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Complementary and Alternative Medicine: What Physicians Should Know

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More than one in three adults and one in nine children in the United States use some form of complementary or alternative medicine to address health and wellness issues, according to a CDC *National Health Statistics Report* (2008). Despite this, many patients don't discuss the use of complementary and alternative medicine (CAM) with their health care providers. The reasons for this are varied, including that some patients do not relate CAM use with medical care so would not think to bring it up during a medical visit. Therefore, if patients do not discuss their use of CAM and their physicians do not inquire about it, it can create a gap in the patient's history.

To provide fully integrated and optimal care, it's crucial that health care providers obtain a complete and accurate view of their patients'

conventional and CAM practices. This then allows the physician to create a safe, integrated treatment plan that is based on all health care approaches.

This article provides basic information on CAM, presents data on the prevalence of CAM use, stresses the importance of communication between providers and patients, and offers some resources to facilitate these discussions.

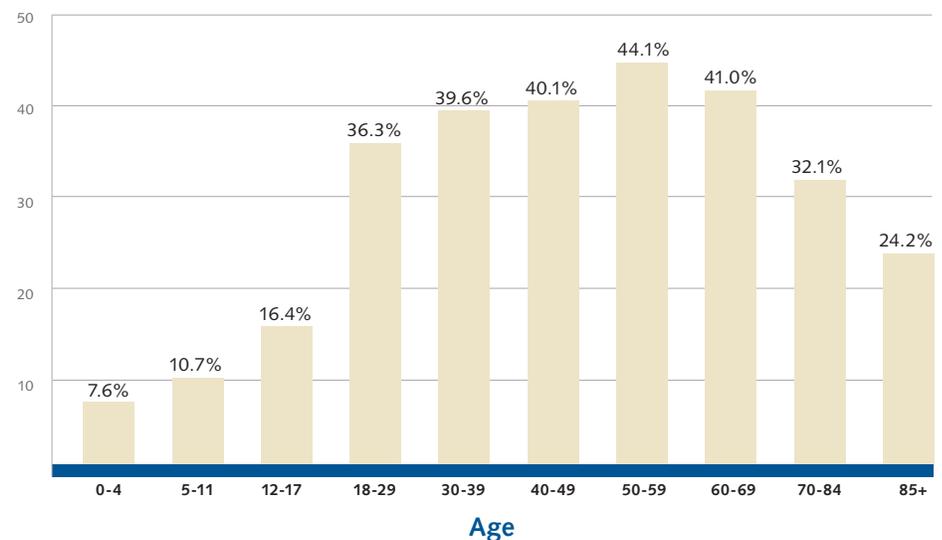
What Is CAM?

CAM is defined as a group of diverse medical and health care systems, practices, and products that are not generally considered part of conventional medicine. CAM includes products and practices such as herbal supplements, meditation, chiropractic care, and acupuncture.

The terms "complementary" and "alternative" refer more to the manner in which these treatments, practices, and products are used rather than the

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Figure 1. CAM Use by Age, 2007



Source: Barnes PM, Bloom B, Nahin R. Complementary and Alternative Medicine Use Among Adults and Children: United States, 2007. CDC *National Health Statistics Report* #12; December 2008.



Table 1. Characteristics of Adults and Children More Likely to Use CAM

Adults (38.3%)	Children (11.8%)
<ul style="list-style-type: none"> • Women (42.8%) compared to men (33.5%) • Adults aged 30-69 (Figure 1) • Adults with graduate-level degrees (55.4%) compared with those with less than a high-school education (20.8%) • Adults who were more than 200% of the federal poverty level (43.3%) compared to those under the poverty level (28.9%) • Adults living in the western region of the U.S. (44.6%) • Former smokers (48.1%) • Adults who were hospitalized in the last year (42.1%) 	<ul style="list-style-type: none"> • Children whose parents used CAM (23.9%) compared with those whose parents did not (5.1%) • Adolescents aged 12-17 (16.4%) compared to younger children • White children (12.8%), compared to Hispanic children (7.9%) and black children (5.9%) • Children whose parents had more than a high-school education (14.7%) • Children with six or more health conditions (23.8%) • Children whose families delayed conventional care because of cost (16.9%)
<p>Source: Excerpted from <i>CDC National Health Statistics Report #12</i>, December 2008</p>	

nature of the treatments themselves. Specifically, the National Institute of Health’s National Center for Complementary and Alternative Medicine (NCCAM) defines “alternative medicine” as the use of CAM *in place of* conventional medicine.¹ In contrast, “complementary medicine” is defined as the use of CAM *together with* conventional medicine.

Who Uses CAM?

The 2007 National Health Interview Survey asked individuals throughout the United States about their health behaviors and practices, including CAM use. The types of CAM listed in the survey included acupuncture, ayurveda, biofeedback, chelation therapy, chiropractic or osteopathic manipulation, deep breathing exercises, diet-based therapies, energy healing therapy/Reiki, guided imagery, homeopathic treatment, hypnosis, massage, meditation, movement therapies, natural products, naturopathy, progressive relaxation, qi gong, tai chi, traditional healers, and yoga.

Results from the 2007 National Health Interview Survey include the following

- One-third of adults reported some CAM use in the past year: 38.3 percent of those surveyed used some form of CAM in the past 12 months.² At 44%, the highest rates of recent CAM use were reported by people aged 50 to 59 years (Figure 1).
- One in nine children used CAM in the past year: The same 2007 survey also revealed that CAM use is not limited to adults. The survey compiled data regarding more than 9,000 children from birth to 18 years of age. In the past

12 months, approximately one in nine children (11.8%) reportedly used CAM.³ Parents frequently do not tell their child’s health care provider about CAM use. In one study, only one-third of parents discussed their child’s current CAM use with their child’s pediatrician.⁴

An overview of those more likely to use CAM based on the 2007 survey is presented in Table 1. In general, women, adults aged 30 to 69 years, those with higher levels of education, those living in the western United States, and those hospitalized in the past year were more likely to use CAM. Its use was higher among children whose parents also used CAM, youth 12 to 17 years of age, children with multiple health conditions, and those whose families delayed or did not use conventional medical care due to cost.

Conditions and Diseases for Which CAM Is Most Frequently Used

Among adults, CAM was most frequently used for management of back, neck, and joint pain; arthritis and other musculoskeletal concerns; as well as anxiety, headache, migraine and insomnia (Table 2).³ In comparison, children used CAM most frequently for back pain and other musculoskeletal conditions, head and chest colds, asthma, sinusitis, other allergies, attention deficit hyperactivity disorder/attention deficit disorder, anxiety/stress, and insomnia.

Therapies for Which CAM Is Most Frequently Used

Natural products, deep breathing, meditation, and chiropractic, osteopathic and massage therapies were the most commonly used CAM among adults in 2007 (Table 2).³ Between 2002 and 2007, there were significant increases in the use of deep breathing exercises, meditation, massage therapy, and yoga.

The most common CAM therapies used by children were similar to that of adults. In both children and adults, natural products (excluding vitamins and minerals) were the most commonly used therapies. The most common natural products respondents reported using in the past 30 days are shown in Table 3.³ Fish oil/omega 3, glucosamine, echinacea, flaxseed oil, and ginseng were the top five most common natural products used in the past 30 days by adults; for children, the top five most common natural products used in the past 30 days were echinacea, fish oil/omega 3, combination herb pills, flaxseed oil, and prebiotics/probiotics.

Use of Natural Products/Dietary Supplements

Natural products (including probiotics, and herbal medicines) were the most frequently cited type of CAM used. A 2007 survey estimated that U.S. consumers spent \$14.8 billion on non-vitamin, non-mineral, natural products without evidence of efficacy.⁵ This is equivalent to approximately one-third of total out-of-pocket spending on prescription drugs. Categorized as dietary supplements, consumers often believe that these “natural” products are safer than pharmaceutical drugs. However, many consumers are unaware that the Food and Drug Administration (FDA) medication regulations do not apply to dietary supplements.

Table 2. CAM Use Among Adults and Children

Conditions and Diseases		Therapies	
Adults	Children	Adults	Children
Back Pain (17.1%)	Back Pain (6.7%)	Natural Products* (17.7%)	Natural Products* (3.9%)
Neck Pain (5.9%)	Head or Chest Cold (6.6%)	Deep Breathing (12.7%)	Chiropractic/Osteopathic (2.8%)
Joint Pain (5.2%)	Anxiety/Stress (4.8%)	Meditation (9.4%)	Deep Breathing (2.2%)
Arthritis (3.5%)	Other Musculoskeletal (4.2%)	Chiropractic/Osteopathic (8.6%)	Yoga (2.1%)
Anxiety (2.8%)	ADHD/ADD (2.5%)	Massage (8.3%)	Homeopathic Treatment (1.3%)
Cholesterol (2.1%)	Insomnia (1.8%)	Yoga (6.1%)	Traditional Healers (1.1%)
Head or Chest Cold (2.0%)	Asthma (1.6%)	Diet-Based Therapies (3.6%)	Massage (1.0%)
Other Musculoskeletal (1.8%)	Sinusitis (1.5%)	Progressive Relaxation (2.9%)	Meditation (1.0%)
Severe Headache/Migraine (1.6%)	Other Allergies (1.4%)	Guided Imagery (2.2%)	Diet-Based Therapies (0.8%)
Insomnia (1.4%)	Respiratory Allergies (1.3%)	Homeopathic Treatment (1.8%)	Progressive Relaxation (0.5%)

* Natural products excludes minerals and vitamins

Source: Excerpted from *CDC National Health Statistics Report #12*; December 2008

CAM Use by People Aged 50 and Older

A joint AARP and NCCAM study in 2010 of persons 50 years of age and older found that 53 percent had used CAM in the past, with 47 percent reporting use in the past 12 months. As with adults overall, women were more likely to use CAM than men, and CAM use increased with educational level. The study also revealed that among those with recent CAM use, 42 percent had not discussed their use of CAM with a health care provider.⁶

The reasons why patients did not discuss their CAM use with a health care provider were varied: 42 percent said the provider never asks about CAM, and 30 percent said that they did not know they should bring it up.

- Patients discussed CAM most frequently with physicians (28%) or nurses/nurse practitioners (12%).
- Patients usually initiated CAM discussions (55%) compared to physician-initiated discussions (26%).
- Physicians most frequently discussed potential drug interactions (44%), gave advice on initiating CAM use (41%), and talked about CAM effectiveness (41%).

More than half of adults over 50 surveyed used CAM to improve or maintain their health. Among this group, CAM was used for general wellness, to reduce pain, treat a painful condition, to treat a specific condition, or to supplement conventional medicine. Of those reporting CAM use, approximately one-third (37%) used herbal products and dietary supplements. Massage therapy, chiropractic manipulation, and other bodywork, were used by approximately one-fifth of respondents (22%). Approximately one in four respondents (26%) cited family and friends as their primary source of information about CAM; the next most frequently cited sources were the Internet (14%) and their personal physicians (13%).

CAM Use and Prescription Medications

The AARP/NCCAM survey also documented the degree to which CAM is used concurrently with prescription medications.⁷ Among those surveyed, four out of five (78%) reported taking one or more prescription medications. Younger respondents were less likely to take prescription medications. Twenty-eight percent of those aged 50 to 64 years took no prescription medications, compared with 10 percent of those aged 65 and older. Among those reporting CAM use in the past 12 months, 77 percent of people reported taking one or

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Table 3. Most Common Natural Products Used by Adults and Children

Adults	Children
Fish Oil/Omega 3 (37.4%)	Echinacea (37.2%)
Glucosamine (19.9%)	Fish Oil/Omega 3 (30.5%)
Echinacea (19.8%)	Combination Herb Pills (17.9%)
Flaxseed Oil/Pills (15.9%)	Flaxseed Oil/Pills (16.7%)
Ginseng (14.1%)	Prebiotics/Probiotics (13.6%)
Combination Herb Pills (13.0%)	Goldenseal (8.6%)
Ginkgo Biloba (11.3%)	Garlic Supplements (5.9%)
Chondroitin (11.2%)	Melatonin (5.8%)
Garlic Supplements (11.0%)	Cranberry Pills/Gelcaps (1.8%)
Coenzyme Q-10 (8.7%)	

Source: Excerpted from *CDC National Health Statistics Report #12*; December 2008

Table 4. Toxicities Induced by Dietary Supplements, by Body System

System	Toxicity	Supplement
Central Nervous System	Stimulation	<i>Ephedra sinica</i> * Guaraná/Yerba maté
	Sedation	Kava*
Cardiovascular	Vasopressive	<i>Ephedra sinica</i> * Guaraná Yohimbine*† (poisonous plant database) <i>Citrus aurantium</i> (bitter orange)†
	Electrophysiological	<i>Ephedra sinica</i> * Hawthorn
	Hypertension	Hawthorn Ginseng
Dermatological	Skin rash	Kava
	Photodermatitis	St. John's wort* Goldenseal
Immune	Allergic reaction	Echinacea Bee pollen Milk thistle
Hematological	Antiplatelet/anticoagulant	Feverfew Ginkgo biloba Garlic Ginseng Willow bark
Hepatic	Hepatitis	Black cohosh Chaparral† Comfrey* Kava Pennyroyal Lipokinetix (usinic acid)
Metabolic	Hypokalemia	Licorice Aloe Senna Cascara
	Hyperglycemia	Glucosamine <i>Ephedra sinica</i> * Licorice
	Hypoglycemia	Fenugreek Garlic Ginseng
Mutagenic/Carcinogenic	Urothelial	Aristolochic acid*
	Hepatocellular	Pyrrrolizidine alkaloids
Renal	Renal failure	Aristolochic acid*

* Cited with warning or ban by FDA

† Included on Consumer Report List

Source: Adapted from Waldman SA, Terzic A. Pharmacology and Therapeutics: Principles to Practice. Philadelphia; Elsevier/WB Saunders; 2008: 1536.2

Tools and Resources

The NIH's National Center for Complementary and Alternative Medicine has launched Time to Talk, an educational campaign to encourage patients—particularly those age 50 or older—and their health care providers to openly discuss the use of CAM. The campaign is a part of NCCAM's effort to educate both consumers and health care providers about the importance of discussing CAM and providing evidence-based information to help with health care decision-making. This campaign encourages patients to tell their providers about CAM use and for providers to ask about it by offering tools and resources—such as wallet cards, posters, and tip sheets—all of which are available for free on the NCCAM website (www.nccam.nih.gov/timetotalk) or by calling 1-888-644-6226.

more prescription medications. Almost two-thirds (63%) of those reporting simultaneous CAM and prescription drug use also reported taking two or more prescription medications.

Dietary Supplements: Prior Proof of Safety and Efficacy Are Not Required by the FDA

The FDA requires pharmaceutical manufacturers to conduct clinical trials to establish both a drug's efficacy and safety before it can be marketed. The same scrutiny does not apply to dietary supplements, which are categorized as foods and, therefore, do not require proof of efficacy or safety prior to sale. Supplement manufacturers must only certify that they follow good manufacturing practices, thereby ensuring supplements are processed consistently and meet specified quality standards. At best, good manufacturing practices are intended to ensure that products contain the listed ingredients in the listed amounts and do not contain contaminants. The FDA does monitor supplement safety. If the FDA finds a product to be unsafe, it may issue a warning or require that the product be removed from the market. Table 4 lists the physiological impacts of some common dietary supplements, including a few for which FDA warning or bans were issued.

During the nearly six-year period from January 1, 2003, through October 31, 2008, the FDA received 3,502 adverse event reports related to dietary supplements, with nearly one-third (31.6%) requiring hospitalization.⁸ Among these, 471 events were considered life-threatening, and 142 resulted in death.

The NCCAM offers a series of fact sheets titled, *Herbs at a Glance*, that provide basic information about specific herbs or botanicals. This includes common names, uses, potential side effects, and resources for more information (www.nccam.nih.gov/health/herbsataglance.htm).

Discussing CAM with Patients

CAM is used by adults and children to promote health and wellness, often in conjunction with conventional medicine and prescription drugs. However, most patients do not proactively disclose their use of CAM to health care providers. Although patients with chronic and acute medical conditions turn to CAM in large numbers—most frequently to treat pain (including back, neck, or joint pain; arthritis; or other musculoskeletal conditions), as well as anxiety, cholesterol, head or chest colds, and other medical conditions⁹—many do not share their information with their physicians.

While physicians may not have sufficient time to fully explore CAM use during a patient visit, it is important to at least ask about CAM use and provide general advice. In addition to the use of prescription and over-the-counter medications, patients should be asked about their use of alternative treatment systems (e.g., acupuncture, homeopathy treatment, naturopathic treatment, traditional healers, manipulation/body-based treatments, and mind-body treatments) and the use of specific products (e.g., folk medicines, herbal/natural products, diet-based treatments, and megavitamins). Methods to collect this information include the following:

- Include a question about CAM use on medical history forms.
- Ask patients to bring a list of all therapies they use, including prescription, over-the-counter, herbal therapies, natural products, folk medicine therapies, and vitamins.
- Have a nurse, nurse practitioner, or physician assistant initiate the conversation.

Patients using CAM should be asked why they are using these complementary and alternative therapies. They should be advised that well-designed clinical trials for many CAM therapies are often lacking; therefore, the safety and effectiveness of many CAM therapies are uncertain. Because many CAM products are not regulated by the FDA, the composition of some CAM products may vary. Patients should be advised that some dietary supplements may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. They should also be informed that most supplements have not been tested in pregnant women, nursing mothers, or children.

Physicians don't need to know everything about all CAM treatments. There are several credible resources that offer evidence-based information for clinicians as well as patient education materials. Here are a few:

Resources for Providers

National Center for Complementary and Alternative Medicine
www.nccam.nih.gov
www.nccam.nih.gov/health/providers

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CAM on PubMed

Journal citations specific to CAM

www.nccam.nih.gov/research/camonpubmed

Online Continuing Education Series

Video lectures available for CME/CEU credits

www.nccam.nih.gov/training/videolectures

Resources for Patients

National Center for Complementary and Alternative Medicine

www.nccam.nih.gov

1-888-644-6226 (Toll-free clearinghouse)

MedlinePlus

www.medlineplus.gov

Discussing Children's Use of CAM

When discussing CAM use by children, physicians may share the following points with their patients:

- Few high-quality studies have examined how CAM therapies may affect young people, and results from studies in adults do not necessarily apply to children. Children are not small adults. Their immune and central nervous systems are not fully developed, so they may respond to treatments differently than adults. This is especially true for infants and young children.
- Herbs and other dietary supplements may interact with medicines or other supplements, or they may cause problems during surgery, such as bleeding-related complications. In addition, "natural" does not necessarily mean "safe." CAM therapies can have side effects, and these may be different in children than in adults.
- Scientific studies provide valuable information about how safe and effective a specific CAM therapy is in children. However, since few, if any, rigorous studies in young people exist, additional scientific studies are needed. Anecdotes and testimonials (personal stories) about CAM therapies are common and can be compelling, but they are not evidence.

Conclusion

Since many patients do not initiate discussions about their use of CAM with their physicians during a medical visit, physicians should view the visit as a prime opportunity to ask the patient about his or her use of CAM. This proactive approach opens the door to communication and allows the physician to create a safer and more integrated treatment plan for the patient. 

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9. Barnes, P, Powell-Griner E, McFann K, Nahin R. *CDC Advance Data Report #343. Complementary and Alternative Medicine Use Among Adults: United States, 2002.* May 27, 2004.

Continuing Medical Education Courses

The Los Angeles County Department of Public Health is pleased to offer the following free, online CME courses, which have been approved for AMA PRA Category 1 credit:

- Advance Care Planning: Assuring the Care that Patients Want at the End of Life
- Common Causes of Low Vision in Adults Aged 40 Years and Older
- Detection and Management of Age-Related Hearing Loss
- Successful Treatment of Tobacco Addiction

Sign in or register as a New Member at <https://publichealth.lacounty.gov/elearning>

Addressing Racial/Ethnic Disparities in Preventive Services

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Americans suffer from inequalities in access to preventive health care and disparities in health outcomes by race/ethnicity,¹ and elimination of such disparities is one of the four goals of Healthy People 2020.² There are many causes of disparities that clinicians can concretely address in their practice.

Racial/ethnic disparities have been found for preventive services recommended by the U.S. Preventive Services Task Force (USPSTF), notably³:

- Screening for cancers
- Counseling for tobacco cessation
- Aspirin use for cardiovascular disease
- Screening for hypertension.

In addition, racial and ethnic disparities for childhood and adult immunizations are well-documented. For instance, in 2009 Latinos and African Americans in LA County were less likely to receive a seasonal flu vaccination in comparison to Asians.⁴ In 2003, whites were more likely than other racial/ethnic groups to have received a pneumococcal vaccination in their lifetime⁵ (Figure 1).

Underuse of effective preventive services leaves some groups at higher risk for preventable morbidity and premature death. For instance, nationally, African Americans have been found to have the highest age-adjusted death rate due to influenza and pneumonia⁶ and non-Hispanic black children have been found to have higher seasonal flu-related hospitalization rates than non-Hispanic white children.⁷ Locally, African

Americans in Los Angeles County experience the highest death rates due to breast cancer and coronary heart disease.⁸

The causes for disparities are varied but, in 2002, the Institute of Medicine (IOM) recognized that there was sufficient evidence to suggest that racial/ethnic disparities in health persist largely due to economic and social inequities.⁹ Those who are unemployed, uninsured and/or residing in impoverished communities are less likely to receive some universally recommended preventive services. In addition, a history of inequities has influenced care-seeking behavior and attitudes toward preventive services.¹⁰ Thus, traditional health care decision-making has shifted to include patients as active and collaborative partners in medical decisions and treatment plans. Strategies to promote this partnership are the focus of this article.

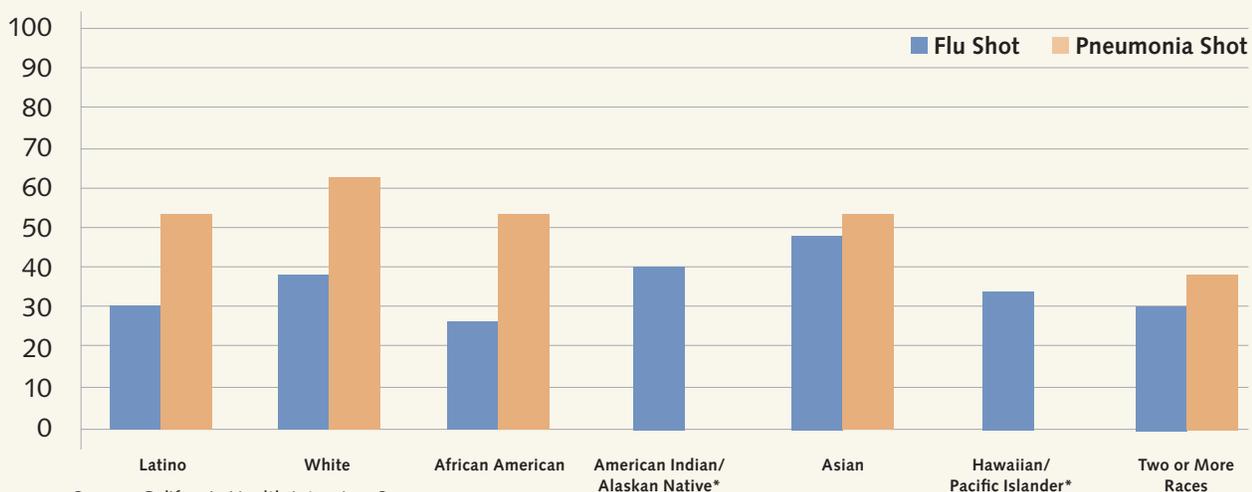
Addressing Disparities in the Medical Practice Build trust with your patients and confidence in preventive services.

Why? Nearly a decade of research shows that a lack of patient trust has an adverse impact on doctor-patient interactions, compliance with physician recommendations, self-reported health status, and health care utilization.

How? Use a comforting and caring tone, pose nonjudgmental open-ended questions to learn of concerns, encourage and respond to questions, explain recommendations, address misconceptions, and tell your patients why you personally recommend the preventive service. For instance, when promoting the flu vaccine, consider a conversation opener like “I’ve recommended that you get your flu vaccine because the research and my experience have convinced me that it’s

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Figure 1. Proportion of LA County Residents Who Received a Flu Vaccination and a Pneumococcal Vaccination



Source: California Health Interview Survey

- Flu vaccine in the past 12 months, all ages excluding individuals 12-17 years of age, 2009
- Pneumococcal vaccine ever, adults ≥ 65 years of age, 2003

* Note: Pneumonia vaccination rates were statistically unstable for American Indian/Alaskan Native and the estimate was less than 500 people for the Hawaiian/Pacific Islander category.

the best way to avoid the flu. I get my vaccine every year and so do my kids. But some of my patients have had questions about this vaccine. What questions or concerns can I address for you?"

Consider recruiting a diverse clinical and support staff that shares the cultural and ethnic background of your patients.

Engage family members while being sensitive to confidentiality and HIPAA issues.

Why? In some cultures, family members play an important role in health care decisions. For instance, caregiving has been an explicit role expectation for women in African American families as a means of individual/group survival and remains a valued experience.^{11,12} Thus, daughters in some African American families play a critical role as informal caregivers and may wish to be involved in their family members' preventive health decisions. In some families, including Hispanic families, the father or husband may be seen as the decision-maker, and some patients look to elders for advice.

How? When appropriate, ask patients who they wish to involve in medical decisions, engage these individuals in visits, and provide written materials that patients can bring home to discuss with family members.

Use plain language.

Why? Health literacy is the capacity to "obtain, process and understand basic health information and services needed to make appropriate health decisions and follow instructions for treatment."¹³ Patients with limited health literacy have been found to have less awareness of preventive and self-care measures and to exhibit less healthy behaviors.¹⁴⁻¹⁶ Nearly 45% of all high-school graduates have limited health literacy and the majority of adults have difficulty using everyday health information.¹⁴ Therefore, many of your patients may have trouble reading a typical patient educational handout, deciphering an immunization schedule, or identifying a healthy weight range on a BMI chart.

How? The following strategies, recommended by the American Medical Association Foundation, may help physicians address health literacy issues in their practice.¹³

- Provide easy-to-understand information to all patients. Some groups may be more likely to have limited health literacy, but even highly educated, articulate, and health-literate individuals can have trouble understanding recommendations, and most will never tell a provider of their challenge.
- Speak slowly, avoid medical terms, use plain language (Figure 2), limit information, and give the most important points first.
- Provide educational materials that use short words and sentences, include only essential information, and list recommended actions. Underline key points and use

Figure 2. Examples of Plain Language Medical Terms¹⁷

- Say "hand washing" instead of "hand hygiene."
- Say "length of time a disease is in someone's body before they feel or look sick" instead of "incubation period."
- Say "a tool used to measure how fast you can blow out air" instead of "peak flow meter."
- Say "more open to, in danger of getting, likely to get" instead of "susceptible."

pictures to enhance understanding (Figure 3). A sample low-literacy educational flyer is posted at www.publichealth.lacounty.gov/acd/docs/Handwashing/StopGerms.pdf.

- Use nonjudgmental language to confirm patient understanding and encourage questions.
 - Ask patients to explain what they've been told ("teach back" technique) to confirm understanding. For example, say "Please explain the steps you'll be taking to complete the TB skin test." or "When your wife asks you about your exercise plan, what will you tell her?" or "Please recap when you'll need to come back for Bridget's vaccines."
 - Encourage questions with a statement like "It can be tough to sort through all of the health-related information. Please feel comfortable asking questions and letting me know if there is anything that you don't understand."

See the Resources box for downloadable educational materials and health literacy resources.

Provide culturally sensitive care.

Why? Physician cultural competence and the ability to engage in relationship-based care that promotes communication, partnership, respect, and trust have been linked with greater satisfaction with care, treatment adherence, and use of preventive health services.¹⁸⁻²⁰

How? Providing culturally sensitive care requires actions at many levels. Consider completing an assessment like the Cultural and Linguistic Competence Policy Assessment (www.clcpa.info) to help identify areas to focus on in the practice. Think about whether you and your staff

- Address misconceptions in a nonjudgmental way.
- Speak the predominant languages and reflect the cultural background of your patients.
- Use competent interpreters, as recommended, rather than relying on patients' family members.
- Use materials that are translated and culturally tailored.
- Understand cultural standards for greetings, eye contact, gestures, interruptions, and turn-taking.

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Figure 3. Checklist for Selecting Effective Educational Materials²¹⁻²²

Design

- Is it easy to read, with at least one-inch margins?
- Does it use pictures and diagrams to clarify concepts and motivate action?
- Does it group information under informative headings and use bullets to concisely summarize key points?
- Are there fewer than three font types used? Are font sizes 12 points or larger? Are *italics*, **bolded** text, and ALL CAPS used sparingly?

Message

- Does it clearly communicate the action that you want the reader to take and spell out realistic action steps?
- Does it present the most important concepts first?
- Is it written below a 7th-grade reading level?
- Is it written in an active voice?
- Does it use common words and avoid jargon and medical/technical language?
- Does it use personal pronouns, such as “you” or “we,” to speak directly to the audience?

Resources

Background Information and Suggestions for Addressing Disparities

AMA Roadmaps for Clinical Practice
www.ama-assn.org/ama/pub/physician-resources/public-health/general-resources-health-care-professionals/roadmaps-clinical-practice-series.page

Centers for Disease Control and Prevention
Community Health & Health Equity Program
www.cdc.gov/nccdphp/dach/chhep/library/social_determinants.htm

Centers for Disease Control and Prevention
Office of Minority Health & Health Disparities
www.cdc.gov/omhd/populations/populations.htm

Cobb Institute/National Medical Association
www.nmanet.org/index.php/Publications_Sub/jnma

Network of Ethnic Physician Organizations
www.ethnicphysicians.org

Health Literacy, Plain Language, and Cultural Competency

AMA/AMA Foundation Health Literacy and Patient Safety/ Help Patients Understand, Manual for Clinicians
www.ama-assn.org/resources/doc/ama-foundation/healthlitclinicians.pdf

Centers for Disease Control and Prevention
Health Literacy Resources
www.cdc.gov/healthliteracy

HHS Office of Minority Health and Physician's Guide to Culturally Competent Care
www.minorityhealth.hhs.gov
<https://cccm.thinkculturalhealth.hhs.gov>

Institute for Healthcare Advancement Health Literacy Tools
www.iha4health.org

Institute of Medicine (IOM): Innovations in Health Literacy
www.iom.edu/Reports/2011/Innovations-in-Health-Literacy.aspx

Los Angeles County Department of Public Health
Plain Language Guide and Educational Materials
www.publichealth.lacounty.gov/hea/Materials_Review/10.18.2010_Plain%20Language%20Manual_Final.pdf
www.publichealth.lacounty.gov/hea/Materials_Review/2011.Sept.27_Print%20Materials%20Inventory.pdf

University of Washington's Culture Clues™ Tip Sheets
www.depts.washington.edu/pfes/CultureClues.htm

- Have a sense of how cultural or religious values and beliefs impact patient attitudes. Culture may influence beliefs about disease causation, heredity, holistic practices, home remedies, stigma, illness, healing, and control of health-related decisions.

Conclusion

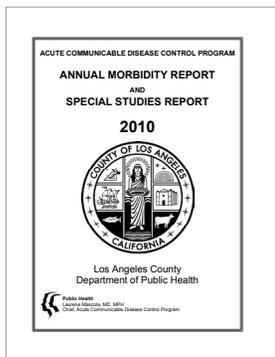
By working to build trust, using plain language, and providing culturally sensitive care, physicians and their care teams can address disparities. While these strategies will not resolve the underlying causes of disparities, they are expected to improve care and the uptake of preventive health services in culturally diverse communities. 

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New Report Summarizes Annual Morbidity in LA County



The LA County Department of Public Health has just released its “Annual Morbidity Report, 2010.” The 225-page report, published in November, contains surveillance data of notifiable diseases and disease summaries with trends, highlights, graphs, maps and tables of disease incidence rates compared to previous years.

Data-rich summaries are provided for 32 diseases, including

amebiasis, legionellosis, listeriosis, malaria, mumps, salmonellosis, shigellosis, vibriosis, and West Nile virus. The report also features disease outbreak summaries for community-acquired diseases, foodborne illness, and health care-associated illnesses. Information on tuberculosis, sexually transmitted diseases, and HIV and AIDS is not included in this report, as data on these topics are available from the department’s Tuberculosis Control Program and the Division of HIV and STD Programs.

This annual report, created by the department’s Acute Communicable Disease Control Program, is compiled to summarize morbidity trends of many communicable diseases occurring in LA County, identify patterns of disease as a means of directing future disease prevention efforts, identify limitations of and means of improving data, and serve as a resource for health care providers, public health officials, and others seeking communicable disease data and surveillance information.

To view the report, go to www.publichealth.lacounty.gov/acd/reports/annual/2010Annual.pdf.

Educational Materials Inventory Offers Resources for Physicians and Patients

To assist physicians in educating their patients about a variety of health topics, the LA County Department of Public Health has developed an Educational Materials Inventory, which lists dozens of health education materials available through the department’s various programs.



This 61-page resource lists a variety of materials, such as brochures, information sheets, posters, presentations, and stickers. It covers many topics, including antibiotics, communicable diseases, distracted driving, flu vaccine, food safety, genital warts, hypertension, West Nile virus, and whooping cough.

Each resource lists a website address where the material may be downloaded or contact information where the material can be ordered.

The inventory, which was compiled by the department’s Health Education Administration unit, allows physicians and other health care providers to access and distribute this useful information to improve the health of communities in Los Angeles County.

To view the Educational Materials Inventory, go to www.publichealth.lacounty.gov/hea/EdMaterials.htm. 

Influenza Watch Offers the Latest Flu Surveillance Info for LA County

What are the levels of local respiratory illness in LA County? How many flu-related deaths have there been? Find out the answers to these questions and more by reading *Influenza Watch*, the LA County Department of Public Health’s e-newsletter that describes influenza and other respiratory viruses in Los Angeles County. This weekly e-newsletter is published during the traditional influenza surveillance season (October to mid-May).

To read the latest issue of *Influenza Watch*, log on to www.publichealth.lacounty.gov/acd/FluSurveillance.htm. To receive the newsletter via e-mail, sign up on the ListServ at www.publichealth.lacounty.gov/listserv (select “Public Health Topics” and then “FLUWATCH”).

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

Rx for Prevention

Promoting health through prevention in Los Angeles County

Upcoming Trainings

Immunization Training Resources for Clinicians

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

Immunization Skills Training for Medical Assistants

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

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Index of Disease Reporting Forms

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

Reportable Diseases & Conditions

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

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

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

Adult HIV/AIDS Case Report Form

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

Pediatric HIV/AIDS Case Report Form

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

Pediatric AIDS Surveillance Program

(213) 351-8153
Must first call program before reporting
www.publichealth.lacounty.gov/HIV/hivreporting.htm

Tuberculosis Suspects & Cases

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

Lead Reporting

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

Animal Bite Report Form

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

Animal Diseases and Syndrome Report Form

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

Use of trade names and commercial sources in *Rx for Prevention* is for identification only and does not imply endorsement by the Los Angeles County Department of Public Health (LACDPH). References to non-LACDPH sites on the Internet are provided as a service to *Rx for Prevention* readers and do not constitute or imply endorsement of these organizations or their programs by LACDPH. The Los Angeles County Department of Public Health is not responsible for the content of these sites. URL addresses listed in *Rx for Prevention* were current as of the date of publication.