



Contra Costa Health Plan

COMMUNITY PROVIDER NETWORK MEETING

Please Note: New building and conference room location.

1340 Arnold Drive, Conference Room #112, Martinez

Tuesday, July 24, 2012 7:30 AM to 9:00 AM

Continental Breakfast will be served

- | | | |
|------|---|---|
| I. | Call to order | J. Tysell, MD |
| II. | Approval of Minutes | J. Tysell, MD |
| III. | Autism Screening | Patrick Maher, MD
Developmental Pediatrics |
| IV. | Medical Director's Report <ul style="list-style-type: none">• Immunization Update• Childhood Obesity | J. Tysell, MD
B. Jacobs, RN, FNP
M. Berkery, RN |
| V. | Provider Concerns | J. Tysell, MD |
| VI. | Adjourn | J. Tysell, MD |

Next Meeting – October 23, 2012

Please RSVP–(check one) yes ___ I will attend/no ___

Provider Name: _____

Fax back to: (925) 646-9907 Ph#: 925-313-9500

CONTRA COSTA HEALTH PLAN
 Community Provider Network – Central/East County
Meeting Minutes – July 24, 2012

Attending:

J. Tysell, MD; B. Jacobs, FNP ; M. Berkery, RN; S. Ming, MD; S. Sachdeva, MD; R. Tracy, MD;
 S. Huerta, RN, J. Sequeira, MD; J. Hoffman, MD; J. O’Meany, PA; I. Salceda, PA

Guests: Patrick Maher, MD

Discussion	Action	Accountable
Meeting called to order @ 7:35 am.		J. Tysell, MD
I. Agenda approved with no change.		J. Tysell, MD
II. Approval of Minutes: Minutes approved as read.		J. Tysell, MD
III. Dr. P Maher, MD – Medical Director of Developmental Pediatrics @ RCSC and CCRMC presented an overview on autism and discussion of the CAAD (Clinic for Autism Spectrum Diagnosis and Attention Deficient Disorder) at Contra Costa Regional Medical Center. Focus will be on non Medi-Cal insured while those covered by Medi-Cal will continue to receive diagnosis and interventions thru Regional Center of the East Bay. Discussion followed. Dr. Maher discussed a pending change in classification of autism which will include Asperger’s through comprehensive neuro-developmental diagnoses.		P. Maher, MD
IV. Medical Reports/Updates: <ul style="list-style-type: none"> • Immunization updates • Pediatric Obesity • “Plan to Play” a brochure discussing the benefits of daily outdoor planned activities for children <ul style="list-style-type: none"> - including obesity reduction - water bottles available for children - request from Provider Relations - Brochure included 		J. Tysell, MD B. Jacobs, FNP
VI. Adjourn: Meeting adjourned @ 9:05 am.		J. Tysell, MD

Next meeting – October 23, 2012

CONTRA COSTA HEALTH PLAN
 Community Provider Network – Central/East County
Meeting Minutes – April 24, 2012

Attending:

J. Tysell, MD; M. Berkery, RN; B. Jacobs, FNP ; C. S. Ming, MD; G. Graves, MD; E. Risgalla, MD;
 S. Sachdeva, MD; G. J. Zimmerman, MD; L. Yang, MD; J. Quan, MD; S. Huerta, RN, CPNP; T.
 Mostaghasi, MD

Guests: Patricia Tanquary, CCHP CEO; P. Hackett, RN

Discussion	Action	Accountable
Meeting called to order @ 7:35 am.		J. Tysell, MD
I.	Agenda approved with no change.	J. Tysell, MD
II.	Approval of Minutes: Minutes approved as read.	J. Tysell, MD
III.	<p>Report of current legislation affecting CCHP presented by CEO.</p> <p>SPD Report: CCHP has been receiving this population on monthly allocations since June 2011. 91% of referrals have selected CCHP from a two plan choice. The last group will be received by transfer on May 1st. For those patients who request a continuing relationship with their previous provider, CCHP is developing Letters of Agreements (LOA) with those providers who wish to continue seeing these patients. This LOA is developed and is in effect for one year.</p> <p>Dual Eligible: A plan to transfer all dually eligible Medicare and Medi-Cal eligible SPD and low income persons is in effect in fiscal year 2012-13. A demonstration model for four counties will start in July 2012 with an additional six counties joining in January 2013. Contra Costa is being considered for the January implementation. Continuation of this plan for dual eligible will continue in this demonstration phase during the next six months. A tentative raise in PCP reimbursement to Medicare rates continues to be included in the Federal Budget scheduled for implementation in FY 2012-13. This issue continues to be reviewed through the revision process.</p>	P. Tanquary, CEO
IV.	<p>Medical Director's Report:</p> <ul style="list-style-type: none"> • New RMC Clinic building to be completed in San Pablo near DMC is scheduled to open in Sept 2012. • Referral Dept is increasing to avoid long wait for appointments for both PCP and RMC • Review of Provider's Bulletin 	J. Tysell, MD

What is Autism?**Early Signs****Getting Diagnosed****Treatment****What is ABA?****Coping****Schools****Glossary****Resources****What is Autism?**

Autism is a term used for a number of developmental disabilities called Autism Spectrum Disorders — or ASD. ASD emerges in the first three years of a child's life, and can affect the child's ability to communicate, understand language, and to develop social relationships.

The symptoms of ASD vary, and can range from mild to severe, but all children on the spectrum show difficulties with:

- Social Interaction
- Verbal and nonverbal communication
- Repetitive behaviors or limited interests

Official Diagnoses

Though some people refer to all ASDs simply as "autism," doctors usually diagnose patients with a specific classification from The Diagnostic and Statistical Manual (DSM-IV-TR)

Here are the five subcategories of diagnoses:

- Autistic Disorder
- Asperger's Disorder
- Childhood Disintegrative Disorder (CDD)
- Rett's Disorder
- Pervasive Development Disorder - Not Otherwise Specified (PDD-NOS)

Each subcategory has its own set of criteria, but they all fall under the heading of PDD, or Pervasive Developmental Disorder.

A Child with ASD

No two children with ASD are alike. Some may never develop language, and can have other problems, such as mental retardation or seizure disorder. A child on the mild end of the spectrum may be able to function in a regular classroom and with intervention may overcome many of the challenges associated with the disability to the point where he is no longer identified as having an ASD.

Children on the autism spectrum may avoid eye contact, ignore others, speak little, or lose language or social skills they once had. They may exhibit self-stimulatory behavior for example flapping their hands repetitively or they may focus on one activity with little interest in anything else, for example fixating on the wheels of a toy car for hours.

This year, one out of every 88 babies born in the United States will be diagnosed with autism.* It's more common than pediatric cancer, diabetes and AIDS combined. It occurs in all racial, ethnic, and social groups and is four times more likely to strike boys than girls.

There is no medical test for ASD. A diagnosis is made by observing the presence or absence of specific age-related behaviors and skills. (For instance, does a 3 year-old child communicate using short phrases like "want more juice" or is she uncommunicative? Does she like playing with friends or does she prefer to play alone?) ASD is usually recognizable by the time a child is 3, and can sometimes be detected in a child as young as 12 months. See Early Signs for a full list of possible early indicators of ASD.

Parents are often the first to notice something is "different" about their child and may worry their child is not reaching developmental milestones. Maybe their infant doesn't cry when they leave the room, or is overly anxious around strangers. Some babies seem to develop typically at first, then, around 12 to 36 months, suddenly lose the ability to speak or point, or otherwise show drastic changes in behavior.

It's crucial that parents speak to their pediatrician right away if they suspect developmental delays. The earlier a child is diagnosed with an ASD, the greater the chance that he or she can be helped through treatment.

There is no known single cause for ASD, but significant strides have been made in its understanding and treatment in recent years. Intensive early intervention can significantly reduce the impact of autism, and can dramatically help children to learn, grow, and enjoy happy, fulfilling lives.

* Centers for Disease Control (2012) - for complete report, visit: CDC

[Home](#)[About ACT](#)[About Autism](#)[Collaborative Autism
Diagnostic Clinic](#)[Local Resource Directory](#)[Be Involved](#)[Calendar](#)

Patrick J. Maher, M.D.

Patrick J. Maher, M.D., was born in Portland, Ore. He attended Santa Clara University. His college education was interrupted by a year in Volunteers in Service to America (VISTA) in Roanoke, Va. His initial medical education was at Autonomous University of Guadalajara in Mexico. He then transferred to the University of California Davis Medical School, where he received his Doctor of Medicine (MD) degree. He then did a residency in pediatrics at Martin Luther King Jr. Medical Center in South Central Los Angeles and followed that with a fellowship in neonatology at U.C.S.F. Medical Center at Mt. Zion.

After completing his training, he practiced neonatology at Washoe Medical Center in Reno. Because of his interest in the outcome of premature infants he had been treating, he decided to do a fellowship in developmental pediatrics. Fortunately, he was able to do his developmental pediatric fellowship with Dr. T. Barry Brazleton at Children's Hospital, Boston.

Patrick has been medical consultant at North Bay Regional Center since 1994. At NBRC, he does neurodevelopmental evaluations and consultation and is a member of the multidisciplinary eligibility team. He has been a member of the Advisory Committee for a number of Department of Developmental Services (DDS) projects, including, "Autistic Spectrum Disorders: Best Practice Guidelines for Screening, Diagnosis, and Assessment" and "Autistic Spectrum Disorders: Best Practices in Inter-Organizational Collaboration." He currently is a member of the Oversight Committee for the DDS project: "Autistic Spectrum Disorders: Best Practice Guidelines for Effective Intervention."

Patrick was instrumental in the creation of the Autism Community Team (ACT) in 2002 by obtaining a Learning Collaborative Grant from DDS, which focused on the implementation of the ASD: Best Practice Guidelines for Screening, Diagnosis, and Assessment. The result of that Learning Collaborative was the creation of ACT and the Collaborative Autism Diagnostic (CAD) Clinic, a multi-disciplinary and interagency diagnostic clinic for persons suspected of having an ASD diagnosis. Participants include clinicians from NBRC, the County Office of Education, school districts and private practitioners.

Patrick is the proud father of two daughters, Shona and Alexandra. Shona is 16 and entering her junior year at Bishop O'Dowd High School. Alexandra is 14 and will be entering her freshman year. Patrick is proud to be the chairperson of the health committee at Bishop O'Dowd.

[Return to Members Page](#)

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1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes the need for transparency and accountability in financial reporting.

2. The second part of the document outlines the various methods and techniques used to collect and analyze data. It includes a detailed description of the experimental procedures and the tools used for data collection.

3. The third part of the document presents the results of the study, including a comparison of the different methods and techniques used. It discusses the strengths and weaknesses of each method and provides a summary of the findings.

4. The fourth part of the document discusses the implications of the study and provides recommendations for future research. It highlights the need for further investigation into the effectiveness of the different methods and techniques used.

5. The fifth part of the document provides a conclusion and a summary of the key findings. It reiterates the importance of maintaining accurate records and the need for transparency and accountability in financial reporting.

6. The sixth part of the document provides a list of references and a bibliography. It includes a list of all the sources used in the study and provides a detailed description of each source.

Clinic for ASD & ADHD Diagnostics (CAAD)



Clinic for ASD & ADHD Diagnostics (CAAD)
Contra Costa Regional Medical Center
2500 Alhambra Ave.
Martinez, CA 94553
(925) 370-5394

How to Refer to the CAAD:

Have your child's
Health Care Provider or Therapist
send a referral via fax to 925.370.5277.

For more information please contact
Maria Estrada, LVN by phone at
925.370.5490 or by e-mail at
Maria.Estrada@hsd.cccounty.us

We are located at the
Contra Costa Regional Medical Center
2500 Alhambra Ave.
Martinez, CA 94553

A Comprehensive
Neurodevelopmental
Evaluation Clinic



What is the CAAD?

The Clinic for ASD & ADHD Diagnostics at Contra Costa Regional Medical Center is comprised of a multidisciplinary team, which includes a Medical Director, Developmental Pediatrician, Child Psychiatrist, Pediatric Occupational Therapist, Licensed Clinical Social Worker and a Licensed Vocational Nurse.

Purpose of the CAAD:

The purpose of the Clinic for ASD & ADHD Diagnostics is to conduct comprehensive diagnostic assessments in order to determine the underlying neuro-developmental factors impacting educational and social performance. Recommendations for intervention are provided based on the findings for each individual child.

Who uses CAAD services?

Parents, educators, health professionals or therapists concerned with a child's mental, emotional or academic development.

Their concerns may include:

- Delayed development
- Attention problems
- Hyperactivity problems
- Autistic Spectrum Disorders

Services provided by the CAAD:

The focus of the multidisciplinary CAAD staff is to develop a complete understanding of the strengths and weaknesses of each individual child.

The multidisciplinary team approach includes:

- ❖ Psycho-social assessment
- ❖ Evaluations:
 - Neurodevelopmental for ADHD and/or Autistic Spectrum Disorder
 - Occupational Therapy for Motor & Sensory Issues
- ❖ Case conference
- ❖ Parent conference
- ❖ Medication Management and consultation
- ❖ Consultation for the child health professional
- ❖ ½ hour Neurodevelopmental consult, if warranted as arranged by the Clinic Coordinator

CAAD Medical Team:

Medical Director/Pediatrician:

Gwendolyn Hamilton, MD

Developmental Pediatrician:

Patrick Maher, MD

Child Psychiatrist:

Arnold Gilbert, MD

Pediatric Occupational Therapist:

Catherine Audrey-Quinn, OTR/L

Licensed Clinical Social Worker:

Krista Peterson, LCSW

Clinic Coordinator/

Licensed Vocational Nurse:

Maria Estrada, LVN



TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

June 26, 2012

CHDP Provider Information Notice No.: 12-04

TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP)
PROGRAM PROVIDERS AND MEDI-CAL MANAGED CARE
PLANS

SUBJECT: ADMINISTRATION OF A SINGLE SUPPLEMENTAL DOSE OF
PNEUMOCOCCAL CONJUGATE VACCINE 13 VALENT (PCV13)
FOR CHILDREN WHO HAVE RECEIVED A FULL SERIES OF
PNEUMOCOCCAL CONJUGATE VACCINE 7 VALENT (PCV7)

The purpose of this CHDP Provider Information Notice is to inform you of the recommendation to administer a single supplemental dose of PCV13 (CHDP service code 88) to children who have received a full series of PCV7 (CHDP service code 67).

Pneumococcus pneumonia remains a leading cause of serious bacterial illness in children and adults. After the introduction of PCV7 in 2000, a sharp decrease in invasive pneumococcal disease occurred in disease caused by the 7 serotypes covered by the vaccine. In more recent years, however, an increase was seen in disease caused by serotypes not covered by PCV7. Because of this emergence, PCV13, which includes six additional serotypes not included in PCV7, was introduced.

According to data from an ongoing evaluation of PCV 13 by the Advisory Committee on Immunization Practices (ACIP), 78% (86 out of 110) vaccine-eligible children diagnosed with invasive pneumococcal disease secondary to serotypes unique to PCV13 in the year after the vaccine was introduced had not received the recommended dosage.

The ACIP Recommends:

- A supplemental dose of PCV13 for all children through the age of 59 months who have completed a PCV7 series.
-



TOBY DOUGLAS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

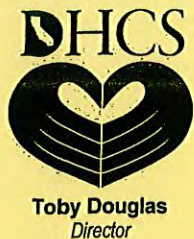
- A supplemental dose of PCV13 for high risk children through the age of 71 months who have completed the PCV7 series. The additional dose may be given through the age of 18.

For more information, see the October 2011 VFC letter on this subject at <http://eziz.org/>

Your continuing participation in the CHDP Program is greatly appreciated. If you have any questions about CHDP vaccine benefits or other CHDP issues, please contact your local CHDP program office.

Sincerely,

Robert Dimand, MD
Chief Medical Officer
Children's Medical Services



State of California—Health and Human Services Agency
Department of Health Care Services



Edmond G. Brown Jr
Governor

June 7, 2012

CHDP Provider Information Notice No.: 12-05

TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM
PROVIDERS AND MEDI-CAL MANAGED CARE PLANS

SUBJECT: REMINDER ABOUT RECOMMENDED BOOSTER DOSE OF
MENINGOCOCCAL CONJUGATE VACCINE (MCV4), CHDP CODE 69

SUMMARY

The purpose of this CHDP Provider Information Notice (PIN) is to inform you of the recommended ages for MCV4 booster dose.

In addition to the recommendation for high-risk children as young as 9 months of age to receive an MCV4 vaccine, adolescents at age 16 years should receive a booster dose.

The Advisory Committee on Immunizations Practices recommends:

- Routine immunization at age at 11-12 years.
- Booster dose recommended at age 16 years for those who received a dose at age 11 through 12 years.
- If vaccinated at age 13 through 15 years, they should receive a one-time booster at age 16 through 18 years.
- Routine vaccination of healthy (non-high risk) persons is not recommended after age 21 years.

For more information, see the November 23, 2011 VFC letter:

Expanded Indications for MCV4 include High-Risk Children at <http://eziz.org/vfc/archived-memo/> and the links to CDC MMWR in that publication.

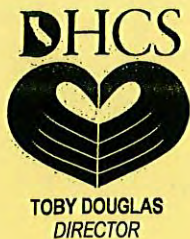
CHDP Provider Information Notice No.: 12-05
Page 2
June 7, 2012

Your continuing participation in the CHDP Program is greatly appreciated. If you have any questions about CHDP vaccine benefits or other CHDP issues, please contact your local CHDP program office.

Original Signed by Robert Dimand, M.D.

Robert Dimand, M.D.
Chief Medical Officer
Children's Medical Services

~~_____~~



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

June 26, 2012

CHDP Provider Information Notice No.: 12-02

TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP)
PROGRAM PROVIDERS AND MEDICAL MANAGED CARE PLANS

SUBJECT: EXPANSION OF CHDP VACCINE BENEFIT FOR QUADRIVALENT
HUMAN PAPILLOMAVIRUS VACCINE (HPV4), CHDP CODE 76 TO
ROUTINE USE IN MALES

The purpose of this Provider Information Notice (PIN) is to inform you that the gender criteria for quadrivalent Human Papillomavirus Vaccine (HPV4), CHDP code 76, has been changed from "routine for females with permissive use in males" to "routine use in females and males".

In 2009, the Advisory Committee on Immunization Practices (ACIP) recommended the use of HPV4 for females to prevent cervical cancer. Stated recommendation in males was 'permissive' in order to prevent transmission to females and to prevent genital warts in females and males. In December 2011, the ACIP recommendation for HPV4 was expanded to routine use females and males. The recommended number and frequency for males is the same as for females, three doses of HPV4 beginning at age 11-12, and as early as age 9. The vaccine is recommended for males between ages 11 – 21. Although the ACIP recommendation is for the vaccine series to be given to males through age 21, at this time the vaccine is only payable through Vaccines For Children, which reimburses vaccines through age 18. Note: the Bivalent Human Papillomavirus Vaccine (HPV2) is for females only.

For more information about this vaccine recommendation, see the memo from the California Department of Public Health, Immunization Branch:
www.eziz.org/assets/docs/vfcletter_2012_01 HPV4.pdf.

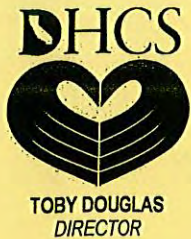
If you have administered HPV4 to a male between 9 and 19 years on or after October 21, 2009 and prior to this notice, you are entitled to reimbursement for the administration of this vaccine. Please submit a PM 160 for the \$9.00 administration fee if you have not been previously reimbursed for the vaccine by any source.

Because there is no change to allowed vaccines, the CHDP Vaccine Benefit and Reimbursement Table is unchanged.

Your continuing participation in the CHDP Program is greatly appreciated. If you have any questions about CHDP vaccine benefits or other CHDP issues, please contact your local CHDP program office.

Sincerely,

Robert Dimand M.D.
Chief Medical Officer
Children's Medical Services



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

June 26, 2012

CHDP Provider Information Notice No.: 12-03

TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP)
PROGRAM PROVIDERS AND MEDICAL MANAGED CARE PLANS

SUBJECT: REVISION OF INJURY HEALTH ASSESSMENT GUIDELINE TO
INCORPORATE ADDITIONAL INFORMATION ABOUT CHILD
BOOSTER SEAT REQUIREMENTS

The purpose of this CHDP Provider Information Notice No. 12-03 is to inform CHDP Providers about updated recommendations and legislation surrounding car seat safety for infants and children. This information adds to, but does not supersede, the Injury section of the CHDP Health Assessment Guide (HAG), Section 56.

Existing California Law SB 929¹ (2011) states: Children under the age of 8 must be secured in a car seat or booster seat. Children under the age of 8 who are 4'9" or taller may be secured by a safety belt in the back seat.

An additional recommendation of the AAP and the NHTSA is that "children should stay in a booster seat until adult seat belts fit correctly, usually when a child reaches about 4'9" in height and is between 8 to 12 years of age." The NHTSA states the following recommendations:

- **Birth – 12 months:** The child under age 1 should always ride in a rear-facing car seat.
- **1 – 3 years:** Keep the child rear-facing as long as possible until he or she reaches the top height or weight allowed by your car seat's manufacturer. Once the child has outgrown the rear-facing car seat, switch to a forward-facing car seat with a harness.

¹ SB 929, Author: Evans. Chaptered October 4, 2011. Prohibits a person from operating a motor vehicle on a highway unless that person and all passengers 16 years of age or older are properly restrained by a safety belt. This bill would define the phrase "properly restrained by a safety belt."

- **4 – 7 years:** Keep the child forward-facing as long as possible until he or she reaches the top height or weight allowed by your car seat's manufacturer. Once the child has outgrown the forward-facing 5 point harness car seat, switch to a booster seat, but have the child remain in the back seat.
- **8 – 12 years:** Keep the child in the booster seat until he or she is big enough to fit in a seat belt properly. The seat belt must lie snugly across the upper thighs, not the stomach. The shoulder belt should lie snug across the shoulder and chest and not across the neck or face.

Car Seat Safety:

It is recommended that the adult driver consider the above criteria and recommendations in determining whether the child over 8 years of age is ready to transition from a booster seat to a standard lap and shoulder belt.

Additional recent recommendations from NHTSA include:

- Always read child seat manufacturers' instructions and the vehicle owner's manual for important information on height and weight limits and how to install the car seat using the seat belt or the LATCH system.
- All children under 13 should ride in the back seat.
- Children in rear-facing car seats should never ride in front of an active passenger air bag.

The revised section and tables may be downloaded from the following link:

<http://www.dhcs.ca.gov/services/chdp/Pages/Pub156.aspx>

Your continuing participation in the CHDP Program is greatly appreciated. If you have any questions about other CHDP HAG issues, please contact your local CHDP program office.

Sincerely,

Robert Dimand, MD,
Chief Medical Officer
Children's Medical Services



IMPORTANT MESSAGE

California Department of Public Health
Immunization Branch
Vaccines for Children (VFC) Program
850 Marina Bay Parkway
Richmond, CA 94804

Toll Free Phone:
877-2GET-VFC (877-243-8832)

Toll Free Fax:
877-FAXX-VFC (877-329-9832)

June 18, 2012

Vaccine Supply Update

Dear VFC Provider,

Please refer to the following items related to VFC supplied vaccines.

VACCINE SUPPLY

- **Hiberix®**, GSK's Hib product, is no-longer available. Alternative products: Sanofi's ActHIB®, Merck's COMVAX®.
- **Pentacel®**, Sanofi's DTaP/IPV-Hib combination Vaccine, continues to be in **limited supply** until early Fall 2012. Alternative Products: Single components (DTaP, Hib, and IPV) are available from Sanofi and GSK. **Important:** Doses should not be deferred or delayed due to Pentacel®'s unavailability; adequate supply of single components is currently available.
- **Tripedia®**, one of the two DTaP products from Sanofi, is no longer available. Alternative products from Sanofi: Daptacel®.
- **Td:** Sanofi Td is currently unavailable. Alternative product: Merck Td.
- **Influenza Vaccine:** VFC has closed influenza vaccine ordering in preparation to the 2012/2013 Influenza Season. Flu Order Confirmation for this coming season will be available from June 18th to July 18th, 2012, for confirming flu orders.

MMR VACCINE RECALL-PRIVATE DOSES ONLY

- This week, Merck initiated a voluntary recall of one lot of MMR (Lot 0851AA) distributed to private customers ONLY. No doses of this lot have been distributed through the VFC Program.
- Though the lot was not released according to the company's lot release procedure, according to a comprehensive internal investigation there are no associated product safety, quality or efficacy issues with the lot. Therefore, no action is necessary if the lot has been administered.

! Important correction regarding Pentacel's vaccine supply included in the Supply Update sent 6/15/2012: Pentacel is available; however, supplies continue to be limited.

Would you like to receive VFC communications via e-mail?
Visit our website at www.eziz.org and register to receive electronic updates.





RON CHAPMAN, MD, MPH
Director

State of California—Health and Human Services Agency
California Department of Public Health



EDMUND G. BROWN JR.
Governor

April 26, 2012

TO: Vaccines for Children (VFC) Providers

FROM: John Talarico, D.O., M.P.H., Chief *Talarico, D.O.*
Center for Infectious Diseases
Division of Communicable Disease Control, Immunization Branch

SUBJECT: Temporary Decrease in Pentacel[®] Vaccine Supply

Background

Sanofi Pasteur has notified the Centers for Disease Control and Prevention (CDC) about a manufacturing delay for its Pentacel[®] (DTaP-IPV/Hib combination) and DAPTACEL[®] (DTaP) vaccines. This has led to an immediate decrease in the doses available to customers nationwide. Until this delay is resolved, estimated to be in early fall 2012, Sanofi Pasteur is limiting orders for Pentacel[®]. Effective April 23, 2012, CDC has reduced Pentacel[®] vaccine allocations for each state's Vaccine for Children (VFC) Program to approximately 2/3 of the prior monthly distribution.

As CDC has adequate supplies of DAPTACEL[®] at the VFC program's vaccine distribution center, no allocations or limitations for VFC orders of DAPTACEL[®] are in place at this time. (However, see the linked [letter from Sanofi Pasteur regarding additional limits on DAPTACEL[®] on orders for children ineligible for the VFC Program.](#))

Impact of Pentacel[®] Supply Limits on Routine Immunization and VFC Orders

The impact of this shortage is likely to be minimal on the routine childhood immunization schedule. VFC Program supplies for individual DTaP, IPV and Hib vaccines, available from all manufacturers, are sufficient to meet provider demand through the summer months. Doses for your patients should NOT be deferred or delayed.

In order to keep within the state's monthly allocation, the California VFC Program is reducing all requests for Pentacel[®] to a limited monthly supply (approximately 60-70% of average usage). These reductions are based on a practice's order frequency, historical vaccine usage and the State's allocation. To compensate for this reduction, ordering limits for individual DTaP, IPV, and Hib vaccines have been increased.

VFC Orders

The following ordering guidelines will be in place for all VFC providers until adequate supplies of Pentacel® are available:

- Effective April 26, 2012, all Pentacel® requests must be submitted monthly to the California VFC Program. For providers on a bi-monthly or quarterly order frequency, these Pentacel® orders will be considered as supplemental orders. Orders for all other VFC vaccines should be submitted at their normal frequency.
- All Pentacel® orders will be limited to approximately 60-70% of historical average usage. Therefore we suggest looking at your practice's monthly usage, and applying this reduction to determine Pentacel® doses to order. Orders for individual DTaP, IPV, and Hib vaccines should be increased to compensate for the reduction in Pentacel®.
- During this period the California VFC Programs recommends reserving Pentacel® for the first three doses, and substituting individual vaccines for the fourth doses of DTaP and Hib:
 - DTaP: DAPTACEL® (Sanofi Pasteur), Infanrix® (GlaxoSmithKline)
 - Hib: ActHIB® (Sanofi Pasteur), PedvaxHIB® (Merck), Hiberix® (GlaxoSmithKline). Note: Hiberix® is temporarily unavailable. However, when it does become available, keep in mind that this product is only licensed for the Hib booster dose at age 12-15 months.
 - IPV: (IPOL® (Sanofi Pasteur)) is also available as needed.

Sample Schedule Using Individual Vaccines for the 4th Doses of DTaP, Hib:

Age	Vaccines
Birth	Hep B
2 months	Pentacel®, RV, PCV13, Hep B
4 months	Pentacel®, RV, PCV13
6 months	Pentacel®, RV, PCV13, Hep B
6 months and older	Influenza
12-15 months	MMR, Varicella, Hib, PCV13
15-18 months	DTaP, Hep A

- Providers should review the specific age indications and recommended dosing schedule for all vaccines. For example, the two-dose PedvaxHIB® primary series schedule differs from the three-dose schedule for ActHIB®. Once the clinic determines which schedule and vaccines will be used to accommodate the Pentacel® shortage, ALL staff should be informed and educated on the new vaccines and schedule.

If you have any questions about this communication, please contact your VFC Representative or VFC Customer Service at 1-877-243-8832.



Morbidity and Mortality Weekly Report (MMWR)

Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis (Tdap) Vaccine in Adults Aged 65 Years and Older — Advisory Committee on Immunization Practices (ACIP), 2012

Weekly

June 29, 2012 / 61(25);468-470

Since 2005, the Advisory Committee on Immunization Practices (ACIP) has recommended a tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine booster dose for all adolescents aged 11 through 18 years (preferred at 11 through 12 years) and for those adults aged 19 through 64 years who have not yet received a dose (1,2). In October 2010, despite the lack of an approved Tdap vaccine for adults aged 65 years and older, ACIP recommended that unvaccinated adults aged 65 years and older be vaccinated with Tdap if in close contact with an infant, and that other adults aged 65 years and older may receive Tdap (3). In July 2011, the Food and Drug Administration (FDA) approved expanding the age indication for Boostrix (GlaxoSmithKline Biologicals, Rixensart, Belgium) to aged 65 years and older (4). In February 2012, ACIP recommended Tdap for all adults aged 65 years and older. This recommendation supersedes previous Tdap recommendations regarding adults aged 65 years and older.

The Pertussis Vaccines Work Group of ACIP reviewed the epidemiology of pertussis in adults aged 65 years and older and two cost-effectiveness models to assess the epidemiologic and economic impact of pertussis vaccination in this population. The Work Group also considered safety and immunogenicity data from clinical trials and observational studies on the use of Tdap in adults aged 65 years and older (3).

The two Tdap vaccines available in the United States, Boostrix and Adacel (Sanofi Pasteur, Toronto, Canada), differ in composition and approved age for use (Table). Only Boostrix is approved for adults aged 65 years and older; however, ACIP discussed the use of Adacel in this age group. On February 22, 2012, ACIP approved use of Tdap for all adults aged 65 years and older. This report summarizes data considered and conclusions made by ACIP and provides guidance for implementing the recommendation.

The Pertussis Vaccines Work Group of ACIP reviewed the epidemiology of pertussis in adults aged 65 years and older and two cost-effectiveness models to assess the epidemiologic and economic impact of pertussis vaccination in this population. The Work Group also considered safety and immunogenicity data from clinical trials and observational studies on the use of Tdap in adults aged 65 years and older (3). The Work Group then presented policy options for consideration to the full ACIP.

Epidemiology of Pertussis in Older Adults

Because pertussis is underdiagnosed and underreported substantially in all age groups, the actual burden of disease in adults aged 65 years and older is unknown (5). During 2000–2010, an annual average of 318 pertussis cases (range: 71–719 cases) in adults aged 65 years and older were reported each year through the National Notifiable Diseases Surveillance System (CDC, unpublished data, 2011). Challenges to diagnosing and reporting pertussis in all adults include 1) underrecognition of pertussis as a cause for cough illness, 2) atypical presentation of symptoms in adults, and 3) a low index of suspicion among providers (6,7). Few studies are focused on the burden of pertussis in adults aged 65 years and older. Among reported prospective studies, the calculated pertussis incidence ranged from 66 to 500 cases per 100,000 persons per year (8–11). Reported pertussis incidence ranges from one to five cases per 100,000 in adults of similar age ranges (CDC, unpublished data, 2011); this 70-fold to 100-fold difference suggests that actual pertussis incidence in older adults is much higher than reported (CDC, unpublished data, 2011). ACIP supported the conclusion that the actual burden of pertussis in adults aged 65 years and older likely is at least 100 times greater than that reported.

Cost Effectiveness Analysis

ACIP reviewed two unpublished cost-effectiveness models, developed independently by GlaxoSmithKline and CDC (12,13). Both models were developed to assess the epidemiologic and economic impact of Tdap vaccination in adults aged 65 years and older and demonstrated that a dose of Tdap for older adults resulted in a moderate decrease in the number of cases and outcomes (e.g., outpatient visits, hospitalizations, and deaths), which might represent a cost-effective intervention. Model results were most sensitive to incidence of pertussis; however, sensitivity analyses showed that even with a range of underreporting of incidence, Tdap vaccination might be cost-effective in this population. Reassured by the concordance between the two cost-effectiveness models, ACIP's interpretations were that the cost per case averted and cost per quality-adjusted life-year saved were modest, and pertussis incidence estimates accounting for underreporting were reasonable based on limited data and expert opinion.

Tdap Products in the United States

Safety and immunogenicity data of Tdap administered to adults aged 65 years and older were reviewed by ACIP in October 2010 and in February 2012 (3). Published and unpublished data from clinical trials of Boostrix (N = 1,104) and Adacel (N = 1,170) on the safety and immunogenicity of Tdap in adults aged 65 years and older who received vaccine were provided by GlaxoSmithKline and Sanofi Pasteur.

Safety. For both Tdap products, the frequency and severity of adverse events in persons aged 65 years and older were comparable to those among persons aged less than 65 years. No increase in local or generalized reactions in Tdap recipients was observed, compared with persons who received Td. No serious adverse events were considered related to vaccination (3). Postmarketing data from the Vaccine Adverse Event Reporting System (VAERS) suggest that the safety profile of Tdap vaccine in adults aged 65 years and older was comparable to that of Td vaccine (14).

Boostrix immunogenicity. For diphtheria and tetanus, immune responses to Boostrix were noninferior to the immune responses elicited by a comparator Td vaccine (15). Immune responses to pertussis antigens (i.e., pertussis toxin [PT], filamentous hemagglutinin [FHA], and pertactin [PRN]) were noninferior to those observed following a 3-dose primary DTaP

series with Infanrix (GlaxoSmithKline), according to predefined criteria discussed with and agreed to by FDA before study initiation (16). Boostrix contains the same three pertussis antigens as Infanrix, but in reduced quantities. The geometric mean concentrations for antibodies to PT, FHA, and PRN after Boostrix administration increased 7.4-fold to 13.7-fold over baseline levels (15).

Adacel immunogenicity. Antibody responses to diphtheria and tetanus toxoids in Adacel were noninferior to a comparator Td vaccine. Because a limited quantity of sera remained from infant efficacy trials, immune responses to three of the four pertussis antigens (FHA, PRN, and fimbriae [FIM]) in Adacel were bridged to a 3-dose DTaP (Daptacel [Sanofi Pasteur]) series, and PT was bridged to a 4-dose series. Immune responses were observed to all Adacel pertussis antigens but some did not meet predefined noninferiority criteria as agreed upon by FDA and Sanofi Pasteur (16); however, a 4.4-fold to 15.1-fold increase in anti-pertussis antibodies, depending on the antigen, was observed. Multiple other countries, including Canada, Australia, and European Union members have approved Adacel for use in persons aged 65 years and older. ACIP concluded that Adacel likely would provide protection in adults aged 65 years and older.

Guidance for Use

Tdap use in adults. ACIP recommends that all adults aged 19 years and older who have not yet received a dose of Tdap should receive a single dose. Tdap should be administered regardless of interval since last tetanus or diphtheria toxoid-containing vaccine. After receipt of Tdap, persons should continue to receive Td for routine booster immunization against tetanus and diphtheria, according to previously published guidelines (1,2). Currently, Tdap is recommended only for a single dose across all age groups. ACIP will begin discussions on the need for additional doses of Tdap and timing of revaccination of persons who have received Tdap previously.

Tdap products in adults aged 65 years and older. Providers should not miss an opportunity to vaccinate persons aged 65 years and older with Tdap. Therefore, providers may administer the Tdap vaccine they have available. When feasible, Boostrix should be used for adults aged 65 years and older; however, ACIP concluded that either vaccine administered to a person 65 years or older is immunogenic and would provide protection. A dose of either vaccine may be considered valid.

Tetanus prophylaxis in wound management for adults. As part of standard wound management care to prevent tetanus, a tetanus toxoid-containing vaccine might be recommended for wound management in adults aged 19 years and older if 5 years or more have elapsed since last receiving Td. If a tetanus booster is indicated, Tdap is preferred over Td for wound management in adults aged 19 years and older who have not received Tdap previously.

diphtheria toxoid, and acellular pertussis (Tdap) vaccines, by trade name — United States, 2012

Trade name	Manufacturer	FDA-approved age for use* (yrs)	Pertussis antigens (μg)				Diphtheria toxoid (Lf)	Tetanus toxoid (Lf)
			PT	FHA	PRN	FIM		
Boostrix	GlaxoSmithKline Biologicals	10 and older	8	8	2.5	—	2.5	5
Adacel	Sanofi Pasteur	11 through 64	2.5	5	3	5 [†]	2	5

Abbreviations: FDA = Food and Drug Administration; PT = pertussis toxin; FHA = filamentous hemagglutinin; PRN = pertactin; FIM = fimbriae; Lf = limit of flocculation units.

* Indicated as a single dose.

[†] Types 2 and 3.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

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****Questions or messages regarding errors in formatting should be addressed to mmwrq@cdc.gov.**

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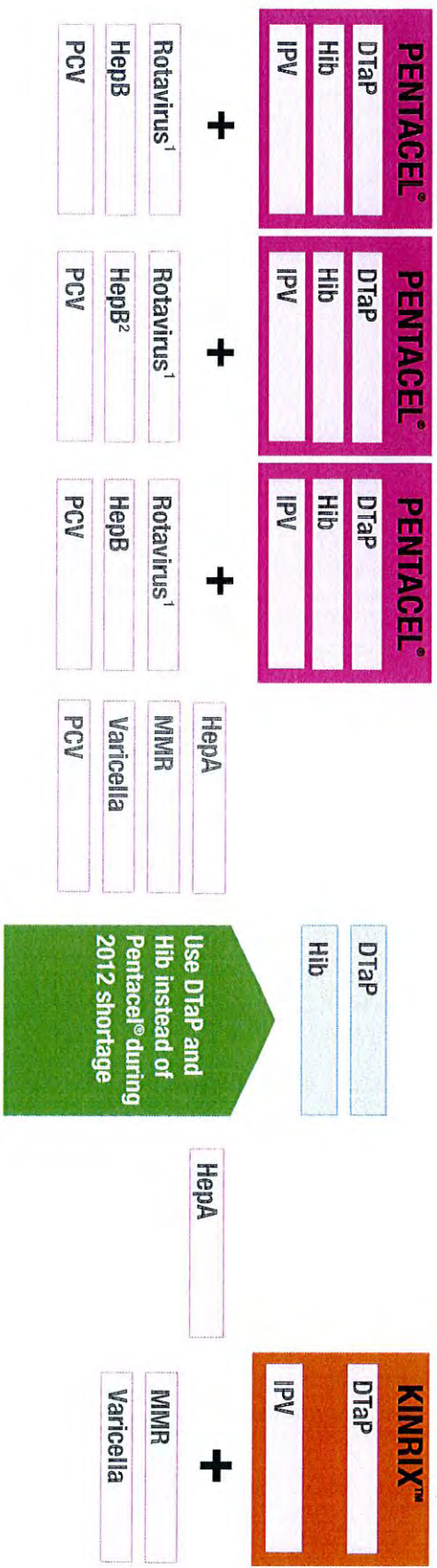
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Immunization Schedule During 2012 Pentacel® Shortage

- 2 MONTHS
- 4 MONTHS
- 6 MONTHS
- 12 MONTHS
- 15 MONTHS
- 18 MONTHS
- 4-6 YEARS



EVERY FALL: FLU VACCINE³ Children age 6 months through 18 years

This is a suggested schedule using Pentacel® during the 2012 shortage. For more info, visit www.eziz.org.

1 The rotavirus vaccines differ in number of doses and timing. Check the package insert.
 2 A dose of Hepatitis B vaccine is not necessary at 4 months if doses are given at birth and 2 months.
 3 Influenza vaccine is available in thimerosal-free options. See California Health and Safety Code § 124172.



Encouraging Physical Activity in Children



Diane Dooley MD
July 10, 2012

Benefits of Physical Activity



- Improved motor skill development
- Improved bone health
- Decreased risk for obesity, cardiovascular disease
- Socialization
- Mental health benefits
- Improved learning

Guidelines for Physical Activity

Children and Adolescents
Physically active at least 60 minutes
daily



Infants

Should interact with
parents in daily
activities dedicated
to promoting
exploration

Toddlers

60 minutes daily
play + structured
Physical activity

Who gets enough physical activity?

Facts to consider

- Boys are more active than girls
- Only 42% of children aged 6-11 obtain recommended 60 minutes PA per day
- Physical activity declines with age
- 7.6% of teens 16-19 met standards
- No relationship to obesity, TV watching in young children
- Kids with asthma less active



Determining Physical Activity Levels in the Provider Visit

How many minutes a day does your child spend outside?

- What does your child like to do?
- How often does she get outside?
- Where does she like to play?
- Is your child attending a child care or preschool program?
- Do you have a park or a place nearby to play?
- Does she have a bike or a scooter?
- Does she like to do any sports or after school activities?
- Does she walk to or from school?



Barriers to Active Play

Access to programs, facilities

- Access to open spaces, parks and play spaces correlates with levels of physical activity
- Programming, staffing and outreach most important determinants of park use
- Other considerations: safety, availability of toilets and water, lighting, playground space and equipment

A significant association exists between race, ethnicity, socioeconomic status and access to physical activity settings



Encouraging Active Play

- Influences on amount of play
 - Gender and ethnicity
 - Indoor rules for household
 - Outdoor rules
 - Convenience of play spaces
 - Time and frequency in play spaces
 - Prompts by siblings and parents



Child Care and Preschool programs

- Preschools should have fun play areas, active toys, nature exposure, scheduled active play times
- More than ½ of all 3-6 year olds are enrolled in center-based child care
- Space, programs and outdoor time at child care centers and preschools very predictive of physical activity levels
- If a TV is present, it will be watched



Finding Quality Programs

Child Care and Preschool programs

Questions to ask about Child Care/ Preschools:

- Amount of teacher-led and child-initiated play per day
- Presence of TV in classroom
- Staff training re: physical activity
- Presence of a written policy regarding play
- Availability of large, open outdoor spaces, play equipment and portable equipment (balls, jump ropes, etc.)



Nutrition And Physical Activity Self Assessment For Child Care

Schools and Afterschool programs

**Value of PE
depends upon
level of activity**



- California Ed Code requires:
 - Elementary: 200 minutes of physical education every ten school days
 - Grades 7-12: 400 minutes of physical education every ten school days

Where do kids play?

Schools and Afterschool programs

- Many school yards closed off hours
- NPLAN: Increased joint use agreements
- After School Education and Safety program/21st Century programs exist at most low income schools



Stages of Change



- **Precontemplation** - Not thinking about change
May be resigned, believes consequences are not serious
- **Contemplation** - Weighing benefits and costs of behavior
- **Preparation** - Experimenting with small changes
- **Action** - Taking a definitive action to change
- **Maintenance** - Maintaining new behavior over time

Information



IDEAS

Resources

Make referrals, educate, offer
community resources

- Contra Costa Child Care Council– www.cocokids.org
- Headstart, State Preschool, First 5 Centers – 211ContraCosta.org
- Chealth.org
- Kaboom.org
- NEW Kids, Healthy and Active Families



Playing Outside is Important

Children need to have at least 60 minutes of active play time daily. Playing outside gives kids more room to run around, have fun, and be children.

Ask your school or daycare about play. Do they:

- ❖ Take kids for walks, go to parks or on nature hikes?
- ❖ Have fun play areas and active toys?
- ❖ Have scheduled active play times and limited TV and screen time?

Questions Parents Have

- ❖ Why should I take my child to play outside?
Outdoor play is more active than playing inside. It burns more calories and lowers the chance of your child being overweight or getting diabetes.
- ❖ Will my child get hurt playing outside?
Kids need a chance to run, climb, and jump. Sometimes they may fall, but playing in safe places should help avoid serious injury.

Resources for Play

- ❖ ContraCostaHealthPlan.org. Find more fun ideas and healthy play.
- ❖ HealthyandActiveBefore5.org. Play resources for young children.
- ❖ Kaboom.org. Find your local playgrounds.



GET YOUR KIDS OUTSIDE EVERY DAY!

**Thirty minutes
Twice a day**



Why Outdoor Play is Good For Your Family

Playing outside gives families more time together, having fun! It also helps keep everyone healthy.

Outdoor play helps kids:

- ❖ Learn better in school
- ❖ Learn new skills and use their imagination
- ❖ Build healthy bones and develop good exercise habits for life
- ❖ Sleep better and reduce their stress
- ❖ Learn how to play with other kids
- ❖ Stay at a healthy weight and avoid future diabetes and obesity



Making Time to Play

- ❖ Schedule time for kids to play the same way you schedule lunch and dinner.
- ❖ Set limits on watching TV. Plan to do a fun activity outside instead.
- ❖ Kids will want to play outside when parents make the time to play with them.
- ❖ Parents can be busy people. Try and take turns with other adults to take the children out to play.



Cost

- ❖ Walking, playing tag, or taking kids to a park are all free of cost.
- ❖ Toys such as a Frisbee, jump rope, chalk, boxes, and beach balls don't cost much and can be shared.



Safety

- ❖ Find a park that has good lights, a bathroom, and room to run and play away from cars.
- ❖ Make sure there is an adult with young children at all times. Take turns with other parents or go as a group.
- ❖ Kids should wear tennis shoes year round for outside play.
- ❖ Bring water to drink. No soda or sweetened drinks!



Weather

- ❖ When it is cold, kids should wear a jacket and a hat.
- ❖ For rainy days, move furniture around to make a safe space for children to play inside.
- ❖ Remember, kids do not get sick from playing outside in the cold.
- ❖ Don't forget sunscreen!