

miniupdate

IMMUNIZATION BRANCH • DEPARTMENT OF HEALTH SERVICES • 2151 BERKELEY WAY • BERKELEY, CA 94704 (510) 540-2067 • www.dhs.ca.gov/ps/dcdc/izgroup

TO: Medical Directors, Community-Based Clinics
Directors, Medical Residency Programs
Directors, Nursing Schools
Interested Others

August 4, 2005

FROM: Howard Backer, MD, MPH, Chief
Immunization Branch



Below for your information and reference is an abbreviated copy of the Immunization Branch's bimonthly UPDATE memorandum. The edited version contains medical and technical information on immunization and vaccines. We hope it is helpful. If you have questions on immunizations, please contact the Immunization Coordinator at your local health department.



For more information on NIAM, please see page 7

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CDC Leads Vaccine Safety News Conference

In response to a renewed interest in vaccine safety, Dr. Julie Gerberding led a joint HHS press conference on July 19th to reinforce public health's commitment to protecting the health of children. The press conference focused on steps being taken to ensure the safety and efficacy of vaccines, the issue of thimerosal in vaccines, and government research on autism. In addition to Dr. Gerberding, speakers included top officials from the National Institutes of Health (NIH), the Food and Drug Administration (FDA), the American Academy of Pediatrics (AAP), the American Medical Association (AMA), and a vaccine researcher who was also a father of a child with autism.

A few key messages and strategies were emphasized throughout the press conference that we can all use in responding to this issue.

1. Speakers were very compassionate and empathetic toward parents of children with autism who "want and deserve" answers about their children's health. Autism is "heart-wrenching" and there currently are not a lot of answers about the causes of the disease. Speakers called for everyone to work together for more research to better understand autism: "We need a war on autism, not a war on childhood vaccines."

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2. The issue of vaccines and vaccine safety was framed as an issue of the “health and safety of our children.” This is a concern that drives the health care community, as well as parents. Vaccines are vital to the health and safety of our children.
3. Speakers tried to create an understanding of the importance of immunizations by engendering an emotional and visual understanding of the world before vaccines. Dr. Eileen Ouellette, president-elect, AAP, described how, in the 1930s, pediatricians spent most of their time caring for children who were sick from measles, polio, and other diseases that we don’t see any longer because of vaccines. Dr. Gerberding and others reinforced that while we do not see many of these vaccine-preventable diseases in the US regularly, the viruses exist. If we stop vaccinating, they will reemerge. The diseases are just “one traveler away.”
4. Today’s childhood vaccines do not contain thimerosal, with the exception of some flu vaccines. Dr. Murray Lumpkin, from the FDA, explained that it was worth removing thimerosal from vaccines, even though they were more expensive now, if it eased parents’ minds in making a decision about vaccinating their child.

The CDC and AAP websites contain additional information on these topics:

- www.cdc.gov/nip/vacsafe/concerns/thimerosal/default.htm#book
- www.cdc.gov/nip/vacsafe/concerns/autism
- www.aap.org/healthtopics/autism.cfm

DISEASE ACTIVITY AND SURVEILLANCE

The surveillance data reviewed in this section are reported in Table 1. The table includes provisional number of cases reported in 2005 with onset in 2005 (as of June 30, 2005). For comparison, the numbers of cases reported in 2004 with onset in 2004 (as of June 30, 2004) are included. If you have any questions about this table, please contact Jennifer Myers at JMyers@dhs.ca.gov.

Pertussis: From January through June 2005, 694 cases of pertussis were reported in California with onset in 2005, resulting in an annualized incidence rate of 3.80 cases per 100,000 population. This is a four-fold increase in cases reported during the same time period in 2004 (January through June) when 169 cases were reported. Several counties have continued to report higher numbers of pertussis cases this year over last year including Alameda, Contra Costa, Fresno, Humboldt, Kern, Los Angeles, Madera, Sacramento, San Diego, Santa Clara, and Tulare. Of the 694 cases, 203 (29%) were in infants less than 12 months old. Race/ethnicity was specified for 592 out of 694 cases. Of these, 286 (48%) were White, 259 (44%) were Hispanic, 27 (5%) were Asian/Pacific Islanders, 13 (2%) were African American and 7 (1%) were American Indian. Two deaths have occurred in 2005. The first was a 23-day-old Los Angeles County resident and the second was a 14-day-old Riverside County resident. Neither case was laboratory-confirmed. Source of infection for both cases was unknown.

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Table 1: Reported Cases with Onset in 2005, (by Age Group) and Incidence of Selected Vaccine Preventable Diseases, California, 2005 (Provisional – as of 4/30/05)

DISEASE	Age Groups			Age Unknown	All Ages	
	0-4 yrs	5-17 yrs	18+ yrs		Cases	Rate ¹
Congenital Rubella Syndrome	1	0	0	0	1	0.01
Diphtheria	0	0	0	0	0	0.00
<i>H. influenzae</i> type b (Hib) ²	2	0	0	0	2	0.03
Hepatitis A	8	33	229	2	272	1.49
Hepatitis B	0	1	168	1	170	0.93
Measles ³	1	0	2	0	3	0.02
Mumps	7	3	12	1	23	0.13
Polio	0	0	0	0	0	0.00
Pertussis	279	236	177	2	694	3.80
Rubella ³	1	0	0	0	1	0.01
Tetanus	0	0	2	0	2	0.01

¹ Annualized Incidence Rate = cases/100,000 population. Population estimates source: California Department of Finance projections based on the 2000 Census.

² *H. influenzae* is reportable only for cases ≤30 years

³ Confirmed cases only

Prepared by California Department of Health Services, Immunization Branch

Measles: From January through June 2005, three confirmed cases of measles were reported, two in San Diego County and one in Santa Barbara County. These cases were reported in detail in the June 2005 Immunization UPDATE.

Mumps: From January through June 2005, 23 cases of mumps were reported in California with onset in 2005. This is an increase from 2004, when, for the same time period (January to June) 13 cases were reported. Twelve of the 23 cases, just over half, were adults (52%). Race/ethnicity was specified for 16 out of 23 cases. Of these, 7 were White, 7 were Hispanic, 1 was African American and 1 was American Indian.

Haemophilus influenzae type b invasive disease (Hib): From January through June 2005, two cases of invasive *Haemophilus influenzae* type b (Hib) were reported. The first case was an Alameda County resident who was reported in detail in the June 2005 Immunization UPDATE. The second case was a six-year-old male Los Angeles County resident with a history of having received four doses of Hib vaccine. This case is currently under investigation.

Tetanus: From January through June 2005, two cases of tetanus were reported. The first case was a Riverside County resident who was reported in detail in the June 2005 UPDATE. The second case was a 44-year-old male Sonoma County resident with a known acute injury and no known history of drug abuse. His vaccination history was unknown.

Hepatitis A: From January through June 2005, 272 cases of hepatitis A were reported in California with onset in 2005, resulting in an annualized incidence rate of 1.49 cases per 100,000 population. This is a decrease from 2004, when, for the same time period (January through June) 402 cases were reported. Most cases (84%) were reported in adults. Race/ethnicity was specified for 189 out of 272 cases. Of these, 78 (41%) were White, 78 (41%) were Hispanic, 23 (12%) were Asian/Pacific Islander, 9 (5%) were African American and 1 (1%) was American Indian.

Hepatitis B: From January through June 2005, 170 cases of hepatitis B were reported in California with onset in 2005, resulting in an annualized incidence rate of 0.93 cases per 100,000 population. This is a decrease from 2004, when, for the same time period (January through June) 208 cases were reported. All reported cases were adults except for one pending case with unknown age and one 16-year-old case pending confirmation from Fresno County. Race/ethnicity was specified for 112 out of 170 cases. Of these, 53 (47%) were White, 25 (22%) were Hispanic, 20 (18%) were Asian/Pacific Islander, 13 (12%) were African American and 1 (1%) was American Indian.

Rubella and Congenital Rubella Syndrome (CRS): From January through June 2005, one confirmed Congenital Rubella Syndrome (CRS) case and one neonatal rubella infection were reported by Los Angeles County. The confirmed CRS case was detected in January 2005 by a geneticist who was evaluating a 21-month-old child with bilateral hearing loss and pulmonic stenosis. The child was born in the U.S. in April 2003 to a Nigerian woman who had a history of a rubella-like illness in her first trimester in Nigeria. In May 2005, CDC performed a rubella IgM ELISA test on a blood spot collected from the infant at birth and the sample tested rubella IgM positive.

The neonatal rubella case was born in May 2005 at 35 weeks gestation with intrauterine growth retardation. The mother, who came from Bangladesh, had a history of a rubella-like illness in her 5th month of pregnancy. At delivery, the mother had very high rubella IgG titers, and the infant had rubella IgM antibody. Apart from intrauterine growth retardation, the infant has not yet displayed other symptoms of CRS; the infant has no cataracts, normal hearing, and normal heart. Specimens collected at birth and 1-1/2 months were negative for rubella virus by RT-PCR performed at CDC.

Other VPDs: As of June 30, 2005, for this report year no confirmed cases of diphtheria or polio have been reported to the Immunization Branch.

ASSESSMENT ACTIVITY

California is Looking Good: 2004 NIS Results

The results of the 2004 National Immunization Survey (NIS) indicate that the nation has reached the National Healthy People 2010 objective of 80% series coverage for children aged 19 to 35 months for all vaccine series. Given the margin of error in the NIS, as shown by the confidence intervals in Table 2 on the next page, California's coverage estimates are statistically equivalent to the 80% HP 2010 goal. The trend over the past several years for each series is shown in Table 2 on the next page. Our hats are off to California's pediatric health care providers for their hard work in achieving this result.

As shown in Table 2 on the next page, coverage levels for all immunization series are comparable to national levels for the state as a whole as well as to the three California Immunization Action Plan (IAP) areas: Los Angeles, San Diego, and Santa Clara counties.

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National NIS data were released at the end of July as part of a press conference for National Immunization Awareness Month that was sponsored by National Foundation for Infectious Diseases. All data are available on the National Immunization Program website at www.cdc.gov/nip/coverage.

manufacturers can not guarantee the vaccine past the expiration date.

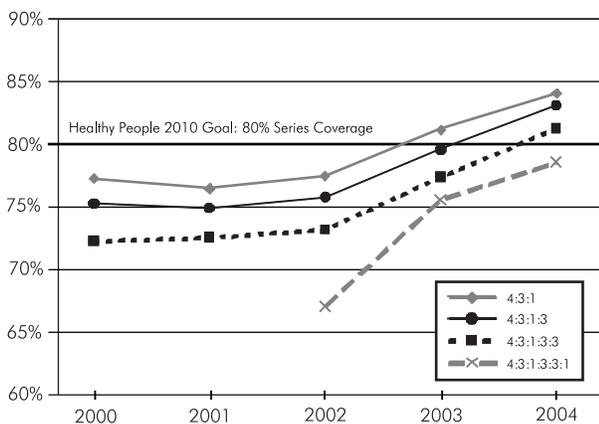
The expiration dates should be checked before administering the vaccine. Inspecting and rotating vaccine stock periodically to reveal the most time sensitive vaccines and using short dated vaccines first can help to avoid administration of vaccines past their expiration date.

IMMUNIZATION SERVICES

Time is Running Out!

The Immunization Branch has recently received several calls regarding vaccine administered just a few days or weeks after the expiration date on the vial. This is a difficult situation, especially for the children who may require revaccination because of this. Vaccines do not necessarily become ineffective exactly on the expiration date but the

Figure 1: Estimated Immunization Coverage, Completed Vaccine Series, Children 19–35 Months, California, 2000–2004



Source: National Immunization Survey, 2000–2004
Prepared by the California Department of Health Services, Immunization Branch

VACCINE RISKS AND BENEFITS

Influenza Interim VIS

Interim 2005 vaccine information statements for influenza, one for trivalent inactivated flu (TIV) vaccine and one for the live nasal spray version (LAIV), are now available online at www.cdc.gov/nip/. CDC indicates a second edition of each flu vaccine information statement will be published later this year. These “interim” vaccine information statements may be used until the final versions become available. A Spanish version will be available soon at www.immunize.org.

VACCINES FOR CHILDREN (VFC) PROGRAM

Meningococcal Conjugate Vaccine Now Available through VFC

California Vaccines for Children (VFC) providers were informed in June that the new meningococcal conjugate vaccine (Menactra® or MCV4) was added to the VFC for-

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Table 2: Estimated Immunization Coverage Among Children 19-35 Months, by Vaccine Series, U.S. and California 2004

Region	4:3:1 ¹	4:3:1:3 ²	4:3:1:3:3 ³	4:3:1:3:3:1 ⁴
US National	83.5 ± 0.9	82.5 ± 0.9	80.9 ± 0.9	76.0 ± 1.0
California	84.1 ± 3.2	83.1 ± 3.3	81.3 ± 3.4	78.6 ± 3.5
CA – Los Angeles County	83.6 ± 5.1	81.7 ± 5.3	80.1 ± 5.5	76.6 ± 5.8
CA - San Diego County	80.0 ± 5.4	79.9 ± 5.4	77.2 ± 5.6	74.3 ± 5.8
CA - Santa Clara County	88.1 ± 4.7	87.7 ± 4.7	84.6 ± 5.1	79.9 ± 5.6

¹ 4+DTP/DTaP, 3+ Polio, 1+ MCV
² 4+DTP/DTaP, 3+ Polio, 1+ MCV, 3+ Hib
³ 4+DTP/DTaP, 3+ Polio, 1+ MCV, 3+ Hib, 3+ Hep B
⁴ 4+DTP/DTaP, 3+ Polio, 1+ MCV, 3+ Hib, 3+ Hep B, 1+ Varicella

Source: National Immunization Survey, 2004
Prepared by the California Department of Health Service, Immunization Branch

mulary. The letter provided recommendations for children age 11-18 and information on ordering. For additional information, please contact the VFC office at (877) 243-8832 or your VFC Field Representative.

Tdap is Coming to VFC Soon

The VFC Program has revised the Vaccine Order form (DHS8501 [8/05]) to include the newly licensed booster tetanus, diphtheria and pertussis (whooping cough) vaccines (Tdap). FDA has approved two Tdap vaccines: Boostrix[®] manufactured by GlaxoSmithKline, and ADACEL[™] produced by sanofi pasteur. Boostrix[®] is currently licensed for persons 10 to 18 years old, while the ADACEL[™] is indicated for persons aged 11 years and older. Federal vaccine contracts are needed before either Tdap vaccine can be offered by the VFC Program. We currently estimate that Tdap vaccine will be available to VFC providers in September 2005.

VFC Providers Can Order Flu Vaccine

The VFC Program will send its annual flu letter later this month. It will notify VFC providers that they can begin ordering their VFC influenza vaccines for the upcoming 2005-06 flu season. Thimerosal-free single dose (.025) syringes for children 6 months through 36 months will be available as well as 10-dose vials.

PROFESSIONAL INFORMATION AND EDUCATION

West Nile Virus Webcast on CDLHN's Public Health Café

A webcast entitled "Protecting Yourself and Your Community from West Nile Virus" is now online at the California Distance Learning Health Network's (CDLHN) Public Health Café. The 19-minute presentation covers the fundamentals of West Nile Virus including transmission, basic elements of human disease and animal infection, and details on how communities and individuals can reduce disease risk. Public Health Café provides an opportunity for workforce development, with educational offerings like this that are suitable for any health worker. It can also be referenced to consumers who are asking for more information about West Nile.

To view this webcast visit www.cdlnh.com. Contact CDLHN at info@cdlnh.com or (619) 594-5912 for more information.

Buy CDC's "Yellow Book" Everywhere

For the first time ever, CDC's newest edition of its travel health book, known as the "Yellow Book", is available at

bookstores nationwide and through online booksellers. The "Yellow Book" is named for its traditionally yellow cover and is officially titled Health Information for International Travel. Intended for medical professionals and travelers, the 2005-2006 edition is now available at bookstores, through Internet book sellers or by contacting Elsevier Book Order Fulfillment at 1-800-545-2522 or online at www.us.elsevierhealth.com. A companion web site that lets travelers look up specific information by travel destination, and view or print custom reports based on individual travel plans, is also available at www.cdc.gov/travel/yb/.

PUBLIC INFORMATION AND EDUCATION

New English/Spanish Immunization Techniques DVD (IMM-712-DVD)

The award-winning Immunization Techniques: Safe, Effective, Caring video and collateral materials now are available in DVD format (IMM-712-DVD). Designed for use as a "hands-on" instructional program for new staff as well as a refresher course for experienced health professionals, the DVD includes the English and Spanish versions of the Immunization Techniques video (IMM-712). Because of the high Latino birth rate in California, immunization programs should recognize California's bilingual health care workers for their contribution to immunization delivery. The DVD of Immunization Techniques provides immunization education for these workers in the language they are expected to use with their patients. Not only does this make sense, it also is often more convenient for Spanish-speaking health care workers to receive professional education in their native language as well as English. Copies can be ordered, please visit www.CDLHN.com.

Immunization Branch Website Now Easier to Find

We have developed a "splash" page to direct visitors to the Immunization Branch website. Instead of using the existing, lengthy URL, you can now find us via www.getimmunizedca.org, which will promptly direct you to the Department of Health Services Immunization Branch home page.

Meningococcal College Outreach Flyer Revised

The meningococcal college outreach flyer (IMM-688) is being revised and will be available in hard copy and online on the Immunization Branch website shortly.

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The flyer has been revised to reflect ACIP's new recommendations for all college freshmen living in dorms to get meningococcal immunization. California requires all public and private colleges with on-campus housing to provide incoming freshmen living in dorms with information about meningococcal disease and vaccination. These colleges also must maintain a record documenting the informing and whether or not the student had received or intended to receive a meningococcal vaccination. However, the law does not require these colleges to provide the vaccination to students, only to inform freshmen students who will be/are living in dorms and to keep a record that they did so.

INFLUENZA AND PNEUMOCOCCAL ACTIVITIES

Influenza Vaccine Now Covered by Injury Compensation Program

Vaccines, like any medicine, rarely may cause serious problems such as severe allergic reactions. People believed to be harmed by influenza vaccines may now be assisted by the National Vaccine Injury Compensation Program (VICP). The VICP was created by Congress in 1986 as an alternative to lawsuits to pay for the medical expenses, lost wages and pain and suffering from vaccine injuries. The VICP maintains an eligibility list of common vaccines for which compensation is available. Trivalent influenza vaccine, whether inactivated or live, was added to this list on July 1, 2005. Claims may be made for past or present injuries with claims due by July 1, 2007, for injuries that occurred between July 1, 1997 and July 1, 2005. For additional information on compensation for vaccine injuries, visit www.hrsa.gov/osp/vicp, or call 1-800-338-2382.

State IZ Law Changes for SNFs

California has required a specific order to immunize each patient residing in a skilled nursing facility (SNF). As of January 2006, the recent passage of Assembly Bill 1711, after lobbying by members of the California Adult Immunization Coalition (www.immunizeadults.org), will permit SNF medical directors to issue standing orders for influenza and pneumococcal immunization. This will allow registered nurses or licensed pharmacists to administer these vaccines to all residents over 50 years of age in facilities with standing orders. Patient-specific orders will still be required for younger residents.

In the future, this new law will streamline the annual flu vaccination process for many SNF residents in California.

Clinical Guidelines for Suspected Avian Influenza

The role of enhanced surveillance to detect and quickly contain early cases of suspect avian influenza has been highlighted recently, particularly as a starting point for pandemic influenza response plans. While surveillance of poultry and other fowl flocks needs to be increased, the need to identify persons most likely at risk for exposure and quickly evaluate them is just as timely. The role of the astute clinician and public health practitioners will be essential for intervening early with the first human cases.

The reported symptoms of avian influenza A (H5N1) in humans have ranged from typical influenza-like illness (ILI) symptoms such as fever, cough, sore throat, and muscle aches, to eye infections (conjunctivitis), pneumonia, acute respiratory distress, and viral pneumonia. For poultry handlers, and others in close constant contact with poultry, conjunctivitis, with ILI accompanying their history should raise your index of suspicion even further. CDC and WHO continue to recommend enhanced surveillance for influenza A (H5N1) infections among travelers with unexplained illness returning from countries that have had H5N1 infections in either persons or poultry.

To date, the majority of human avian influenza A (H5N1) infections have been identified in Southeast Asia. Limited but not sustained direct person to person transmission of influenza A (H5N1) keeps us at the pandemic imminent phase of readiness for a worldwide influenza outbreak. During January 2004 through June 28, 2005, 54 persons have died out of the 108 reported human cases of avian influenza A (H5N1). All of these influenza viruses were avian species genetically, and most of the reported human cases infected with avian influenza A (H5N1) gave a history of direct exposure to sick poultry infected with influenza A (H5N1).

Testing: Testing for avian influenza A (H5N1) should be considered on a case-by-case basis in consultation with state and local health departments for hospitalized or ambulatory patients with:

- documented temperature of $>38^{\circ}\text{C}$ ($>100.4^{\circ}\text{F}$), and
- one or more of the following: cough, sore throat, shortness of breath, and
- history of contact with poultry (e.g., visited a poultry farm, a household raising poultry, or a bird market) or a known or suspected human case of influenza A (H5N1) in an H5N1-affected country within 10 days of symptom onset.

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Testing for avian influenza A (H5N1) is indicated for hospitalized patients with:

- radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established, and
- history of travel within 10 days of symptom onset to a country with documented H5N1 avian influenza in poultry and/or humans (for a regularly updated listing of H5N1-affected countries).

When providers evaluate patients meeting the CDC criteria for testing, they should immediately contact their local health departments who can in turn contact persons at the state public health department and lab to arrange for special testing to rule out influenza A H5N1 if it is indicated. If the patients are not ill enough to warrant hospital admission, they should be advised to rest, increase their oral fluid intake, consider remaining home from work, school, and other environs where there is wide contact with the public, monitor their symptoms closely and report back immediately should they worsen. If possible, a follow up phone inquiry is helpful to assess the patient's progress as well as to inform them promptly of their laboratory results during the ensuing 24 to 48 hours.

This time of heightened pandemic awareness also gives clinicians an excellent opportunity to encourage high risk patients to get their annual influenza vaccinations.

The following links to the CDC website contain more information about Avian flu:

- MMWR 2005;54;631-634; www.cdc.gov/mmwr/preview/mmwrhtml/mm5425a3.htm
- CDC Avian Influenza Health alert for providers and travelers,
- Protecting Workers against Avian influenza.

IZ COALITION ACTIVITIES

Honoring Natalie Smith's Legacy for National Immunization Awareness Month

August is National Immunization Awareness Month (NIAM). This year's observance will also be a tribute to former DHS Immunization Branch Chief Natalie J. Smith, MD, who died two years ago. An immunization outreach campaign targeting underserved ethnic minority communities continues Dr. Smith's long-time commitment to children's health. Through a grant from the CDC's Natalie J. Smith Memorial Fund, the California

Coalition for Childhood Immunization (C3I), in collaboration with the DHS Immunization Branch, has created posters adapted from the successful "Grandma Am I Up-to-Date?" print ad. Posters will be distributed by local immunization coalitions throughout the state to community groups and partners to help raise awareness for child immunizations.

MISCELLANEOUS

New Appointment

DHS is pleased to announce Dr. Howard Backer's appointment as interim State Public Health Officer (SPHO), the position previously held by Dr. Richard Jackson. Dr. Backer will serve as SPHO while recruitment and selection is underway for a permanent SPHO. Howard will continue to serve as Chief of the Immunization Branch and as the senior medical officer for bio-terrorism preparedness. Howard has distinguished himself through his leadership on key public health challenges and his working relations with local health departments. He will return to Immunization Branch Chief full time when a new DHS state public health officer is recruited.

Staff Changes

Three key Immunization Branch positions have been filled. In July Charlotte Wheeler, M.D., MPH joined the Technical Assistance Section as Public Health Medical Officer III. Charlotte has just completed her training as an Epidemic Intelligence Service (EIS) Officer at both CDC and in Berkeley with DHS Infectious Disease Branch. Along the way she received Bachelor's Degrees in English and Computer Sciences, an MD at SUNY Stony Brook, an internship in Internal Medicine at UC Davis Medical Center, and an MPH and Preventive Medicine Residency at OHSU in Portland, Oregon. She brings to the Branch her experience in outbreak investigation, health quality research, information technology and informatics, and clinical care.

John Lewis, MPA, joined the Information & Education Section in June. John will be responsible for the Branch's adult immunization campaign efforts. John formerly was a program manager at the Curry National Tuberculosis Center in San Francisco. Prior to joining the Curry Center John was a regional planning manager for the American Cancer Society and before that he coordinated a special HIV/AIDS project at the Bronx-Lebanon Hospital Center for six years. John has a solid background in strategic data-driven planning and evaluation, as well as

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training. He recently led successful national efforts to develop a Corrections TB Training and Education Resource Guide and a National Strategic Plan for TB Training and Education. John received his BA from Trinity University in San Antonio, TX, and his Masters in Public Administration, Health Policy and Management from New York University's Wagner Graduate School of Public Service.

Timothy Dube, MPH, has joined the Surveillance Investigations, Research and Evaluation section in the Hepatitis Epidemiologist position. Timothy will be responsible for hepatitis A and hepatitis B surveillance, and for supporting local health departments with the planning and implementation of hepatitis A and hepatitis B prevention and control measures, including perinatal hepatitis B programs. Timothy recently received his MPH in Biostatistics from Boston University and has several years of analyst experience.

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