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Reducing Deaths from Suicide: The Importance of Collaborative Care

Nicolle Perras, MA, MPH

Introduction

In 2011, 39,518 people died by suicide in the United States, more than from any of the following: automobile and transportation accidents, unintentional drug poisonings, and all unintentional injuries from falls, drowning, fires, and burns combined (Table 1).¹ The impact of suicide is felt not just by individuals but by countless families, communities, social and medical services, and worksites dealing with the grief, medical costs, lost productivity, and potential years of life lost.^{1,2} Historically, suicide has been viewed strictly as a mental health problem; however, in reality, suicide is a multifaceted problem. It is difficult to address, and risk develops long before people attempt to harm themselves.² Much of the treatment of mental health conditions falls in the realm of primary care and because a high proportion of people who make a suicide attempt have recently seen a primary care provider, primary care physicians play an important role in suicide prevention.²

Suicide rates vary significantly by sex, age and race/ethnicity. Men are four times more likely to die by suicide



than women and account for 80% of all suicide deaths nationally.^{1,3} The rates for men and women peak at different ages across the lifespan, early and mid-adulthood for women and steadily increase with age among men.¹⁻⁴ Variation is also found among different races and ethnicities, with American Indians and Alaskan Natives being most at risk during adolescence and early adulthood. Among African American men, there tend to be two peaks of increased risk during the lifespan, during adolescence and again after age 75.^{2,4} Overall, the majority of deaths from suicide are among males, with suicide rates highest among non-Hispanic white males between the ages of 35 and 64 years.¹⁻⁴ Women, youth and young adults, especially non-Hispanic whites, attempt

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Table 1. Leading Causes of Injury-Related Deaths, United States, 2011

Cause of Death	U.S., 2011
Suicide	39,518
Motor Vehicle/Transportation Accidents	37,280
Unintentional Drug Poisonings	33,071
Falls, Drowning, Fire/Burns	36,111
Homicides	16,238

Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System online. Cited 2014, Aug 4. Available from URL: www.cdc.gov/nipc/.



suicide at higher rates and accounted for over half of all attempts nationally in 2011.¹

In LA County, suicide is the sixth-leading cause of premature death, accounting for 769 deaths, nearly 4,000 hospitalizations, over 2,500 emergency department visits, and 21,754 years of potential life lost in 2011.³ Nationally, suicide attempts are prominent sources of injury with almost 500,000 identified attempts requiring hospitalization or medical attention in an emergency department in 2011.¹ Similar to national trends, non-Hispanic white males 35 to 64 years in LA County were disproportionately impacted with a suicide rate of 34.6 per 100,000 population, 4.5 times that of the overall county suicide rate of 7.6 per 100,000 population.^{1,3} Injuries and premature death from self-inflicted violence are impacting LA County residents in the prime of their lives. When medical costs and lost productivity are calculated, the projected total economic impact of suicides and suicide attempts in LA County during 2011 was nearly \$1 billion (Table 2).⁵

Risk Factors for Suicide

While the reasons behind why a person chooses to end his or her life are complex and most often cannot be reduced to a single factor, several significant risk factors have been identified. These factors may be **psychological** (mental illnesses such as depression, mood disorders, substance abuse, and previous suicide attempts), **social** (exposure to violence, family history of suicide and stigma around mental illness), and **environmental** (easy access to lethal means, social isolation, unemployment and stressful life events) (Table 3).^{2,6-8} There are also several known protective factors such as access to effective clinical interventions, skills in problem solving and ability to regulate emotions, strong family ties and restricted access to lethal means (Table 3).⁶⁻⁸ Additional risk factors, often seen in the primary care setting include those related to physical health status such as illness, chronic medical conditions, pain disorders, and sleep disturbances.^{2,6-8}

Several reasons have been posited for the high suicide rates among white, middle-aged males, including socioeconomic

risk factors, barriers to accessing mental health, and lethality of injury mechanism. Socioeconomic risk factors such as unemployment, low income levels, and occupational stressors have been associated more often with suicide among men, as have rates of self-medication with alcohol and other substances.^{2,4,8} Males most frequently use a firearm for suicide attempts and therefore have a higher fatality rate.¹ Each year twice as many people in the U.S. die by firearm in a suicide compared to homicide: In 2011, 32,351 people nationally died from gun violence, 62% of which were suicides.^{1,6-8} Men composed 87% of suicide deaths by firearm: 46% were white men between 35 and 64 years, and 22% were white men 65 years and older.¹ Restricting access to highly lethal means such as firearms is an essential component of a comprehensive suicide prevention plan.^{1,6-8}

Men are less likely to seek help from mental health professionals, especially for depressive symptoms.⁴ National studies estimate roughly 90% of people who die by suicide (the majority of whom are middle-aged and older white men) met the criteria for a psychiatric disorder before their death, most frequently depression.⁴ A review of the literature found that only about 20% of suicide decedents were seen by a mental health professional in the month preceding their death (one-third in the year prior to death), and these were primarily women and younger adults, age 18-35.⁹ Yet roughly 50% of decedents had seen their primary care provider within a month of their suicide (70% in the year prior to death), including more men and adults 55 years and older.⁹ This increased contact with primary care providers, specifically among middle-aged and older males, is a prime opportunity to screen for depression, alcohol and drug abuse, and suicidality.

Often individuals who die by suicide are known to have been suffering from chronic and sometimes terminal illnesses. Several medical conditions have been associated with increased suicide rates, including neurological disorders such as epilepsy, terminal illnesses such as cancer and HIV/AIDS (especially within the first 5 years after diagnosis, during chemotherapy treatment, and among men), and chronic

Table 2. Projected Costs for Suicides and Suicide Attempts, LA County, Based on 2011 U.S. Cost Estimates

Average Cost Per Incident	Suicides	Suicide Attempts Hospitalizations	Suicide Attempts Emergency Department Visits
Medical	\$3,709	\$11,116	\$3,459
Lost Work	\$1,081,518	\$19,903	\$1,088
Combined Cost	\$1,085,227	\$31,019	\$4,547
Los Angeles County [Quantity]	769 in 2011	3,965 in 2011	2,595 in 2011
Total Costs for 2011	\$834,539,563	\$122,990,335	\$11,799,465

Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System. Injury Cost Reports. www.cdc.gov/injury/wisqars. Last updated September 18, 2014. Accessed on November 24, 2014.

Table 3. Risk and Protective Factors for Suicide

Risk Factors	Protective Factors
<ul style="list-style-type: none"> • Untreated or under-treated mental illness • Alcohol or other drug use and abuse • Previous suicide attempt • Hopelessness • Impulsivity or aggressiveness • Barriers to effective clinical care • Isolation or lack of social support • Unsupported financial/social loss • Stigma associated with seeking care • Access to lethal means • Exposure to media that normalizes or glamorizes suicide 	<ul style="list-style-type: none"> • Strong connections to family and other supports • Access to effective clinical interventions • Restricted access to lethal means • Skills in problem-solving and conflict resolution • Frustration tolerance and ability to regulate emotions • Positive beliefs about future, ability to cope, and life in general • Cultural or religious beliefs discouraging suicide

Source: Suicide Prevention Resource Center
<http://www.sprc.org/collegesanduniversities/campus-data/risk-and-protective-factors>

conditions such as cardiovascular diseases, diabetes, and disorders with chronic pain, limited mobility, and decreasing vision or hearing.¹⁰ It is important to note that the presence of these ailments alone do not increase suicide risk directly but rather indirectly, through increased incidents of depression and suicidal ideation.⁴

While the overwhelming majority of people with a mental illness and/or substance use disorder (95%) will never complete suicide, up to 90% of those who die by suicide have experienced a mood disorder, such as depression, and 25% have experienced an alcohol abuse disorder. Often, the mental health and substance use disorders are co-occurring.^{4,9,15} Screen at-risk patients or those displaying symptoms of depression and substance abuse. Assessing suicide risk for patients who screen positive to determine imminent risk of death from passive suicidal ideation may identify those at risk for suicide.

Suicide Prevention and Treatment

Primary care providers have an important role to play in identifying patients at increased risk of suicide. Research has shown that primary care is one of the largest and most frequented settings by individuals who have died by suicide; almost half accessed health care (excluding ED) within a month of their death.^{7,8} While suicide prevention groups have long advocated for routine suicide screening in primary care, the United States Preventive Services Task Force (USPSTF) has cited an insufficient evidence base for screening the general population.^{11,12} However, the USPSTF does suggest that primary care clinicians should be aware of psychiatric problems in their patients and should consider asking these patients about suicidal ideation and referring them for psychotherapy, pharmacotherapy, or case management.^{11,12} The USPSTF also recommends that primary care clinicians focus on patients during periods of high suicide risk, such as immediately after discharge from a psychiatric hospital or after an emergency department visit for deliberate self-harm, as recent evidence suggests that interventions during these high-risk periods are effective in reducing suicide deaths.^{3,11,12}

The USPSTF recommends routine screening of adults in primary care for alcohol misuse (providing brief behavioral counseling interventions for persons engaged in risky or hazardous drinking) and depression when adequate systems are in place for adequate diagnosis, treatment, and follow-up for depressive disorders.^{13,14} It recommends against routine screening for depression among adults when staff-assisted depression care supports are not in place; however, considerations that support screening for depression in an individual patient should be made.¹⁴ One such system is a collaborative care model for the management of depressive disorders.

A 2006 meta-analysis reviewed 37 randomized studies and found increased short-term (6 months) and long-term (5 years) effectiveness in the improvement of depression symptoms among participants receiving collaborative versus standard primary care for depression.¹⁶

Action Steps

As discussed above, there are no universal interventions to prevent suicide; however, there are roles for primary care providers and public health professionals to address suicide at the individual and system levels.

Primary Care

- Screen patients for depression and alcohol/substance dependence; provide appropriate referrals and follow-up with patients regarding symptom management and treatment.
- Counsel patients and their family members on restricting access to lethal means (specifically, limiting access to firearms and the stockpiling of medications) among depressed and suicidal individuals.
- Consider using suicide screening tools in patients identified with depression (Table 4).
- Know your local suicide prevention resources when a patient with suicidal intent is identified (Resources box).

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RESOURCES

HOTLINES

National Suicide Prevention Lifeline

Hotline: 1- 800-273-TALK (8255), 24/7

www.suicidepreventionlifeline.org

LOCAL

Los Angeles County Department of Mental Health

Hotline: 1-800-854-7771, 24/7 (Bilingual)

<http://dmh.lacounty.gov>

Los Angeles County School Threat Assessment Response Team

(213) 738-4924, 1-800-854-7771

<http://dmh.lacounty.gov>

Los Angeles County Human Services Hotline

Dial 2-1-1, 24/7 (Bilingual)

<https://www.211la.org>

Didi Hirsch Suicide Prevention Center Hotline

1-877-7-CRISIS (1-877-727-4747)

<http://www.didihirsch.org>

Teen Line Hotline

Peer-to-peer helpline for teens

1- 800-TLC-TEEN (1-800-852-8336) in California, 6 pm-10 pm Pacific Time.

(310) 855-4673

Text TEEN to 839863 (U.S. only)

www.teenlineonline.org

Suicide Prevention Toolkit for Rural Primary Care. Developed by the Suicide Prevention Resource Center and the Western Interstate Commission of Higher Education (WICHE), Mental Health Program. It contains assessment guidelines, safety plans, billing tips, sample protocols, and resources to treat suicidal patients in the primary care setting.

Available as a free PDF <http://www.sprc.org/for-providers/primary-care-tool-kit>. For a hard copy, call the WICHE Mental Health Program at (202) 541-0311 or e-mail mentalhealthemail@wiche.edu.

National Action Alliance for Suicide Prevention

A prioritized research agenda for suicide prevention:

An action plan to save lives 2014

<http://www.suicide-research-agenda.org>

Los Angeles County Youth Suicide Prevention Project, I Will Thrive

Suicide prevention, intervention and postvention resources for students, teachers, administrators, and parents

<http://preventsuicide.lacoe.edu>

Didi Hirsch

Community mental health and substance abuse service provider

www.didihirsch.org

- Suicide Attempt Survivors Support Group, (310) 895-2319
- Survivors After Suicide Group, (310) 895-2326

Table 4. Additional Information on Screening Tools for Suicide, Depression, and Substance Abuse

Suicide

- The Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)
- Suicide Behaviors Questionnaire (SBQ-R)

Depression

- Patient Health Questionnaire (PHQ-9) is the most common screening tool to identify depression. It is available in Spanish as well as in a modified version for adolescents.
- The MacArthur Foundation Initiative on Depression and Primary Care – Depression Toolkit

Substance Abuse

- Screening, Brief Intervention and Referral to Treatment (SBIRT)

The U.S. Preventive Services Task Force prefers the following tools for alcohol misuse screening in the primary care setting:

- 1) Alcohol Use Disorders Identification Test (AUDIT)
- 2) Abbreviated AUDIT-C
- 3) Single-question screening, such as asking,

For men: "How many times in the past year have you had 5 or more drinks in a day?"

For women and adults older than 65: "How many times in the past year have you had 4 or more drinks in a day?"

Source: <http://www.integration.samhsa.gov/clinical-practice/screening-tools>

- When possible, increase utilization of collaborative care models that integrate mental health and primary care and have referral systems in place.

Public Health/System Level

- Educate primary care providers, their staff, and patients about suicide warning signs and the overlap between depression and many physical illnesses/conditions.
- Spread awareness among health care providers, medical staff, and the patient's family members of the increased risk of suicide among those with untreated or unmanaged depression and/or alcohol/drug misuse.
- Educate and reduce stigma about suicide; promote the message that suicide is preventable.
- Seek effective approaches to reduce the suicide burden through research and adoption of evidence-based interventions.
- Support policy changes aimed at reducing access to firearms among individuals at risk for harming themselves or others.
- Co-locate mental health and primary care services to facilitate referrals through a collaborative care model.⁶⁻⁸ The impact of suicides and suicide attempts are spread throughout systems, including education, hospitals, primary care, mental health, and corrections.
- Incorporate suicide prevention coordinators in high patient-volume clinical settings (i.e., residential health and assisted living facilities, hospitals, and public clinics) to conduct

suicide risk assessment, link patients and caregivers to resources/referrals, and assist actively suicidal patients, limiting impact on primary care providers and staff.⁷

Conclusion

Primary care providers play an important role in identifying depression and other risk factors for suicide and providing treatment and necessary referrals; however, to achieve any meaningful reduction in the number of people dying from suicide, multidimensional, collaborative, system-level strategies are needed (Research Agenda, 2014). Suicide prevention efforts need to address populations versus individuals to have greater impact in reducing deaths and suicide attempts. Collaborative care models are an example of a promising population-level strategy that improves the management of depression in a large number of patients. In the short-term, this model has the potential to reduce suicides and suicide attempts and, in the long-term, increase population well-being and reduce the global burden of illness and disability associated with depression.¹⁶ 

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LA County Department of Public Health Launches Ebola Website



To keep the public, health care providers, emergency responders, the media, and others up to date on the Ebola situation, the Los Angeles County Department of Public Health has launched webpages dedicated to informing various audiences about this topic.

The easy-to-navigate webpages include an updated message from the Interim Health Officer, fact sheets and posters, and links to helpful resources.

For the latest information, go to www.publichealth.lacounty.gov/media/ebola.htm

New Influenza Vaccination Recommendations, 2014-2015

Melanie Barr, RN, MSN

On August 15, 2014, the Advisory Committee on Immunization Practices (ACIP) published recommendations for the 2014-15 influenza season.¹ As in previous years, routine annual influenza vaccination is recommended for all persons age 6 months and older who do not have contraindications to the vaccine. It is important that everyone get an influenza vaccination; however, certain high-risk groups, including persons with chronic medical conditions and personnel (e.g., health care providers) who may have contact with high-risk populations, should receive an influenza vaccination to protect those who are most vulnerable.

Vaccination optimally should occur before onset of influenza activity in the community and continue as long as influenza viruses are circulating.

2014-2015 Influenza Vaccine Strains

The 2014-15 U.S. influenza vaccines are being supplied in both a trivalent or quadrivalent formulation and include the same strains used in the 2013-2014 influenza vaccine. The trivalent influenza vaccines contain:

- A/California/7/2009 (H1N1)-like virus
- A/Texas/50/2012 (H3N2)-like virus
- B/Massachusetts/2/2012-like virus.

All quadrivalent influenza vaccines include an additional B virus, B/Brisbane/60/2008-like virus.

Live Attenuated Influenza Vaccine Recommended for Children Age 2 through 8 Years

In 2014, ACIP modified its recommendations to strongly encourage health care providers to use live attenuated influenza vaccine (LAIV) to vaccinate healthy children age 2 through 8 years. While the inactivated influenza vaccine (IIV) and LAIV both protect against the flu, there is evidence that LAIV may be more effective in younger children.²⁻⁴ One study suggests that LAIV prevents about 50% more cases of flu than IIV in

younger children. However, this recommendation does not include children with chronic medical conditions, such as asthma, diabetes, or heart disease. These children should be vaccinated with IIV only. ACIP does not recommend delaying vaccination if LAIV is not available.

Two Doses of Influenza Vaccine Recommended for Some Children Age 6 Months through 8 Years of Age

As in previous years, ACIP recommends that children age 6 months through 8 years receive 2 doses (at least 4 weeks apart) of flu vaccine (LAIV or IIV) if this is their first season receiving a flu vaccination. Children in this age range should receive at least 2 doses of 2009 influenza A(H1N1)-containing vaccine (2009 monovalent H1N1 vaccine, or 2010-11, 2011-12, 2012-13, and 2013-14 seasonal influenza vaccines) to ensure that they are adequately protected against this strain of influenza. Because the strains contained in the 2014-2015 seasonal influenza vaccine are the same as those contained in the 2013-2014 vaccines, only 1 dose is required this season for any child who received 1 or more doses of influenza vaccine last season. Two doses of vaccine are required this season for other children in this age range who have not received at least 2 doses of seasonal influenza vaccine since July 2010 (see Figure 1).

Updated Recommendations for Vaccinating Persons with an Egg Allergy

The recommendations for persons who report an allergy have been updated as well. ACIP recommends that persons who have an egg allergy but do not meet the age requirement for the recombinant hemagglutinin influenza vaccine (RIV3) receive IIV if it's administered by a physician with expertise in the identification and management of anaphylaxis (see Figure 2). RIV is the only influenza vaccine that is 100% egg-free and it is licensed for person age 18 through 49 years.

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Influenza Vaccination Recommendations and Resources

Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices, United States, 2014-15 Influenza Season
www.cdc.gov/mmwr/preview/mmwrhtml/mm6332a3.htm

California Department of Public Health
[www.cdph.ca.gov/HealthInfo/discond/Pages/Influenza\(Flu\).aspx](http://www.cdph.ca.gov/HealthInfo/discond/Pages/Influenza(Flu).aspx)

California Vaccines for Children Program Educational Materials
<http://eziz.org/resources/flu-promo-materials/>

Centers for Disease Control and Prevention
<http://www.cdc.gov/flu/>

Los Angeles County Department of Public Health
www.publichealth.lacounty.gov/ip/flu/index.htm



Influenza Vaccination/Masking Health Officer Order Remains in Effect for the 2014-2015 Influenza Season

In 2013, the Los Angeles County Health Officer issued an order that was designed to protect health care personnel from influenza and lower the risk of the transmission of influenza to patients. This order remains in effect for the duration of the current influenza season and all future seasons, unless rescinded.

The order's provisions:

- Requires selected health care facilities to require all health care personnel to receive an influenza vaccine or wear a mask while in contact with patients or when working in patient care areas during the influenza season.
- Applies to all licensed acute care hospitals, intermediate care facilities, and skilled nursing facilities in the Los Angeles County Department of Public Health's jurisdiction. Facilities in Long Beach or Pasadena, which are outside of the jurisdiction, may confirm with their respective health departments whether a similar order is in effect.
- Is in effect from November 1, 2014, through March 31, 2015, unless surveillance data suggest that flu activity in Los Angeles County continues after March 31, 2015.

The health officer order, an FAQ, influenza immunization educational materials, and other resources are posted at www.publichealth.lacounty.gov/ip/flu_order.htm.

Importance of Vaccinating Pregnant Women

Flu is more likely to cause severe illness in pregnant women than in women who are not pregnant. During pregnancy, women experience physiological changes that may affect their immune system, heart, and lungs. These changes put them at an increased risk for influenza-related complications as well as hospitalizations and even death. Pregnant women who contract influenza may expose their unborn baby to increased risk, including premature labor and delivery. As such, ACIP and the American College of Obstetricians and Gynecologists recommend an influenza vaccination for all women who are or will be pregnant during the influenza season, regardless of trimester. Influenza vaccination during pregnancy also provides protection for infants (up to 6 months old) who are too young to receive the vaccine. As a reminder, providers should administer only IIV to pregnant women, not LAIV.

In a recent report issued by the CDC, approximately 52% of pregnant women in the U.S. received an influenza vaccination during the 2013-14 flu season.⁵ Although this was a significant improvement compared to previous years before the 2009 pandemic, almost half of pregnant women and their babies remain unprotected from influenza. Of the women who reported receiving an influenza vaccination, almost two-thirds reported they received a strong recommendation and the vaccine from their health care provider. Even women with a negative attitude toward vaccination reported receiving the vaccine based on a recommendation and offer from their health care provider. This report highlights the importance of a clinician recommendation and offer of influenza vaccination to increase vaccination coverage among pregnant women.

Health care providers are encouraged to implement systems within their practice to reduce missed opportunities for vaccination, such as provider reminders, client-based education, and expanded vaccination services to ensure that pregnant women are vaccinated. Health care providers who cannot

provide the vaccine should provide a referral to other vaccination resources such as pharmacies to receive their vaccination. Providers are also encouraged to increase efforts to educate pregnant women on the safety and efficacy of influenza vaccination and the risk for influenza for themselves and their infants.

As a reminder, California law prohibits administering vaccines that contain the preservative thimerosal to pregnant women and to children younger than 3 years of age. Visit www.eziz.org/assets/docs/IMM-859.pdf to learn which influenza vaccines are preservative-free.

For more details on influenza vaccines for pregnant women, including educational materials, visit the CDC's Influenza page at <http://www.cdc.gov/flu/protect/vaccine/pregnant.htm>.

Flu Vaccinations for Health Care Personnel

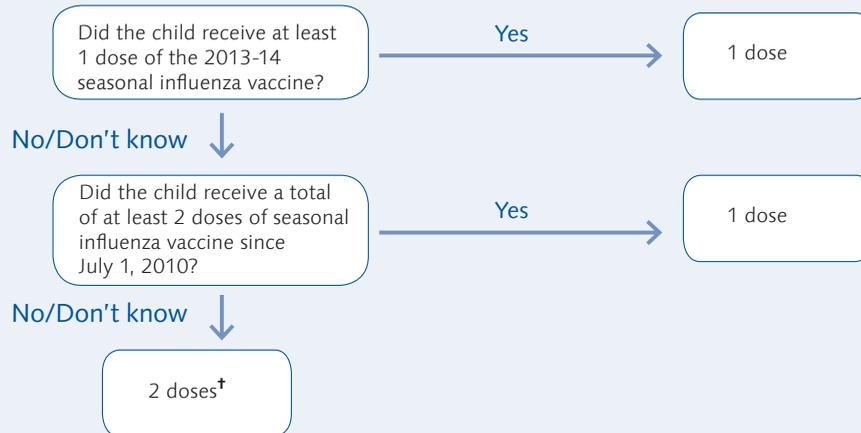
ACIP recommends that all health care personnel (HCP) be vaccinated annually against influenza. High influenza vaccination rates among HCP and patients are critical in preventing transmission of influenza from HCP to patients and from patients to HCP.

Cal/OSHA Aerosol Transmissible Disease (ATD) Standards require all health care facilities, including clinics, skilled nursing, hospitals, and long-term care centers to offer flu vaccinations to their employees and to establish an infection control program to increase flu vaccination rates among HCPs. More information and resources can be found on the California Department of Public Health website at www.cdph.ca.gov/programs/ohb/Pages/ATDStd.aspx.

In addition to Cal/OSHA standards, the Los Angeles County Department of Public Health issued a Health Office Order in 2013 requiring all HCP who work in hospitals, skilled nursing facilities, and intermediate care facilities receive an influenza

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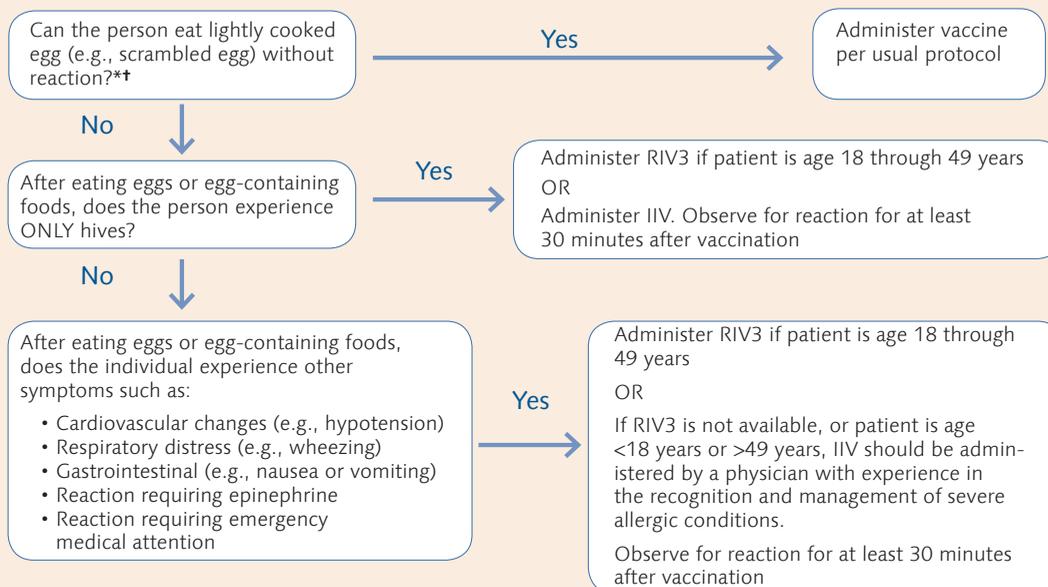
Figure 1. Influenza vaccine dosing algorithm for children age 6 months through 8 years — Advisory Committee on Immunization Practices, United States, 2014-15 influenza season*



* For simplicity, this algorithm takes into consideration only doses of seasonal influenza vaccine received since July 1, 2010, to determine the number of doses needed for the 2014-15 season. As an alternative approach in settings where vaccination history from before July 1, 2010, is available, if a child age 6 months through 8 years is known to have received either 1) at least 1 dose of 2013-14 seasonal influenza vaccine, or 2) at least 2 seasonal influenza vaccines during any previous season, and at least 1 dose of a 2009(H1N1)-containing vaccine (i.e., seasonal vaccine since 2010-11 or the monovalent 2009[H1N1] vaccine), then the child needs only 1 dose for 2014-15. Using this approach, children age 6 months through 8 years need only 1 dose of vaccine for 2014-15 if they have received any of the following: 1) at least 1 dose of 2013-14 seasonal influenza vaccine; or 2) 2 or more doses of seasonal influenza vaccine since July 1, 2010; or 3) 2 or more doses of seasonal influenza vaccine before July 1, 2010, and 1 or more doses of monovalent 2009(H1N1) vaccine; or 4) 1 or more doses of seasonal influenza vaccine before July 1, 2010, and 1 or more doses of seasonal influenza vaccine since July 1, 2010. Children in this age group for whom one of these conditions is not met require 2 doses for 2014-15.

† Doses should be administered at least 4 weeks apart.

Figure 2. Recommendations regarding influenza vaccination of persons who report allergy to eggs — Advisory Committee on Immunization Practices, United States, 2014-15 influenza season



IIV = Inactivated influenza vaccine; RIV3 = Recombinant influenza vaccine, trivalent.

* Persons with egg allergy might tolerate egg in baked products (e.g., bread or cake). Tolerance to egg-containing foods does not exclude the possibility of egg allergy. [Erlewyn-Lajeunesse M, Brathwaite N, Lucas JS, Warner JO. Recommendations for the administration of influenza vaccine in children allergic to egg. *BMJ* 2009;339:b3680].

† For persons who have no known history of exposure to egg, but who are suspected of being egg-allergic on the basis of previously performed allergy testing, consultation with a physician with expertise in the management of allergic conditions should be obtained before vaccination. Alternatively, RIV3 may be administered if the recipient is age 18 through 49 years.

vaccination (see box on page 8). The order also requires that HCP who refuse vaccination wear a mask in patient care areas during the flu season. This order remains in effect this flu season as well as subsequent influenza seasons.

Finally, the Los Angeles County Department of Public Health is requiring certain public health employees to be vaccinated to protect themselves and lower the risk of transmission to patients. Public Health employees who provide direct patient care or who visit health care facilities as part of their job are required to receive a flu vaccination or wear a mask when in close contact with patients or the public. 

Melanie Barr, RN, MSN, is Director of Nursing, Immunization Program, Los Angeles County Department of Public Health.

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Reporting Requirements and Testing Recommendations

For Influenza

With influenza season in full swing, the Los Angeles County Department of Public Health's Acute Communicable Disease Control Program (ACDC) would like to highlight the following reminders for health care providers in LA County:

Reporting Requirements

- Continue mandatory reporting of laboratory confirmed influenza-associated fatalities of any age.
- Report respiratory outbreaks in community and health care settings in the following situations:
 - Institutions (e.g. long-term-care facilities, prisons, sleepover camps) with at least 1 case of lab-confirmed influenza in a setting of a cluster (2 or more cases) of ILI within a 72-hour period.
 - Schools and daycare centers with a sudden increase in ILI cases (5 or more cases or above the normal background rate).
 - Clusters of ILI cases associated with hospitalizations or fatalities.
- Reporting of lab-confirmed influenza cases requiring ICU hospitalization are not required, but hospitals may report on a voluntary basis.
- The LA County Department of Public Health urges physicians to include influenza on death certificates if such symptoms contributed to cause of death or was a preceding illness.

To report a case or outbreak of any disease, contact the Communicable Disease Reporting System at (888) 397-3993, Fax: (888) 397-3778.

Testing Recommendations

- Testing is encouraged in the following situations:
 - Those who are at high risk for complications from influenza.
 - Hospitalized or fatal cases with ILI.
 - ILI in those where history of travel or recent unique exposures may suggest concern for novel influenza infection (e.g., variant swine or avian strains). In these cases, the Acute Communicable Disease Control Program should be notified immediately.

Contact: On weekdays, between 8am–5 pm, call (213) 240-7941. During nonbusiness hours, call the Los Angeles County Operator at (213) 974-1234, and ask for the Public Health doctor on-call.

For Severe RSV Infections

New Requirement: Effective December 1, 2014, the LA County Department of Public Health is adding laboratory-confirmed severe respiratory syncytial virus (RSV) disease in children less than 5 years old to its list of reportable diseases and conditions. All health care providers who are legally mandated to report diseases are required to report these cases to Public Health within 7 working days. For this requirement, “Severe RSV Disease” applies to children who died or were admitted to the ICU as a direct or indirect consequence of laboratory-confirmed RSV infection. This new reporting requirement will contribute to improved prevention of RSV infection and its consequences in children.

More information: www.publichealth.lacounty.gov/acd/docs/RSVreporting.pdf or call ACDC at (213) 240-7941.

Physicians Needed for California Children's Services Medical Therapy Program

California Children's Services (CCS) is California's Title V program for children with special health care needs. The Los Angeles County CCS Program provides case management and medical benefits for infants, children, and youth (up to age 21) who meet all the necessary eligibility criteria. More information about the program may be found at www.publichealth.lacounty.gov/cms/index.htm.

An important part of the CCS program is the Medical Therapy Program (MTP). This program is devoted to providing physical and occupational therapy to children with certain chronic neuromuscular and orthopedic disabilities. In LA County, children in the MTP receive their therapies at Medical Therapy Units (MTUs) located within public schools throughout the county. There are cooperative agreements between local school districts and the MTP to help meet the therapy needs of these young people. Most MTP-eligible children are evaluated at regular intervals by pediatricians and orthopedists at multidisciplinary team conferences. These Medical Therapy Conferences are held at each MTU.

The pediatrician's dual role is 1) to provide oversight of MTU-based therapy and 2) to serve as a care coordinator, ensuring that all medical needs related to each child's CCS-eligible conditions are met through the CCS program. For example, the pediatrician will ensure that appropriate subspecialty medical providers are authorized by CCS, while also addressing psychosocial needs and assuring that a medical

MEDICAL CONSULTATIVE POSITIONS

LA County California Children's Services is currently seeking well-qualified orthopedists and pediatricians to serve as consulting physicians at one or more of our county's numerous Medical Therapy Unit sites. Experience in the medical management of children with special health care needs (especially children with physical rehabilitative needs) is preferred.

For further information, please contact Los Angeles County California Children's Services

- Dr. Stephen Melli, Assistant Medical Director
smelli@ph.lacounty.gov, (626) 569-6463
- Dr. Edward Bloch, Medical Director
ebloch@ph.lacounty.gov, (626) 569-6013

home/primary care foundation is in place in the community.

The orthopedist primarily oversees the medical management of the physically disabling medical condition. This oversight frequently includes referrals for interventions (such as surgery or Botox injections) provided under CCS authorizations to the appropriate subspecialists. 

Announcing the Los Angeles Health Alert Network

Would you know how to manage a suspected Ebola case in your practice?

Do you know when pertussis prophylaxis is indicated?

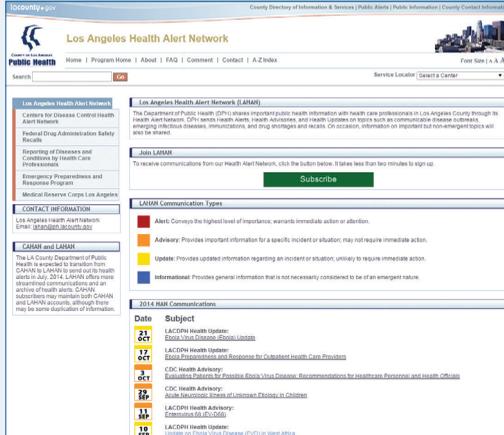
>>> Join LAHAN to stay informed!

The Los Angeles County Department of Public Health has launched the Los Angeles Health Alert Network (LAHAN) to communicate important public health information to health care professionals in Los Angeles. We encourage all primary care providers to join LAHAN to improve communication during public health emergencies.

LAHAN sends health alerts, advisories, and updates on topics such as disease outbreaks, emerging infectious diseases, immunizations, drug shortages and recalls. Users typically receive 1-2 communications a month, and the urgency and target audience are clearly marked.

The Department of Public Health urges you to join this important network. It will be a valuable resource in serving your patients and the Los Angeles community.

Sign up to receive alerts at the LAHAN website. Your contact information will not be shared and you can unsubscribe at any time. Registration takes less than 2 minutes. Simply log on to www.publichealth.lacounty.gov/lahan.



Date	Subject
21 OCT	LACOH Health Update: Ebola Outbreak - Sierra Leone
17 OCT	LACOH Health Update: Ebola Progression and Response for Outpatient Health Care Providers
04 OCT	CDC Health Advisory: Evaluation Patients for Possible Ebola Virus Disease: Recommendations for Health Care Personnel and Outpatient Offices
03 OCT	CDC Health Advisory: Public Health Status of Outbreak of Ebola in Guinea
03 OCT	LACOH Health Advisory: Communicable Disease
10 SEP	LACOH Health Update: Update on Ebola Virus Disease (EVD) Case in Africa

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Rx for Prevention

Promoting health through prevention in Los Angeles County

Thank You, Steve!



After more than 5 years as the Chief Science Officer of the LA County Department of Public Health as well as a coeditor of *Rx for Prevention*, **Steven Teutsch**,

MD, MPH, has transitioned to consulting and academic work. With red pen in hand, or red track changes on, Steve painstakingly edited the many articles that have appeared in this publication, elevating both its content and quality.

Steve, you have set the bar high for editorial standards. We will do our best to continue your legacy. We thank you, miss you, and wish you the very best in your future endeavors!

Best wishes,

~ The *Rx for Prevention* Editorial Board and Staff



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Comments or Suggestions? If so, or if you would like to suggest a topic for a future issue, e-mail Dr. Jeffrey Gunzenhauser, editor, at jgunzenhauser@ph.lacounty.gov.

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/dhsp/ReportCase.htm (web page)
www.publichealth.lacounty.gov/dhsp/ReportCase/STD_CMV.pdf (form)

Adult HIV/AIDS Case Report Form
For patients over 13 years of age at time of diagnosis
Division of HIV and STD Programs
(213) 351-8196
www.publichealth.lacounty.gov/dhsp/ReportCase.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/dhsp/ReportCase.htm

**Tuberculosis Suspects & Cases
Confidential Morbidity Report**
Tuberculosis Control (213) 745-0800
www.publichealth.lacounty.gov/tb/forms/cmrv.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

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