



Agenda

Quarterly Community Provider Network (CPN) Meeting

Contra Costa Health Plan – Community Plan

When: Time: 7:30 – 9:00 AM
Date: **January 15, 2013**

Where: West County Health Center, 13601 San Pablo Ave., Conference Room #A,
San Pablo

The agenda for the meeting is as follows:

I.	CALL TO ORDER and INTRODUCTIONS	J. Tysell, MD
II.	REVIEW and APPROVAL of MINUTES from previous meeting	J. Tysell, MD
III.	REGULAR REPORTS	
	<ul style="list-style-type: none"> • Medical Directors Report • HEDIS Final Report • Immunization Update <ul style="list-style-type: none"> ○ Norovirus Outbreak 	J. Tysell, MD M. Berkery, RN
IV.	NEW BUSINESS	
	<ul style="list-style-type: none"> • Public Health Clinical Re-organization <ul style="list-style-type: none"> ○ School Based Clinics • Provider Concerns • West County Health Center <ul style="list-style-type: none"> ○ Brief Orientation Visit/Tour 	S. Nairn, PHN J. Tysell, MD M. Berkery, RN
V.	ADJOURNMENT	

Unless otherwise indicated below, Contra Costa Health Plan – Community Plan hereby adopts all issues, findings, or resolutions discussed in the Agenda for Contra Costa Health Plan, dated January 15, 2013, and attached herein.

Our next scheduled meeting is:

Tuesday, April 16, 2013
7:30 – 9:00 AM

CPN Quarterly Meeting

CONFIDENTIAL – Protected by California Evidence Code 1157

CONTRA COSTA HEALTH PLAN
 West County
 Quarterly Community Provider Network (CPN)
Meeting Minutes – January 15, 2013

Attending:

CCHP Staff: J. Tysell, M.D., Chair; M. Berkery, RN; J. Galindo, RN, PHN; L.M. Perez, Secretary

CPN Providers: G. Aguilar, PA; N. Banks, MD; A. Barocio, PA; K. Ceci, MD; O. Eaglin, PA; R. Harrison, RN, NP; K. Kaminski, PA; P. Mack, MD; T. Smith, MD; A. Wallach, MD

Guests: S. Nairn, PHN

Discussion	Action	Accountable
Meeting called to order @ 7:30 am.		J. Tysell, MD
I. Agenda approved with no revisions.		J. Tysell, MD
II. Review and Approval of Minutes from October 16, 2012: Minutes were approved as presented.		J. Tysell, MD
III. Medical Director Report: <ul style="list-style-type: none"> • CCHP's website can be accessed at: www.contracostahealthplan.org <ul style="list-style-type: none"> ◦ Updated monthly • Announced: P. Mack, MD has joined CCHP's JCC (Joint Conference Committee). This group meets quarterly and includes 2 county supervisors. • Discussion re: Affordable Care Act <ul style="list-style-type: none"> ◦ Medicare reimbursement rates are still pending. Adjustment not anticipated until the State adjusts capitation to the Plans. Rates will include medical specialists; excludes OB/GYN and surgical disciplines. • CPN Providers concern re: claims payments. Reported improvements have been made. Claims submitted through December will be paid by February. Payment delay has been caused by implementation of new electronic accounting system. • Discussed web portal. Portal is still not ready for medical information. • Discussed CCHP Healthy Families children transition into Medi-Cal in March 2013. • State requires two quality improvement projects (QIPs). The following two projects were discussed: Reducing readmissions and OB care (Timeliness of Prenatal Care and Postpartum Care) • Pain Management policy currently under review and revision. • HEDIS Final Report – Item deferred. • Immunization Update – the following information was distributed: <ul style="list-style-type: none"> ◦ California Department of Public Health (CDPH) <ul style="list-style-type: none"> • Combined Measles, Mumps, Rubella and Varicella (MMRV) Vaccine is Again Available from the California VFC Program (dated: 11/19/12) • New online resource for reporting vaccine administration errors – http://verp.ismp.org/ (dated: 		J. Tysell, MD

Our website can be accessed at: cchealth.org

Go to **Health Plan** on the left side column.

When you get to Health Plan, go to **For Providers** on the left column.

The formulary is on the left side column under **For Providers**, called **Preferred Drug List**.

The Specialist search engine is called **Provider Directory**.

Our entire **Provider Manual** can be found at this site, as well as **Provider Bulletins**, **Clinical Guidelines**, and information about our **Community Provider Network Meetings**.

Also under **For Providers**, you can find:

- SPD Training materials
- Clinical Guidelines for Adults
- CPN meeting minutes and handouts
- FSR Tools



RON CHAPMAN, MD, MPH
Director & State Health Officer

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



EDMUND G. BROWN JR.
Governor

TO: Vaccine for Children (VFC) Providers IZB-FY-1213-09

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

DATE: October 2, 2012 *J. Talarico, D.O.*

SUBJECT: Further Large Decrease in Pentacel[®] Vaccine Allocations Beginning
October 2012

Pentacel[®] Vaccine Allocation Update

The California Vaccines for Children (VFC) Program has just been notified that its monthly allocation for Sanofi Pasteur's Pentacel[®] will decrease to 20% of its current allocation beginning in October 2012. This decreased allocation is expected to continue through at least March 2013.

Impact of Shortage

VFC continues to have adequate supplies of individual DTaP (including DAPTACEL[®]), IPV, and Hib vaccines to meet provider demand. GlaxoSmithKline's Pediarix[®] (DTaP-Hep B-IPV) is also an option for providers. Providers should review potential vaccine schedule options for their offices to provide the recommended immunizations; providers should NOT defer or delay immunizing patients at the recommended ages.

Providers switching to Pediarix[®] should use up remaining supplies of Pentacel[®] and order more doses of Hib vaccine and fewer doses of hepatitis b vaccine to compensate for the switch. Practices may wish to refer to the [Centers for Disease Control and Prevention's \(CDC\) sample schedules](#) for switching to Pediarix[®].

Providers continuing to use Pentacel[®] and individual DTaP, IPV, and Hib vaccines: The California VFC Program recommends using Pentacel[®] for the first dose and individual DTaP, IPV, and Hib vaccines for additional doses. Practices may wish to refer to the [CDC's sample schedules](#) for completing the series with individual vaccines. The California VFC Program will continue to monitor allocations of Pentacel[®] and will increase dose allocations as supplies allow.

When implementing a new schedule in your practice, please review minimum intervals and licensed age ranges carefully. All staff should be thoroughly informed and

educated on any changes to vaccines and schedules prior to implementation to avoid errors in administration.

VFC Orders

The California VFC Program will limit Pentacel[®] orders to approximately 20% of their recent monthly allocation beginning October 2012. Providers ordering Pentacel[®] should continue to submit monthly Pentacel[®] requests and order adequate doses of other vaccines to compensate for the reduction in Pentacel[®].

We appreciate your flexibility, understanding, and your continued efforts to immunize our young children against serious vaccine preventable diseases. The California VFC Program will continue to inform providers about Pentacel[®] supply. If you have any questions about this communication, please contact your VFC Representative or VFC Customer Service at 1-877-243-8832.

cc: CDPH Immunization Branch Field Representatives
Local Health Officers
Local Health Department Immunization Coordinators
Local Health Department CHDP Program Directors
Tanya Homman, Acting Chief, Medi-Cal Managed Care Division, DHCS
Susan McClair, M.D., Medi-Cal Managed Care, DHCS
Shabbir Ahmad, D.V.M., M.S., Ph.D., Acting Chief, Maternal, Child and Adolescent Health Program, CDPH
Laurie Weaver, Chief, Office of Family Planning, CDPH
Shelley Rouillard, Deputy Director, Benefits and Quality Monitoring Division, MRMIB
Emmee Nguyen, Benefits and Quality Monitoring, MRMIB
Jill Young, Benefits and Quality Monitoring, MRMIB
Sherie Smalley, M.D., Chief, Medical Policy Section, Medi-Cal Benefits, Waiver Analysis and Rates Division, DHCS
Steve Shih, M.D. Medical Policy Section, Medi-Cal Benefits, Waiver Analysis and Rates Division, DHCS
Alan Morita, Pharm.D. Medi-Cal Pharmacy Policy Branch, DHCS
Robert Dimand, M.D., Chief, Children Medical Services Branch, DHCS
Jill Abramson, M.D., M.P.H., Children Medical Services Branch, DHCS



RON CHAPMAN, MD, MPH
Director & State Health Officer

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



EDMUND G. BROWN JR.
Governor

TO: Vaccine for Children (VFC) Providers IZB-FY-1213-10

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

DATE: November 19, 2012

SUBJECT: Combined Measles, Mumps, Rubella and Varicella (MMRV) Vaccine is
Again Available from the California VFC Program

BACKGROUND

The combined measles, mumps, rubella, and varicella (MMRV) vaccine is now again available for ordering through the California Vaccines for Children (VFC) Program. Due to manufacturing constraints limiting the availability of this vaccine, MMRV had not been available for ordering by the California VFC Program since May 2007.

RECOMMENDATIONS FOR USE

VFC-Eligible Groups

Children aged 12 months through 12 years are eligible to receive MMRV vaccine.

Recommended Schedule

The routinely recommended ages for measles, mumps, rubella and varicella vaccination continue to be age 12–15 months for the first dose and age 4–6 years for the second dose. The minimum interval between measles, mumps and rubella vaccine doses is 4 weeks. The minimum interval between varicella doses is 3 months for children younger than 13 years (and 4 weeks for persons 13 years and older).

Due to an increased risk of febrile seizures, the federal Advisory Committee on Immunization Practices (ACIP) and the Centers for Disease Control and Prevention (CDC) updated its [recommendations for MMRV in 2010](#).

For the first dose of the series given at age 12–47 months, CDC recommends that MMR vaccine and varicella vaccine be administered as separate vaccines, unless the parent or caregiver expresses a preference for the quadrivalent MMRV vaccine. Providers considering administration of MMRV vaccine as a first dose should discuss the benefits and risks of both vaccination options with the parents or caregivers.

Considerations should include provider assessment, patient preference, and the potential for adverse events.

For the second dose of measles, mumps, rubella, and varicella vaccines at any age and for the first dose at age 48 months and older, use of MMRV vaccine generally is preferred over separate injections of MMR vaccine and varicella vaccine.

Use of MMRV and Febrile Seizures

Compared with children who had received separate simultaneous doses of MMR vaccine and varicella vaccine:

- For children age 12-23 months receiving their first dose of MMRV, one additional febrile seizure occurred per 2,300-2,600 children (0.04%) 5-12 days after vaccination.
- For children age 4-6 years receiving their first dose of MMRV, the risk of febrile seizures was not increased.

Febrile seizures are common in young children. By age 5 years, approximately one in every 25 children (4%) will have had a febrile seizure. The peak age is 14-18 months and approximately 97% occur in children <4 years. Young children who have febrile seizures generally have an excellent prognosis; however, febrile seizures are distressing to parents and may result in a visit to an emergency department. Children who have a febrile seizure after MMR vaccination are no more likely to have future epilepsy or neurodevelopment disorders than children who have febrile seizures for other reasons. For additional information on MMRV vaccine and febrile seizures, please see <http://www.cdc.gov/mmwr/pdf/rr/rr5903.pdf>.

Precautions and Contraindication to MMRV Vaccine Use

A personal or family (i.e., sibling or parent) history of seizures of any etiology is a precaution for MMRV vaccination. For additional details on all contraindications and precautions for MMRV vaccine, please see the ACIP recommendations at: <http://www.cdc.gov/mmwr/pdf/rr/rr5903.pdf>.

Administration

MMRV is administered by the subcutaneous route. MMRV vaccine may be administered simultaneously with other recommended vaccines. MMRV should not be administered within 28 days before or after another injectable or nasally administered live-virus vaccine. A minimum interval of 3 months is recommended between a dose of MMRV and a varicella-containing vaccine.

Storage and Handling

The vaccine is supplied as a package of 10 single-dose vials of lyophilized vaccine and a separate package of 10 vials of sterile water diluent.

Before reconstitution, MMRV vaccine must be stored frozen at a temperature between -58°F and +5°F (-50°C to -15°C). Do not store on dry ice. Adequacy of the freezer

should be checked before obtaining or storing MMRV vaccine. The diluent should be stored separately at room temperature (68-77°F, 20-25°C) or in the refrigerator (36-46°F, 2-8°C).

MMRV should be reconstituted with the packaged diluent only. Once reconstituted, the vaccine should be used immediately to minimize loss of potency and should be discarded if not used within 30 minutes. Protect the vaccine from light at all times since such exposure may inactivate the vaccine viruses.

MMRV doses are shipped directly by Merck in new shipping packaging, similar to varicella vaccine shipment packaging, utilizing gel packs instead of dry-ice. Use of dry ice for storing, or transporting varicella containing vaccines, including MMRV and Varicella vaccines is no longer allowed. Use of dry ice may expose vaccines to temperatures below -58°F (-50°C). Routine transport or relocation of MMRV is not recommended.

ORDERING

MMRV vaccine is available for ordering through MyVFCVaccines. You may find it in the "Vaccines stored in the freezer" section. Prior to placing a vaccine request for MMRV, practices should carefully review ACIP recommendations for use of this vaccine and decide how it will be incorporated into the practice's routine immunization schedule.

Orders for MMRV should be placed according to 1) the estimated number of children to be vaccinated in the practice, and 2) MMR and Varicella vaccine doses currently in inventory. Providers may need to reduce current MMR and Varicella inventories prior to ordering MMRV. Additionally, as doses of MMRV are requested, doses for MMR and Varicella requested should be reduced accordingly.

BILLING

CHDP: The CHDP administration fee is \$9.00 using CHDP code 74 for MMRV vaccine supplied by VFC and administered to children 12 months through 12 years of age enrolled in the CHDP Program.

Medi-Cal: The administration fee for the Measles, Mumps, Rubella and Varicella (MMRV) vaccine provided by VFC is billed with CPT-4 code 90710 and modifier -SL for VFC-eligible children who receive a first or second dose of MMR and varicella vaccine. For details, see: http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/vaccine_m00o03o04o11.doc.

SELECTING PRODUCTS FOR YOUR PRACTICE

The decision on whether to use MMR and varicella vaccines separately or as a combination MMRV vaccine should be carefully considered by each practice. When considering use of MMRV vaccine for the first dose of measles, mumps, rubella, and varicella vaccines for children ages 12 through 47 months, the benefits

and risks should be thoroughly discussed with the parent or guardian. Because practices may stock MMR, varicella, and MMRV vaccines, thorough education of all staff and clear labeling of vaccines will be important to avoid administration errors. Communication between providers ordering specific vaccines and staff administering vaccines will be important to avoid administration errors.

QUESTIONS?

For additional information, contact your local VFC Representative or the VFC customer service line at (877) 243-8832.

RESOURCES

2010 ACIP Recommendations for MMRV: <http://www.cdc.gov/mmwr/pdf/rr/rr5903.pdf>

VFC Resolution No. 06/09-3:

<http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/0609-mmr.pdf>.

MMRV Vaccine Information Statement:

<http://www.cdc.gov/vaccines/pubs/vis/default.htm>.

FDA Information:

<http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM123796.pdf>.

Combined MMRV Vaccine VFC Letter dated February 28, 2006:

<http://www.cdph.ca.gov/programs/immunize/Documents/MMRV%20Letter.pdf>.

cc: CDPH Immunization Branch Field Representatives
Local Health Officers
Local Health Department Immunization Coordinators
Local Health Department CHDP Program Directors
Tanya Homman, Acting Chief, Medi-Cal Managed Care Division, DHCS
Susan McClair, M.D., Medi-Cal Managed Care, DHCS
Shabbir Ahmad, D.V.M., M.S., Ph.D., Acting Chief, Maternal, Child and Adolescent Health Program, CDPH
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New online resource for reporting vaccine administration errors - <http://verp.ismp.org/>

October 3, 2012

Dear Healthcare Provider:

Vaccine administration errors (see box below) are common and can potentially reduce vaccine efficacy and safety. However, unless such errors are quantified it is difficult to advocate for vaccine name or labeling changes or other changes that might reduce the possibility of errors. To better understand and prevent such errors, we strongly encourage you to report all vaccine administration errors to <http://verp.ismp.org/>, a new online system sponsored by the Institute for Safe Medication Practices (ISMP). This system allows for a confidential method of reporting vaccine administration errors so that they can be tracked and analyzed.

ISMP is a nonprofit, federally-certified patient safety organization (PSO) respected worldwide as the premier resource for medication safety information. ISMP guarantees confidentiality of all information received. ISMP will securely share error data with the federal Vaccine Adverse Event Reporting System (VAERS) and, when applicable, with the vaccine manufacturer. When reporting an error, providing your name is optional.

The new system is designed to register errors regardless of whether any harm may have resulted. Please continue to report any adverse events that occur after immunization, whether given correctly or incorrectly, to VAERS at <http://vaers.hhs.gov/esub/index>.

Your participation can help to reduce future errors. Thanks for your consideration.

Sincerely,

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



TO: Immunization Provider or Grantee

RE: FluMist® 2012-2013 Replacement Program

This letter is to inform you of the FluMist® Replacement Program for product purchased through the CDC contract for 2012-2013 ("Replacement Program"). The Replacement Program allows for the replacement of unused, expiring FluMist doses, at no cost, to help you maximize product usage opportunities. MedImmune has contracted with McKesson Specialty Health Distribution for implementation of this Replacement Program. **This contract is between MedImmune and McKesson, and is separate from and unrelated to the CDC's contract for centralized product distribution.** The Replacement Program requirements are listed below:

- FluMist doses must be purchased through the CDC contract and must expire between August 2012 and January 31, 2013 to be eligible for the Replacement Program.
- Product must be used on a first-to-expire/first-used basis to be eligible for the Replacement Program.
- Providers or Grantees have from 15 days prior to the expiration date stamped on the sprayer until January 31, 2013 to request replacement doses. Any doses sent prior to 15 days of expiry will not be replaced.
- Requests for replacement doses by Providers or Grantees will be accepted until 7:00 PM (CT) on January 31, 2013. Requests for replacement doses after this date will not be honored. All requests should be placed with McKesson Specialty Health by calling 1-877-633-7375.
- All expired/expiring doses must be received by McKesson by Friday, February 15, 2013. Replacement product will not be shipped until expired/expiring doses are received.
- Replacement Request Rounding:
 - All requests for replacement doses must be in multiples of 10 units of product. It is permissible to mix doses from multiple eligible expired Lots to achieve a minimum of 10 units. Requests not in multiples of 10 will be rounded down to the nearest multiple of 10. Rounding up is prohibited.
 - There will be no credit for doses returned in excess of those shipped for replacement.

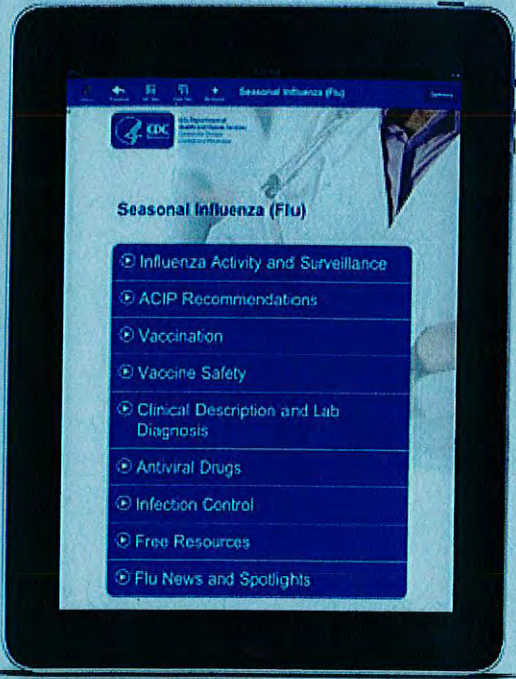
The process to request replacement product is outlined below:

- 1) Call McKesson Specialty Health's MedImmune FluMist CDC Replacement Request line at 1-877-633-7375. Call center operating hours are 7:00 am CT – 7:00 pm CT, Monday through Friday.
- 2) McKesson Specialty Health will instruct Providers or Grantees on date and time of pickup and provide all necessary instructions and return shipping labels at the time of call. Providers or Grantees are to pack FluMist and have it ready for the scheduled pick-up day. FluMist does not have to be returned cold.
- 3) Providers or Grantees are to place only the doses confirmed on the phone with McKesson Specialty Health in the box for return. NOTE: Any doses included that were not confirmed during the original replacement request call will not be replaced.
- 4) Within 1 business day from receipt of request and verification of information, McKesson Specialty Health's preferred courier partner will pick up the boxed FluMist from the specified location at no charge to the Provider.
- 5) Upon receipt and verification of the expired/expiring doses with the replacement request information provided to McKesson Specialty Health's Call Center, replacement doses will be shipped at no charge to you.

If you have any questions regarding the Replacement Program, please call 1-877-633-7375. **Live response to inbound calls on the Replacement Hotline will begin on November 19, 2012.**



CDC Influenza Application for Clinicians and Health Care Professionals



The CDC Influenza application for clinicians and other health care professionals makes it easier than ever to find CDC's latest recommendations and influenza activity updates on your iPad, iPhone or iPod Touch. (Android support will be added in a future update). When your mobile device is connected to the internet, new information and content will update automatically. This is an official application of the Centers for Disease Control and Prevention.

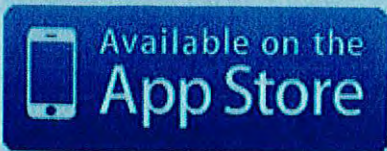
With this application, you can:

- View updated information on national flu activity
- Find influenza vaccination recommendations endorsed by CDC and the Advisory Committee on Immunization Practices (ACIP)
- Obtain information on diagnosis and treatment of influenza, including antiviral treatment recommendations by CDC and the ACIP
- Obtain information on laboratory testing for influenza
- Find CDC recommendations on influenza infection control
- View videos of CDC subject matter experts discussing influenza topics
- Order official CDC designed print products for posting in the workplace or distributing to patients.

For more information please visit [Information For Health Professionals \(/flu/professionals/index.htm\)](http://www.cdc.gov/flu/professionals/index.htm).

For questions and comments, [contact CDC-INFO \(http://www.cdc.gov/cdc-info/requestform.html\)](http://www.cdc.gov/cdc-info/requestform.html).

You can personalize your experience with features like highlighting, notes, and bookmarks to suit your own needs. Share the content with others through social media such as Facebook and Twitter.



<https://itunes.apple.com/us/app/cdc-influenza-flu/id577782055>

<http://www.cdc.gov/Other/disclaimer.html>

Download it free from the App Store today (<https://itunes.apple.com/us/app/cdc-influenza-flu/id577782055>)

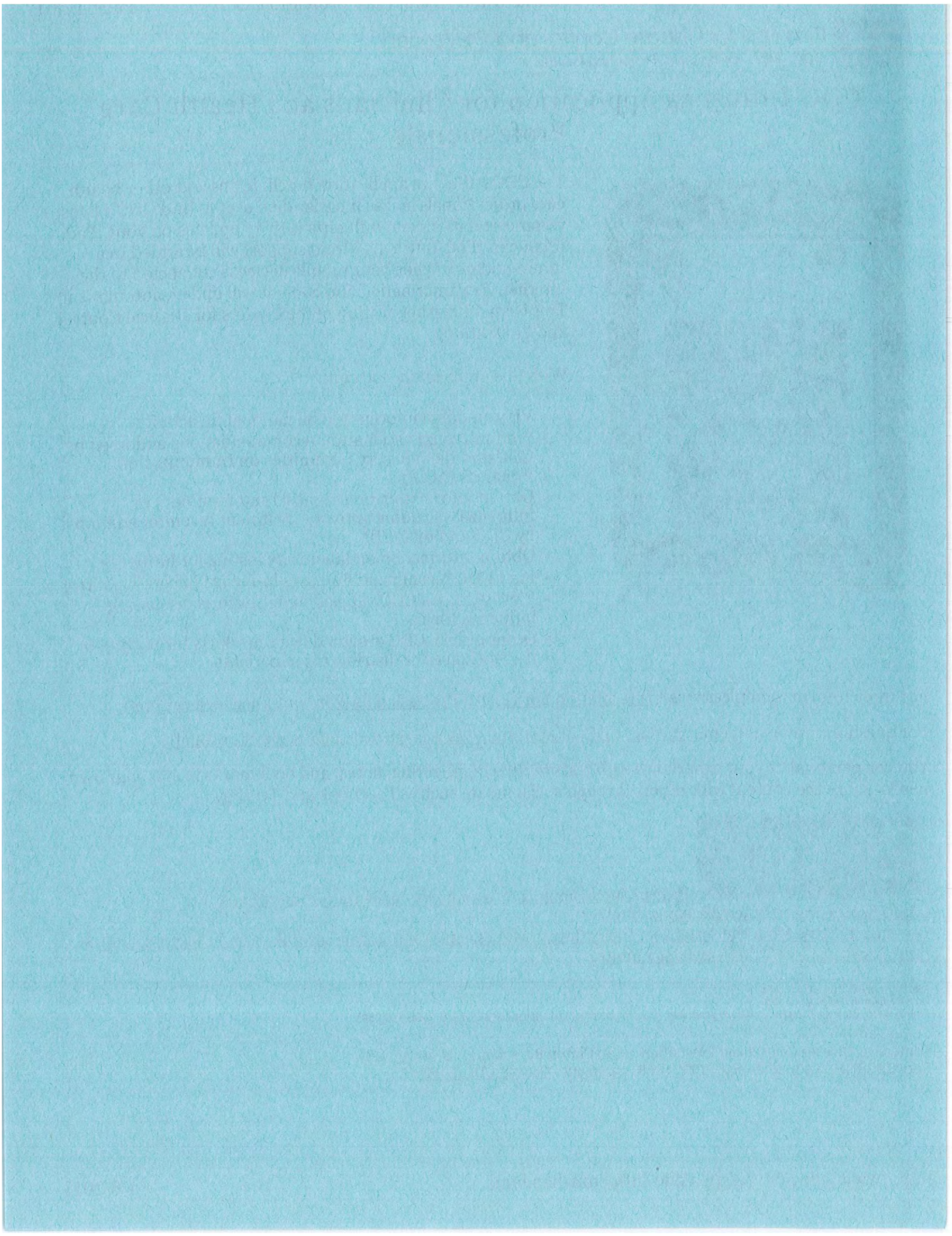
<http://www.cdc.gov/Other/disclaimer.html>.

Page last reviewed: December 14, 2012

Page last updated: December 14, 2012

Content source: Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases (NCIRD)

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348 - [Contact CDC-INFO](http://www.cdc.gov/Other/disclaimer.html)





PROTECT Their Health for the Years Ahead

Preteen Vaccine Week | February 10-16, 2013

Immunize your Preteen Today!

Join us by celebrating Preteen Vaccine Week

February 10-16, 2013!

The goal of 2013's Preteen Vaccine Week campaign is raise awareness about California's Tdap requirement for incoming 7th grade students, immunization recommendations for 11-and 12-year-olds, and promote the preteen doctor visit through multiple avenues such as schools, providers, and the media.

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








- **Tdap (tetanus, diphtheria, whooping cough)**
All students entering 7th grade will need proof of a Tdap booster shot before starting school.
- **HPV (human papillomavirus)**
Boys and girls need 3 shots for full protection.
- **Meningococcal**
Preteens need one shot now and a booster at age 16.
- **Influenza (flu)**
Flu vaccine is needed every year!
- **Chickenpox**
Many kids didn't get their second chickenpox shot. Check with the doctor.

2013 Preteen Campaign Kit

- [Introduction](#)
- [PVW action plan](#)
- [Talking points in Spanish and English](#)
Use these talking points to generate newsletter articles, press releases, and other communications.
- [Suggested activities](#)
- [Template matte article](#)
- [Template matte article for physician newsletter](#)
- [Template press release](#)
- [Template social media messages](#)
Developed in partnership with San Diego County.
- [Template e-newsletter article for schools](#)
- [Template Order Form](#)
- [Comfort Tips for Preteens](#)
- [Resources](#)
- [Educational activities](#)
Conduct these activities schools, health fairs, and youth group gatherings!

Preteen Educational Materials

- [Bilingual HPV fotonovela for moms of preteens](#)
An animated booklet in Spanish and English about cervical cancer and the HPV vaccine.

- [Parent Immunization Flyer](#)  ... [en Español](#) 
Parent flyer that discusses all recommended adolescent immunizations and features a section for questions.
- [Parent Flyer from Schools](#) ... [en Español](#) 
Flyers can be sent to students' homes to encourage parents to get their children vaccinated against whooping cough and meet the new school requirement.
- [Preteen Doctor Visit Brochure](#) ... [en Español](#) 
A color brochure aimed at preteens. You can order copies of this brochure from your [local health department](#).
- [Preteen Doctor Visit Poster](#) ... [en Español](#) 
A colorful poster for schools, school health centers, doctor's offices and other venues.
- [Preteen Doctor Visit Postcard \(4-up for laser or ink jet printing\)](#) 
A color postcard to remind families of preteens to schedule a check-up for their 11-and 12-year-olds.
- [Preteen Vaccine Week 2013 "Protect Their Health for the Years Ahead" banner](#) 
- [One Shot Heroes](#)
A short film for preteens on the importance of immunizations.

Public Service Announcements

- [Vaccine Rap Targeting Preteens](#) ([60s](#)) (MP3) ([30s](#)) (MP3) [Rap Lyrics](#) (Word Document)
- [Radio PSA Targeting English-speaking Parents of Preteens](#) ([30s](#)) (MP3) ([15s](#)) (MP3)
- [Radio PSA Targeting Spanish-speaking Parents of Preteens](#) ([30s](#)) (MP3)
- [Podcasts, Television Public Service Announcements & CDC-TV Videos](#) (CDC)
Tune in, subscribe or download CDC podcasts and videos about the vaccines for preteens and teens. Broadcast quality versions available in English or Spanish.

Other Resources

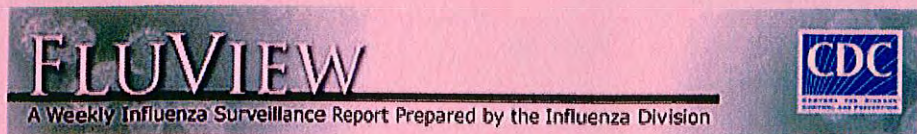
- [Healthcare Professional Resources](#) (CDC)
Materials and resources to help doctors, nurses and other health care professionals address the questions patients or parents might have about adolescent vaccines.
- [Matte Articles](#) (CDC)
Ready-to-use news articles that can be reprinted in publications, organizational newsletters, Websites, or other communication vehicles.
- [Print Materials](#) (CDC)
Flyers, fact sheets and posters developed in multiple languages and created to reach underserved communities.
- [Web Buttons, Banners, E-Cards, and Widgets](#) (CDC)
Share and distribute visual and online products to help spread important health-related information online.
- [Tweens, Teens and Vaccines: Can't Live With Them, Can't Live Without Them?](#) (Webinar, 58 minutes, Available from VIC Network)
This Webinar features data and information about the vaccination status of our nation's teens and tweens and discusses upcoming campaigns to promote vaccination of this sometimes hard to reach population and their parents.
- [CDC & Medscape training: Adolescent Immunizations: A Practice-based Approach, 2010](#) (Webcast, 26 minutes)
Strategies for improving adolescent immunization rates.
- [Video clips of VPDs and immunization issues](#) (IAC)
- [GIVE IT A SHOT Toolkit](#) (3MB, PDF, New Window)
For nurses and other immunization champions working with secondary schools. Includes more than 40 easy-to-use and resources are described and available on a convenient CD available from the [American School Health Association](#)
- [GetVaxed Videos](#) (CDC)
Quick facts and edgy videos targeting teens and young adults.
- [References and Publications](#)
Peer-reviewed journal articles and MMWR publications related to each of the adolescent vaccines and improving adolescent vaccination rates.

Past Preteen Vaccine Week Campaigns

- [2012](#)
- [2011](#)



Seasonal Influenza (Flu)



2012-2013 Influenza Season Week 52 ending December 29, 2012

All data are preliminary and may change as more reports are received.

Synopsis:

During week 52 (December 23-29), influenza activity increased in the U.S.

- **Viral Surveillance:** Of 9,363 specimens tested and reported by U.S. World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) collaborating laboratories, 2,961 (31.6%) were positive for influenza.
- **Pneumonia and Influenza Mortality:** The proportion of deaths attributed to pneumonia and influenza (P&I) was below the epidemic threshold.
- **Influenza-Associated Pediatric Deaths:** Two influenza-associated pediatric deaths were reported and were associated with influenza B viruses.
- **Outpatient Illness Surveillance:** The proportion of outpatient visits for influenza-like illness (ILI) was 5.6%; above the national baseline of 2.2%. Nine of 10 regions reported ILI above region-specific baseline levels. New York City and 29 states experienced high ILI activity; 9 states experienced moderate ILI activity; 4 states experienced low ILI activity; 6 states experienced minimal ILI activity, and the District of Columbia and 2 states had insufficient data.
- **Geographic Spread of Influenza:** Forty-one states reported widespread geographic influenza activity; 7 states reported regional activity; the District of Columbia reported local activity; 1 state reported sporadic activity; Guam reported no influenza activity, and Puerto Rico, the U.S. Virgin Islands, and 1 state did not report.

A description of surveillance methods is available at: <http://www.cdc.gov/flu/weekly/overview.htm>

National and Regional Summary of Select Surveillance Components

Data for current week

Data cumulative since September 30, 2012 (Week 40)

HHS Surveillance Regions*	Out-patient ILI†	% positive for flu‡	Number of jurisdictions reporting regional or widespread activity§	2009 H1N1	A (H3)	A (Subtyping not performed)	B	Pediatric Deaths
Nation	Elevated	31.6%	48 of 54	194	10,612	5,621	5,621	18
Region 1	Elevated	45.3%	6 of 6	18	850	204	59	1
Region 2	Elevated	36.6%	2 of 4	21	722	683	161	3
Region 3	Elevated	43.3%	4 of 6	37	1,688	105	171	0
Region 4	Elevated	28.3%	8 of 8	20	1,410	3,368	1,058	4
Region 5	Elevated	58.4%	6 of 6	29	1,985	174	417	5
Region 6	Elevated	24.7%	5 of 5	7	599	529	971	4
Region 7	Elevated	33.9%	4 of 4	2	868	173	422	0
Region 8	Elevated	30.3%	6 of 6	25	940	297	1,174	0
Region 9	Normal	22.9%	3 of 5	32	599	58	137	0
Region 10	Elevated	31.5%	4 of 4	3	951	30	138	1

*HHS regions (Region 1 CT, ME, MA, NH, RI, VT; Region 2: NJ, NY, Puerto Rico, US Virgin Islands; Region 3: DE, DC, MD, PA, VA, WV; Region 4: AL, FL, GA, KY, MS, NC, SC, TN; Region 5: IL, IN, MI, MN, OH, WI; Region 6: AR, LA, NM, OK, TX; Region 7: IA, KS, MO, NE; Region 8: CO, MT, ND, SD, UT, WY; Region 9: AZ, CA, Guam, HI, NV; and Region 10: AK, ID, OR, WA).

† Elevated means the % of visits for ILI is at or above the national or region-specific baseline

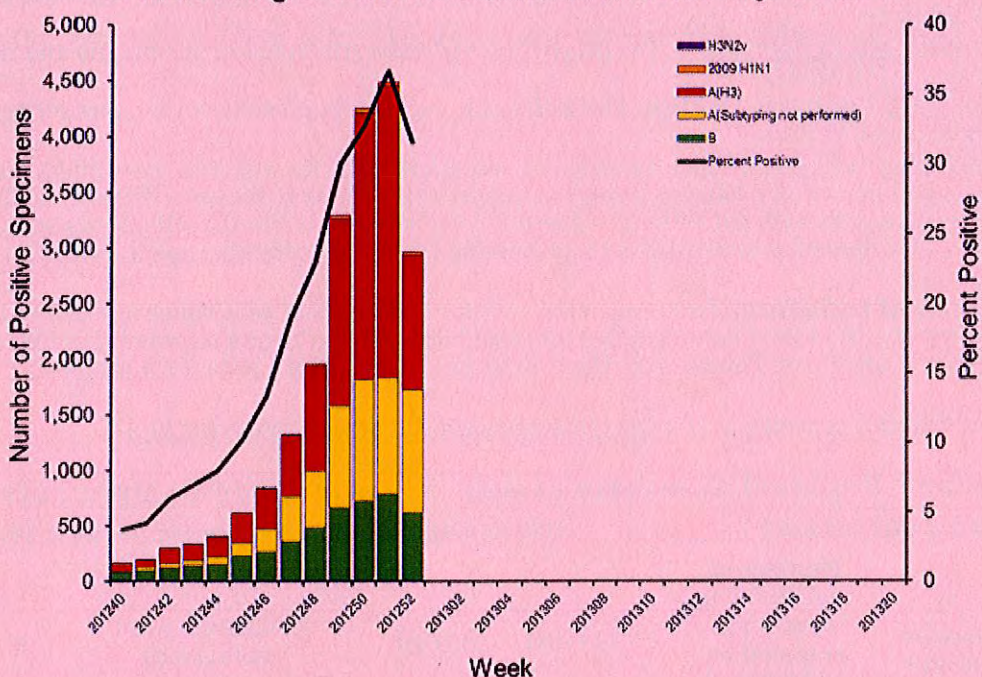
‡ National data are for current week; regional data are for the most recent three weeks


U.S. Virologic Surveillance:

WHO and NREVSS collaborating laboratories located in all 50 states and Puerto Rico report to CDC the number of respiratory specimens tested for influenza and the number positive by influenza virus type and influenza A virus subtype. Region specific data can be found at <http://gis.cdc.gov/grasp/fluview/fluportaldashboard.html>.

	Week 52
No. of specimens tested	9,363
No. of positive specimens (%)	2,961 (31.6%)
Positive specimens by type/subtype	
Influenza A	2,346 (79.2%)
2009 H1N1	25 (1.1%)
Subtyping not performed	1,112 (47.4%)
H3	1,209 (51.5%)
Influenza B	615 (20.8%)

Influenza Positive Tests Reported to CDC by U.S. WHO/NREVSS Collaborating Laboratories, National Summary, 2012-13



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Since the start of the season, influenza A (H3N2) viruses have predominated nationally, followed by influenza B viruses, while 2009 H1N1 viruses have been identified rarely. The predominant circulating virus has varied by state and by region.

Antigenic Characterization:

CDC has antigenically characterized 413 influenza viruses [17 2009 H1N1 viruses, 281 influenza A (H3N2) viruses, and 115 influenza B viruses] collected by U.S. laboratories since October 1, 2012.

2009 H1N1 [17]:

- All 17 2009 H1N1 viruses tested were characterized as A/California/7/2009-like, the influenza A (H1N1) component of the 2012-2013 influenza vaccine for the Northern Hemisphere.

Influenza A (H3N2) [281]:

<http://www.cdc.gov/flu/weekly/>

- 279 (99.3%) of the 281 H3N2 influenza viruses tested have been characterized as A/Victoria/361/2011-like, the influenza A (H3N2) component of the 2012-2013 Northern Hemisphere influenza vaccine.
- 2 (0.7%) of the 281 H3N2 viruses tested showed reduced titers with antiserum produced against A/Victoria/361/2011.

Influenza B (B/Yamagata/16/88 and B/Victoria/02/87 lineages) [115]:

- **Yamagata Lineage [79]:** 79 (68.7%) of the 115 influenza B viruses tested so far this season have been characterized as B/Wisconsin/1/2010-like, the influenza B component of the 2012-2013 Northern Hemisphere influenza vaccine.
- **Victoria Lineage [36]:** 36 (31.3%) of 115 influenza B viruses tested have been from the B/Victoria lineage of viruses.

Antiviral Resistance:

Testing of 2009 H1N1, influenza A (H3N2), and influenza B virus isolates for resistance to neuraminidase inhibitors (oseltamivir and zanamivir) is performed at CDC using a functional assay. Additional 2009 influenza A (H1N1) clinical samples are tested for a single mutation in the neuraminidase of the virus known to confer oseltamivir resistance (H275Y). The data summarized below combine the results of both testing methods. These samples are routinely obtained for surveillance purposes rather than for diagnostic testing of patients suspected to be infected with antiviral-resistant virus.

High levels of resistance to the adamantanes (amantadine and rimantadine) persist among 2009 influenza A (H1N1) and A (H3N2) viruses (the adamantanes are not effective against influenza B viruses). As a result, data from adamantane resistance testing are not presented below.

Neuraminidase Inhibitor Resistance Testing Results on Samples Collected Since October 1, 2012

	Oseltamivir		Zanamivir	
	Virus Samples tested (n)	Resistant Viruses, Number (%)	Virus Samples tested (n)	Resistant Viruses, Number (%)
Influenza A (H3N2)	526	0 (0.0)	526	0 (0.0)
Influenza B	226	0 (0.0)	226	0 (0.0)
2009 H1N1	39	0 (0.0)	30	0 (0.0)

The majority of currently circulating influenza viruses are susceptible to the neuraminidase inhibitor antiviral medications oseltamivir and zanamivir; however, rare sporadic cases of oseltamivir-resistant 2009 H1N1 and A (H3N2) viruses have been detected worldwide. Antiviral treatment with oseltamivir or zanamivir is recommended as early as possible for patients with confirmed or suspected influenza who have severe, complicated, or progressive illness; who require hospitalization; or who are at greater risk for serious influenza-related complications. Additional information on recommendations for treatment and chemoprophylaxis of influenza virus infection with antiviral agents is available at <http://www.cdc.gov/flu/antivirals/index.htm>.

Novel Influenza A Virus:

No new human infections with novel influenza A viruses were reported to CDC during week 52.

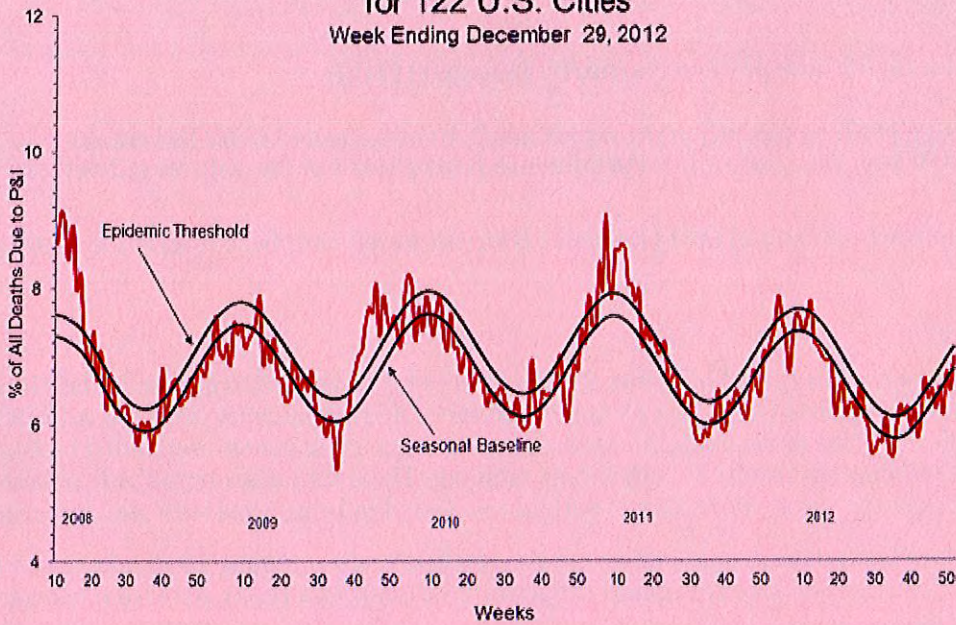
A total of 312 infections with variant influenza viruses (308 H3N2v viruses, 3 H1N2v viruses, and 1 H1N1v virus) have been reported from 11 states since July 2012. More information about H3N2v infections can be found at <http://www.cdc.gov/flu/swineflu/h3n2v-cases.htm>.

Pneumonia and Influenza (P&I) Mortality Surveillance:

During week 52, 7.0% of all deaths reported through the 122 Cities Mortality Reporting System were due to P&I. This percentage was below the epidemic threshold of 7.1% for week 52.

Pneumonia and Influenza Mortality for 122 U.S. Cities

Week Ending December 29, 2012

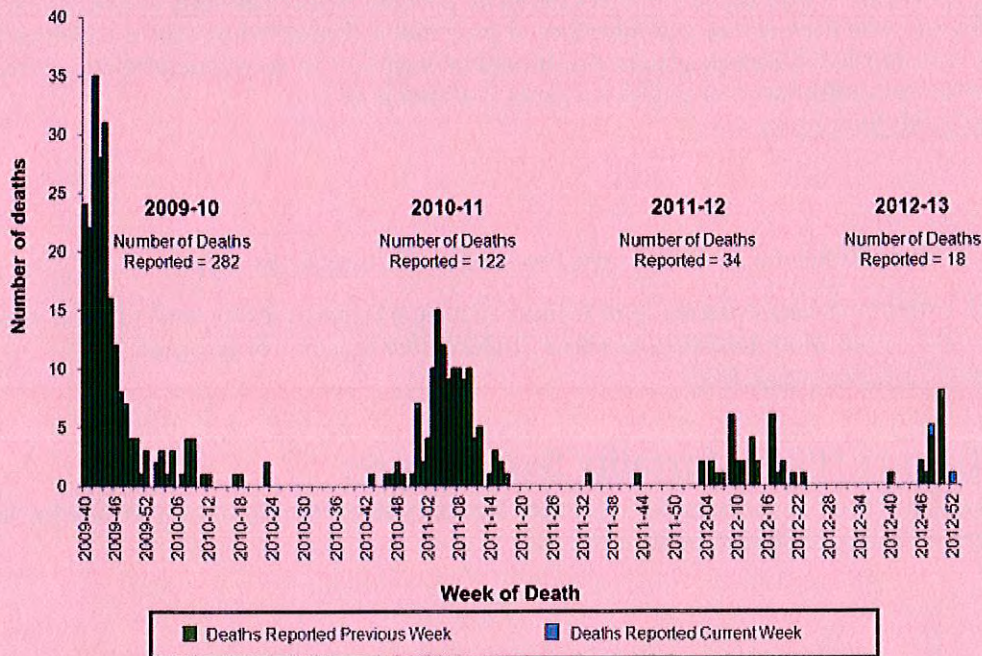


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Influenza-Associated Pediatric Mortality:

Two influenza-associated pediatric deaths were reported to CDC during week 52 and were associated with influenza B viruses. One death occurred during week 48 (week ending December 1) and one death occurred during week 52 (week ending December 29). This brings the total number of influenza-associated pediatric deaths reported during the 2012-2013 season to 18. Additional data can be found at <http://gis.cdc.gov/GRASP/Fluview/PedFluDeath.html>.

Number of Influenza-Associated Pediatric Deaths by Week of Death: 2009-10 season to present



Influenza-Associated Hospitalizations:

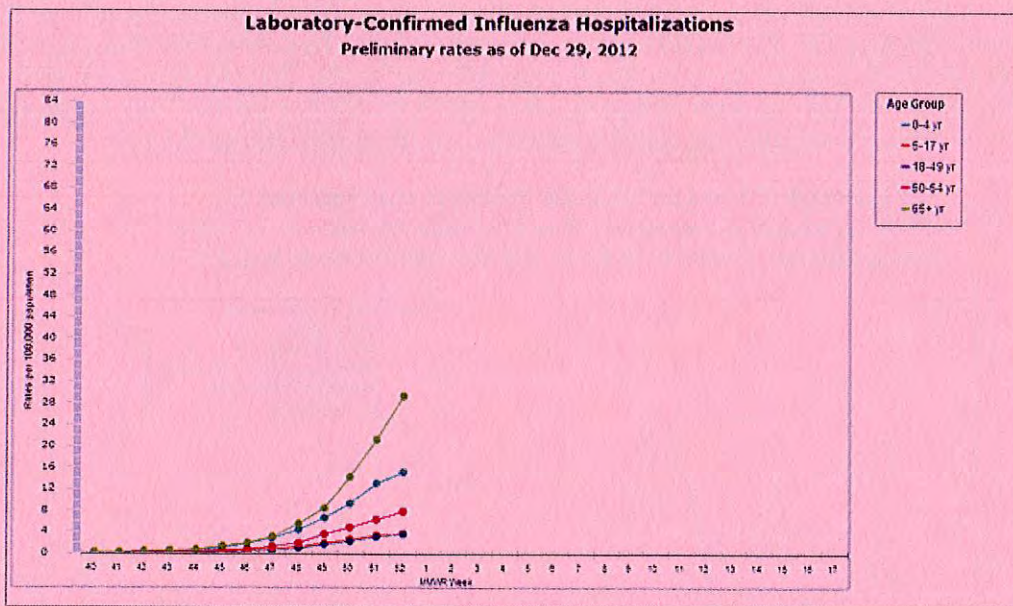
The Influenza Hospitalization Surveillance Network (FluSurv-NET) conducts population-based surveillance for laboratory-confirmed influenza-related hospitalizations in children younger than 18 years of age (since the 2003-2004 influenza season) and adults (since the 2005-2006 influenza season).

The FluSurv-NET covers more than 80 counties in the 10 Emerging Infections Program (EIP) states (CA, CO, CT, GA, MD, MN, NM, NY, OR, TN) and additional Influenza Hospitalization Surveillance Project (IHSP) states. The IHSP began during the 2009-2010 season to enhance surveillance during the 2009 H1N1 pandemic. IHSP sites included IA, ID, MI, OK and SD during the 2009-2010 season; ID, MI, OH, OK, RI, and UT during the 2010-2011 season; MI, OH, RI, and UT during the 2011-2012 season; and IA, MI, OH, RI, and UT during the 2012-2013 season.

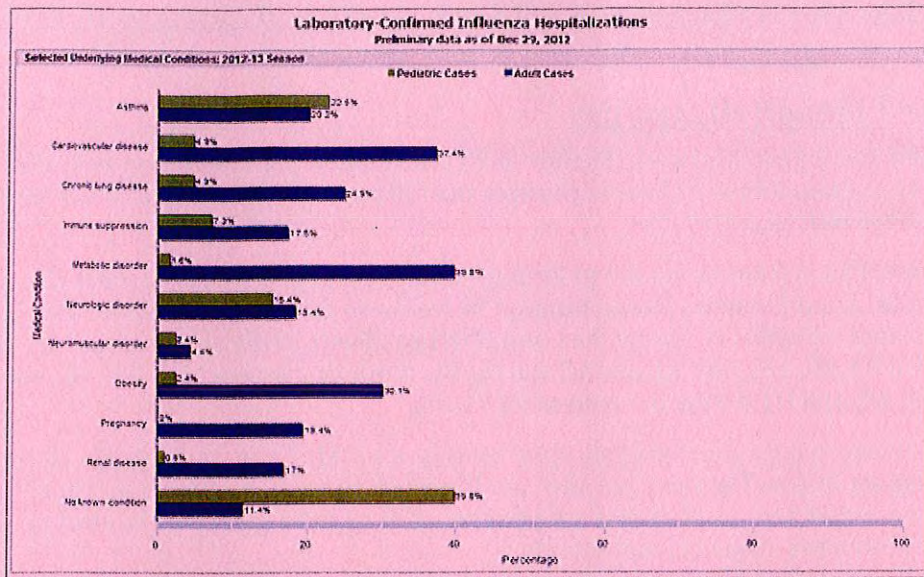
Data gathered are used to estimate age-specific hospitalization rates on a weekly basis, and describe characteristics of persons hospitalized with severe influenza illness. The rates provided are likely to be an underestimate as influenza-related hospitalizations can be missed, either because testing is not performed, or because cases may be attributed to other causes of pneumonia or other common influenza-related complications.

Between October 1, 2012 and December 29, 2012, 2,257 laboratory-confirmed influenza-associated hospitalizations were reported. This is a rate of 8.1 per 100,000 population. Among all hospitalizations, 1,924 (85.2%) were associated with influenza A and 312 (13.8%) with influenza B. There was no virus type information for 19 (0.8%) hospitalizations. Among hospitalizations with influenza A subtype information, 475 (98.1%) were attributed to H3 and 9 (1.9%) were attributed to 2009 H1N1. The most commonly reported underlying medical conditions among hospitalized adults were metabolic conditions, cardiovascular disease, obesity, and chronic lung disease (excluding asthma). Among 36 hospitalized women of childbearing age (15-44 years), seven were pregnant. The most commonly reported underlying medical conditions in hospitalized children were asthma, neurologic disorders, and immune suppression. Approximately 40% of hospitalized children had no identified underlying medical conditions. Additional FluSurv-NET data can be found at:

<http://gis.cdc.gov/GRASP/Fluview/FluHospRates.html> and <http://gis.cdc.gov/grasp/fluview/FluHospChars.html>.



Data from the Influenza Hospitalization Surveillance Network (FluSurv-NET), a population-based surveillance for influenza related hospitalizations in children and adults in 15 US states. Incidence rates are calculated using the National Center for Health Statistics' (NCHS) population estimates for the counties included in the surveillance catchment area.



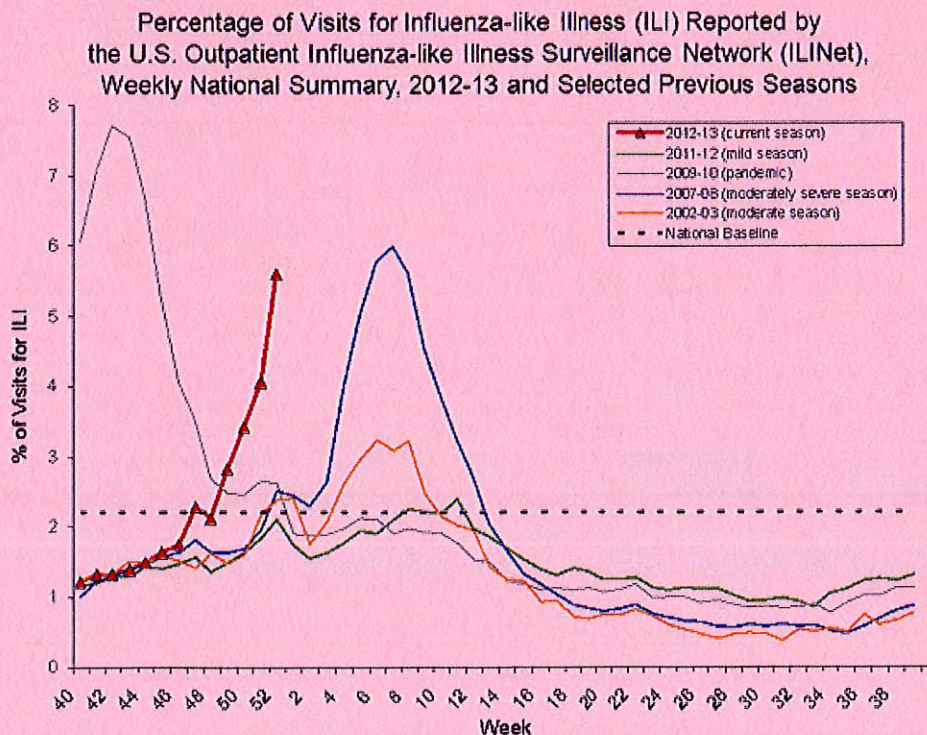
Asthma includes a medical diagnosis of asthma or reactive airway disease; **Cardiovascular diseases** include conditions such as coronary heart disease, cardiac valve disorders, congestive heart failure, pulmonary hypertension, and aortic stenosis. Does not include hypertension disease only; **Chronic lung disease** includes conditions such as bronchiolitis obliterans, chronic aspiration pneumonia, and interstitial lung disease; **Immune suppression** includes conditions such as immunoglobulin deficiency, leukemia, lymphoma, HIV/AIDS, and individuals taking immunosuppressive medications; **Metabolic disorders** include conditions such as diabetes mellitus, thyroid dysfunction, adrenal insufficiency, and liver disease; **Neurologic diseases** include conditions such as seizure disorders, cerebral palsy, and cognitive dysfunction; **Neuromuscular diseases** include conditions such as multiple sclerosis and muscular dystrophy; **Obesity** was assigned if indicated in patient's medical chart or if body mass index (BMI) >30 kg/m²; **Pregnancy** percentage calculated using number of female cases aged between 15 and 44 years of age as the denominator; **Renal diseases** include conditions such as acute or chronic renal failure, nephrotic syndrome, glomerulonephritis, and impaired creatinine clearance; **No known condition** indicates that the case did not have any known underlying medical condition indicated in medical chart at the time of hospitalization.

Only includes cases for which data collection has been completed through the medical chart review stage.

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Outpatient Illness Surveillance:

Nationwide during week 52, 5.6% of patient visits reported through the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) were due to influenza-like illness (ILI). This percentage is above the national baseline of 2.2%. This increase may be attributed in part to a reduced number of routine health care visits during the Christmas holidays, which has been observed in previous seasons. (ILI is defined as fever (temperature of 100°F [37.8°C] or greater) and cough and/or sore throat.) Region specific data is available at <http://gis.cdc.gov/grasp/fluview/fluportaldashboard.html>.



On a regional level, the percentage of outpatient visits for ILI ranged from 2.0% to 9.1% during week 52. Nine regions (Regions 1-8 and 10) reported a proportion of outpatient visits for ILI above their region-specific baseline levels.

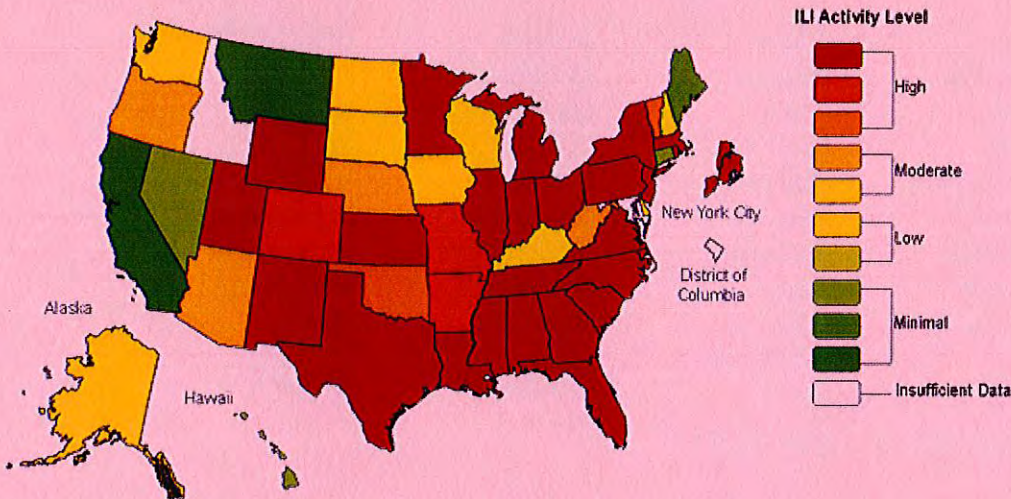
ILINet Activity Indicator Map:

Data collected in ILINet are used to produce a measure of ILI activity* by state. Activity levels are based on the percent of outpatient visits in a state due to ILI and are compared to the average percent of ILI visits that occur during spring and fall weeks with little or no influenza virus circulation. Activity levels range from minimal, which would correspond to ILI activity from outpatient clinics being below the average, to high, which would correspond to ILI activity from outpatient clinics being much higher than average.

During week 52, the following ILI activity levels were experienced:

- New York City and 29 states experienced high ILI activity (Alabama, Arkansas, Colorado, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, and Wyoming).
- Nine states experienced moderate ILI activity (Alaska, Arizona, Delaware, Iowa, Nebraska, North Dakota, Oregon, Washington, and West Virginia).
- Four states experienced low ILI activity (Kentucky, New Hampshire, South Dakota, and Wisconsin).
- Six states experienced minimal ILI activity (California, Connecticut, Hawaii, Maine, Montana, and Nevada).
- Data were insufficient to calculate an ILI activity level for the District of Columbia and 2 states (Idaho and Maryland).

**Influenza-Like Illness (ILI) Activity Level Indicator Determined by Data Reported to ILINet
2012-13 Influenza Season Week 52 ending Dec 29, 2012**



[Click on map to launch interactive tool](#)

*This map uses the proportion of outpatient visits to health care providers for influenza-like illness to measure the ILI activity level within a state. It does not, however, measure the extent of geographic spread of flu within a state. Therefore, outbreaks occurring in a single city could cause the state to display high activity levels.

Data collected in ILINet may disproportionately represent certain populations within a state, and therefore, may not accurately depict the full picture of influenza activity for the whole state.

Data displayed in this map are based on data collected in ILINet, whereas the State and Territorial flu activity map are based on reports from state and territorial epidemiologists. The data presented in this map is preliminary and may change as more data is received.

Differences in the data presented here by CDC and independently by some state health departments likely represent differing levels of data completeness with data presented by the state likely being the more complete.

Geographic Spread of Influenza as Assessed by State and Territorial Epidemiologists:

The influenza activity reported by state and territorial epidemiologists indicates geographic spread of influenza viruses, but does not measure the severity of influenza activity.

During week 52, the following influenza activity was reported:

- Widespread influenza activity was reported by 41 states (Alabama, Alaska, Arkansas, Colorado, Connecticut, Florida, Georgia, Kentucky, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming).
- Regional influenza activity was reported by 7 states (Arizona, California, Missouri, Montana, Oregon, South Dakota, and Washington).
- The District of Columbia reported local influenza activity.
- Sporadic influenza activity was reported by 1 state (Hawaii).
- Guam reported no influenza activity.
- Puerto Rico, the U.S. Virgin Islands, and 1 state (Delaware) did not report.


[Flu Activity data in XML Format](#) | [View Full Screen](#)



Additional National and International Influenza Surveillance Information





FluView Interactive: This season, FluView includes enhanced web-based interactive applications that can provide dynamic visuals of the influenza data collected and analyzed by CDC. These FluView Interactive applications allow people to create customized, visual interpretations of influenza data, as well as comparisons across flu seasons, regions, age groups and a variety of other demographics. To access these tools visit <http://www.cdc.gov/flu/weekly/fluviewinteractive.htm>.



U.S. State and local influenza surveillance: Click on a jurisdiction below to access the latest local influenza information.


Alabama	Alaska	Arizona	Arkansas	California
Colorado	Connecticut	Delaware	District of Columbia	Florida
Georgia	Hawaii	Idaho	Illinois	Indiana
Iowa	Kansas	Kentucky	Louisiana	Maine
Maryland	Massachusetts	Michigan	Minnesota	Mississippi
Missouri	Montana	Nebraska	Nevada	New Hampshire
New Jersey	New Mexico	New York	North Carolina	North Dakota
Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island
South Carolina	South Dakota	Tennessee	Texas	Utah
Vermont	Virginia	Washington	West Virginia	Wisconsin
Wyoming	New York City	Virgin Islands		

Google Flu Trends: Google Flu Trends uses aggregated Google search data in a model created in collaboration with CDC to estimate influenza activity in the United States. For more information and activity estimates from the U.S. and worldwide, see <http://www.google.org/flutrends/> 

World Health Organization: Additional influenza surveillance information from participating WHO member nations is available through [FluNet](#)  and the [Global Epidemiology Reports](#). 

WHO Collaborating Centers for Influenza located in [Australia](#) , [China](#) , [Japan](#) , and the [United Kingdom](#) .

Europe: for the most recent influenza surveillance information from Europe, please see WHO/Europe at <http://www.euroflu.org/index.php>  and visit the European Centre for Disease Prevention and Control at http://ecdc.europa.eu/en/publications/surveillance_reports/influenza/Pages/weekly_influenza_surveillance_overview.aspx 

Public Health Agency of Canada: The most up-to-date influenza information from Canada is available at <http://www.phac-aspc.gc.ca/fluwatch/> 

Health Protection Agency (United Kingdom): The most up-to-date influenza information from the United Kingdom is <http://www.cdc.gov/flu/weekly/>

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A description of surveillance methods is available at: <http://www.cdc.gov/flu/weekly/overview.htm>

For Questions About Seasonal Influenza (Flu), Contact Us

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