP now also recommends meningococcal conjugate vaccine (MCV4) for high-risk children as young as 9 months of age.

Children 9 months - 23 months of age with the following risks should receive a primary series of 2 doses of MCV4, 3 months apart:

- Those with persistent complement component deficiencies
- Traveling to or residing in countries where meningococcal disease is hyperendemic or epidemic
- In a defined risk group during a community or institutional meningococcal outbreak

Children 2-10 years of age with the following risks should receive a primary series of 2 doses of MCV4, 2 months apart:

- Functional or anatomic asplenia
- Persistent complement component deficiencies and no prior doses of MCV4
- At increased risk of meningococcal disease and infected with HIV

Children 2-10 years of age not previously immunized with MCV4 and with the following risks should receive 1 dose of MCV4:

- Traveling to or reside in countries where meningococcal disease is hyperendemic or epidemic
- In a defined risk group during a community or institutional meningococcal outbreak

Reminder: ACIP recommends a booster dose of MCV4 for older adolescents

Age in years at first dose of MCV4	Age in years for booster dose
11 or 12	16
13 through 15	16 through 18
≥16	No booster dose needed

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Immunization Update (continued)

Current FDA License Age Indications for MCV4
Menactra® (sanofi pasteur) - 9 months through 55 years of age.
Menveo® (Novartis Vaccines and Diagnostics, Inc.) - 2 through 55 years of age.

Vaccine Information Statement (VIS)
The updated MCV4 vaccine information statement, with new information on contraindications, precautions and adverse events, can be downloaded at www.EZIZ.org or through the CDC at www.cdc.gov/vaccines/pubs/vis/default.htm - mening.

Providers are encouraged to review the details of ACIP recommendations for MCV4

- Use in children as young as 9 months - October 2011 www.cdc.gov/mmwr/preview/mmwrhtml/mm6040a4.htm
- Use in high-risk children age 2 through 10 years; updated booster guidance - August 2011 www.cdc.gov/mmwr/preview/mmwrhtml/mm6030a3.htm
- Adolescent booster dose - January 2011 www.cdc.gov/mmwr/preview/mmwrhtml/mm6003a3.htm
- Revaccination of persons at prolonged increased risk for meningococcal disease - September 2009 www.cdc.gov/mmwr/preview/mmwrhtml/mm5837a4.htm?s_cid=mm5837a4_e

Reminder: Give flu vaccine throughout the season - which can peak in February or March.

OB/GYNs Asked to Screen for Intimate Partner Violence

According to the American College of Obstetricians and Gynecologists (ACOG), in the U.S.:

- Approximately one in every four women has been physically and/or sexually assaulted by a current or former partner.
- Nearly 324,000 pregnant women are abused by their partners each year.
- Homicide is one of the leading causes of maternal mortality.
- OB/GYNs are uniquely positioned to help women who are victims of intimate partner violence (IPV).
- OB/GYNs should routinely screen all women for IPV.
- Signs and symptoms of IPV can present as physical injuries but can also manifest as chronic headaches, chronic pelvic pain, irritable bowel syndrome, and recurrent vaginal infections.
- Women who may not admit to being abused may eventually seek help from their OB/GYN who has brought up the subject in a caring and straightforward manner.

From the article IPV: An Under-Recognized Public Health Epidemic, published January 23, 2012 in the American College of Obstetricians, and is based on the Committee on Health Care for Underserved Women, Opinion #518, Intimate Partner Violence, published in the February 2012 issue of Obstetrics & Gynecology.

Volunteers Promote Community CPR Training

A group of 11 volunteers made up of health care professionals and Public Health Department staff have joined forces with a local nonprofit because they share the same goals: To get more Central Coast residents, young and old, trained in CPR and automated external defibrillator (AED) use.

Mary and Jerry Winokur founded the Ryan J. Clark CPR Fund for Schools in honor of Mary's son Ryan who passed away last year from sudden cardiac arrest at the age of 30. Through their nonprofit, the Winokurs hope to train every high school student on the Central Coast in CPR and AED use.

Since last September, the Winokurs have trained over 2,600 local high school students; an impressive accomplishment for just the two of them. The Winokurs' efforts caught the attention of members of the San Luis Obispo County Emergency Medical Care Committee (EMCC), an advisory body to the County's Emergency Medical Services (EMS) Agency and Board of Supervisors, who recognized the need to further promote CPR and AED training in our county. The EMCC and the Ryan J. Clark CPR Fund for Schools decided to join forces to support the school-based training program and to launch a new Community CPR Campaign to train both the young and old in CPR and AED use.

The EMCC began coordinating a CPR Committee late last year, which includes volunteer members from local fire and ambulance agencies, hospitals, and staff from Public Health's EMS Division. The CPR Committee has made fast progress and has already assisted the Winokurs in training 86 Atascadero High School students in a single day and have plans for two large community CPR events (see below).

The Public Health Department is grateful for the hard work and dedication of all the volunteers involved in providing CPR and AED training in our community. We urge all our residents who are not already trained in CPR and AED use to take advantage of the many opportunities to learn these life-saving skills.

Look for these upcoming Community CPR events:

- May 12, 2012, the Community CPR Campaign will be at Lopez Lake offering hands-only CPR training as part of the Outdoor Discovery Festival sponsored by the Parks and Recreation Department.
- June 7, 2012, the Community CPR Campaign is celebrating National CPR Day with training events taking place all over the county. Details will be posted online at the SLO County EMS Agency, or call (805) 788-2511.

Thirdhand Tobacco Smoke Reaches New Level

Have you ever walked into a completely empty elevator that smelled like someone had just lit a cigarette? That is thirdhand smoke. Thirdhand smoke is the residue and odor left over from secondhand smoke that adheres to surfaces like clothes, hair and skin, wall paint, upholstery and even plastic toys. The toxins found in thirdhand smoke are no different than those found in the two other types of tobacco smoke including things like lead, cyanide and arsenic. Nicotine, a main component of tobacco smoke, mixes with common household contaminants like ozone and natural gas inside homes to form tobacco specific nitrosamines. These nitrosamines settle and mix with other chemicals and stick to both soft and hard surfaces. Tobacco-specific nitrosamines have been causally linked to cancer in humans, especially lung cancer.

Thirdhand smoke affects everyone who comes in contact with a contaminated surface, even pets. Infants and small children are especially vulnerable to thirdhand smoke because of their development. Small children are closer to the ground where the smoke settles, have a tendency to put contaminated objects into their mouths and cannot easily get out of a contaminated area.

Courtesy of CDC Health-e-Cards: Healthy Living - Smoking

The Tobacco Control Program works to decrease all smoke exposure by working with multiunit housing complexes throughout San Luis Obispo County to adopt policies to go smoke-free. Secondhand smoke drifts from unit to unit via ventilation systems, doorways, open windows and cracks. Thirdhand smoke is especially damaging in housing complexes because these units are often quickly turned over to new tenants without adequate cleaning and smoke residue removal. The chemicals found in tobacco smoke are hard to get rid of and usually the damaged property needs to be completely replaced. Smoke-free housing policies are the best way to protect residents and property from the damage of second and thirdhand smoke.

The best way to protect yourself, those around you and even your pets from tobacco smoke exposure is to choose not to smoke. For more information about smoke-free policies or for a schedule of our free quit smoking classes, offered throughout the county, please contact the San Luis Obispo County Tobacco Control Program at (805) 781-5564.

CDC Responds to Questions About the Value of Influenza Antiviral Medications

On February 7, 2012, the Centers for Disease Control and Prevention (CDC) responded to a recent review of randomized clinical trial data for influenza neuraminidase inhibitor antiviral medications and two related commentaries questioning the value of antiviral medications for the prevention and treatment of influenza.

The CDC response stated "After careful consideration of all available evidence, CDC guidance on the use of antiviral medications remains unchanged." Addressing the review published by the Cochran Library, the CDC further stated that a "systematic review of RCTs [randomized controlled trials] should include unpublished and published data . . ." and noted that the Cochrane review authors reported that they did not have full access to all unpublished data. The Cochrane review did not include data from uncontrolled observational studies, which the CDC pointed out, many had been conducted among hospitalized patients, including critically ill children and adults. The CDC stated that "These observational studies from many countries have consistently found that early oseltamivir treatment of influenza patients reduces the duration of hospitalization and risk of severe outcomes such as intensive care unit admission or death."

The CDC added that they, together with the Advisory Committee on Immunization Practices (ACIP), "consider all of the published evidence available from RCTs and observational studies" when issuing their recommendations, and that these reviews of RCTs and observational studies have found consistent clinical benefit of early oseltamivir treatment.

The San Luis Obispo County Public Health Department complies with the CDC and ACIP recommendations and encourages our local health care providers to do the same. While recognizing the benefits of early antiviral medications, we would also like to remind both providers and the public that an annual vaccination is the best way to prevent influenza.

The CDC response titled "Have You Heard?" was published February 7, 2012 in the CDC Online Newsroom and is available at: www.cdc.gov/media/haveyouheard/stories/Influenza_antiviral.html.
For a summary of CDC antiviral guidance for the 2011-2012 influenza season see: www.cdc.gov/flu/pdf/professionals/antivirals/clinician-antivirals-2011.pdf

For the full document outlining ACIP and CDC recommendations and references supporting the statements in the "Have You Heard," CDC response, see "Antiviral Agents for the Treatment and Chemoprophylaxis of Influenza. Recommendations of the Advisory Committee on Immunization Practices (ACIP)" at: www.cdc.gov/mmwr/pdf/rr/rr6001.pdf

To read the review of randomized clinical trial data for the influenza neuraminidase inhibitor antiviral medications, see The Cochrane Library's "Neuraminidase inhibitors for influenza: methods change, principles don't" at: www.thecochranelibrary.com/details/editorial/1442857/Neuraminidase-inhibitors-for-influenza-methods-change-principles-dont.html

To read the related commentaries, see: The British Medical Journal's "Rethinking credible evidence synthesis" at: www.bmj.com/content/344/bmj.d7898; and The British Medical Journal's "Questions remain over safety and effectiveness of oseltamivir" at: www.bmj.com/content/344/bmj.e467.

Near Elimination of Varicella Deaths in the U.S. After Implementation of the Vaccination Program

Authors: Mona Marin, MD, John X. Zhang, PhD, and Jane F. Seward, MBBS, MPH

Abstract

Objective: Varicella has been preventable by vaccination in the United States since 1995. Previous studies reported a 66% decline in mortality rates during the first 6 years of the program. Since then, vaccination coverage has increased substantially. We updated the analysis of U.S. varicella mortality for 2002–2007 and assessed the impact of the first 12 years of the U.S. varicella vaccination program on varicella deaths.

Methods: National data on deaths for which varicella was listed as an underlying or contributing cause were obtained from the Mortality Multiple Cause-of-Death records from the U.S. National Center for Health Statistics. We calculated the age-adjusted and age-specific mortality rates for 2002–2007 and trends since the prevaccine years.

Results: During the 12 years of the mostly 1-dose U.S. varicella vaccination program, the annual average mortality rate for varicella listed as the underlying cause declined 88%, from 0.41 per million population in 1990–1994 to 0.05 per million population in 2005–2007. The decline occurred in all age groups, and there was an extremely high reduction among children and adolescents younger than 20 years (97%) and among subjects younger than 50 years overall (96%). In the last 6 years analyzed (2002–2007), a total of 3 deaths per age range were reported among children aged 1 to 4 and 5 to 9 years, compared with an annual average of 13 and 16 deaths, respectively, during the prevaccine years.

Conclusions: The impressive decline in varicella deaths can be directly attributed to successful implementation of the 1-dose vaccination program. With the current 2-dose program, there is potential that these most severe outcomes of a vaccine-preventable disease could be eliminated.

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San Luis Obispo County Reported Cases of Selected Communicable Diseases - Spring 2012

Disease	4th Quarter 2011	Total 2011	1st Quarter 2012	Total 2012
AIDS/HIV	**0/5**	**2/14**	**Not available**	**Not available**
Campylobacteriosis	30	92	14	14
Chlamydial Infections	**180**	**822**	**233**	**233**
Coccidiodomycosis	94	226	54	54
Cryptosporidiosis	**1**	**11**	**3**	**3**
E. Coli	1	3	0	0
Giardiasis	**1**	**16**	**3**	**3**
Gonorrhea	10	53	16	16
Hepatitis A	**10**	**20**	**1**	**1**
Hepatitis B (Chronic)	7	50	9	9
Hepatitis C (Community)	**102**	**309**	**90**	**90**
Hepatitis C (Correctional)	127	410	95	95
Lyme Disease	**0**	**0**	**0**	**0**
Measles (Rubeola)	0	0	0	0
Meningitis (Bacterial)	**4**	**7**	**1**	**1**
Meningitis (Viral)	5	25	1	1
MRSA	**0**	**0**	**0**	**0**
Pertussis	4	21	4	4
Rubella	**0**	**0**	**0**	**0**
Salmonellosis	5	21	4	4
Shigellosis	**1**	**3**	**0**	**0**
Syphilis (Primary/Secondary)	0	1	1	1

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 as their primary residence and are reported as having a communicable disease are reported in their primary county of residence.

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