CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

Agenda

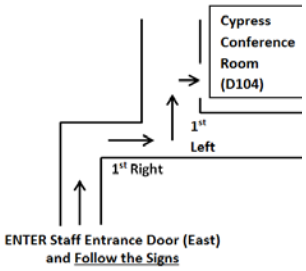
Quarterly Community Provider Network (CPN) Meeting

Contra Costa Health Plan

When: **Time: 7:30 AM – 9:00 AM****

Date: April 25, 2018

Where: Pittsburg Health Center
2311 Loveridge Rd.,
Cypress Conference Room – 1st Floor, #D104
Pittsburg, CA 94565



The agenda for the meeting is as follows:

I.	**CALL TO ORDER and INTRODUCTIONS** • **Review Online Access to Clinical Guidelines & Preventive Services Information**	Christine Gordon, RN, BSN, DHCS-MT
II.	**REVIEW and APPROVAL of Previous Meeting Minutes**	Jose Yasul, MD Acting Medical Director, CCHP
III.	**NEW BUSINESS**	
	• **Opiate P & T Meeting** • **Head Start** • **USPSTF**	Andrew Haydon, Pharm.D Pharmacy Director/Staff Debi Marsee, Manager, Employment and Human Services Dept. Comprehensive Services Christine Gordon, RN, BSN, DHCS-MT
IV.	**DISCUSSION ITEMS**	
	• **CCHP Updates** ➢ **Legislative Update** ➢ **Clinical Guidelines** ➢ **Preventive Services** ➢ **Behavioral Health** ➢ **CCHP Benefits Update** ➢ **Quality** ➢ **Pharmacy** ➢ **Utilization Management**	Jose Yasul, MD Acting Medical Director, CCHP
V.	**CLAIMS Q&A**	Staff

Our next scheduled meeting is: July 25, 2018 ** CPN meeting reimbursement will be prorated based on length of time attendee is present in the meeting.

CONTRA COSTA HEALTH PLAN

East County

Quarterly Community Provider Network (CPN)

Meeting Minutes – April 25, 2018

Attending:

CCHP Staff: Jose Yasul, MD, Acting Medical Director; Christine Gordon, RN, BSN, DHCS-MT; Alejandro Fuentes, RN; Joe Cardinalli, Pharmacist; Sylvia Rodriguez, Claims Dept. Supervisor; Delaina Gillaspy, Secretary

CPN Providers: Christine Cave, NP; Siamak Elyasi, MD; Desiree Espinoza, NP.

Guests: Debi Marsee, Head Start

Discussion	Action	Accountable
Meeting called to order at 7:46 A.M.		Christine Gordon, BSN, DHCS-MT
I. Agenda was approved with no revisions.		Jose Yasul, MD Acting Medical Director, CCHP
II. Review Online Access to Clinical Guidelines & Preventive Services Information ➢ Behavioral Health • Behavioral Health Access Handout o Alcohol and drug abuse treatment contact information. ▪ Toll Free: 1-800-846-1652 ▪ Outside Contra Costa County: 925-335-3310 ▪ Information Available 24/7 at: www.cchealth.org/aod ▪ All calls are completely confidential. o Challenges ▪ Making contact for services can be challenging/intimidating for patients. ➢ Clinical Guidelines • Reviewed how to access Clinical Guidelines on Contra Costa Health plan website and provided handout to providers. o http://cchealth.org/healthplan/clinical-guidelines.php ➢ Preventive Services • USPSTF o USPSTF A and B recommendations handout provided during meeting. • Skin Cancer Prevention: Behavioral Counseling o Skin Cancer Prevention: Behavioral Counseling handout provided during meeting. ▪ UV Radiation ▪ Child/Adult recommendations		Christine Gordon, BSN, DHCS-MT

III. New Business **Head Start** ➢ Overview • Federal and State funded program that provides comprehensive services and works with families to receive medical and dental services. o Head Start has up to 30 days to have all children enrolled in medical and dental services and will also provide transportation to appointments if needed. • Head Start is a free program that is for low income families that are income eligible. o Head start is mandated to serve 10% of children with disabilities and provided with an income eligibility waiver. • Head Start will provide assistance to families with medical, dental, homelessness, mental health and continue to follow up with the child/children's health. • Services are provided to undocumented children/families. ➢ Services Provided • Childcare o Childcare services are provided based on the needs of the family. ▪ Non-working- 3 ½ hours provided ▪ Working/School- Hours based on need for work, commute time, school and/or study time. • Preschool • Parenting Classes • Behavioral Health • Depending on the type of services needed Head Start can provide services at the child/children's school to assist in eliminating transportation issues for families. • Bilingual Services • Homes Based system for children that are unable to leave the home. ➢ Forms Included in packet 1. Report of Health Examination- Well Child Check 2. Individualized Health Plan Routine Care 3. Individual Health Plan- Emergency Care 4. Contra Costa County- Community Services Bureau Medical Statement to Request Special Meals and/or Accommodations o On this form if there are foods that are omitted, please list substitutes for the child. 5. My Asthma Plan ➢ Challenges • Challenges that Head Start experiences are getting the forms from families filled out completely. • All paperwork must be completely filled out to receive funding. **Opiate P & T Meeting** ➢ Overview • On Friday 03/23/2018, an ad hoc meeting of the CCHP Pharmacy & Therapeutics committee was held, dedicated to pain management. • >30 providers from the community & CCRMC attended the meeting and formulated a plan to address the opiate epidemic in Contra Costa County. • Topics for discussion included: o Background information on the opiate epidemic and CCHP		Debi Marsee Head Start EHSD Joe Cardinalli Pharmacy Staff

data.
    - Individual presentations & discussions on each of the 3 major goals set by CCHP.
- Quantifiable Goals:
    - Reduce users on both opioids and benzos.
    - Reduce the duration of initial immediate release of opioid prescriptions.
    - Reduce opioid users on >120 MED
        - Reduce opioid users (>120 MED) on an escalating dose.
        - Reduce the total opioid prescriptions (>120 MED) PMPM

➢ Action Items proposed at Ad-Hoc P&T

1. To reduce co-prescribing of both opioids and benzos.
    - A Tapestry report will identify co-prescribed opioids, benzodiazepines ± soma for ALL CCHP member & ALL CCHP providers.
    - A formal letter will be sent to providers on a monthly basis, clearly stating which of their CCHP patients is on this potentially deadly combination of drugs, and that the regimen should be re-considered immediately.
        - After first notification about the dangers of using these two drugs together there has been a 51% reduction.
2. To reduce the duration of initial immediate release opioid prescriptions
    - Limit all initial immediate release opioid prescriptions for acute pain treatment to a 7 day supply.
        - Exceptions: Patients with a paid claim for an opioid in the past 180 days (continuation of therapy), chronic pain patients, palliative care or hospice patients, and cancer patients.
3. To Reduce opioid users on >120 MED
    - Placing quantity limits on all formulary opioids for each single-dose strength to a max. of 120 MME.
        - Single tablet doses that exceed, or that would exceed 120mg MME in a typical dosing will be removed from the CCHP formulary completely.
    - Creation of registry (managed by CCHP clinical pharmacist staff) for all high-dose opiate patients to track treatment plan will require an explanation for all stable, high-dose opioids and a taper plan.
    - Prior authorization requests for escalating doses >120 without valid medical justification will be denied.
    - No more than 3 months of opioids are approved under any authorization request.

IV. Discussion Items ➢ Legislative Update • CPN Care Matters Bulletin o Proposition 56 Directed Payments Expenditures for Physician Services. ➢ CCHP Benefits Update • Palliative Care Benefit o Currently have two contracted providers. o 4 conditions for eligibility ▪ Cancer ▪ Congestive Heart Failure (CHF) ▪ Chronic Obstructive Pulmonary Disease (COPD) ▪ Liver Disease ➢ Quality • Case Management o Case management coordinates individual services for member whose needs include assistant with coordinating health care services. ▪ Refer to Case Management for transportation benefits for emergencies/appointments and transportation to pick up medications. ▪ Providers and patients can call to arrange services. ▪ Phone: 925-313-6887 ➢ Utilization Management • Utilization Management Communication Services o Interpreter Services Resources provided in Care Matters Bulletin.		Jose Yasul, MD Acting Medical Director, CCHP
V. Claims Q&A ➢ Transition from Medic-Cal Local Codes to National Codes • Important Changes to billing o Goes into effect June 2018 • Training webinars will be available for billing staff or billing company.		Sylvia Rodriguez Claims Department
VI. Adjournment: Meeting adjourned at 9:00 A.M.		

CONTRA COSTA
HEALTH SERVICES

Contra Costa Alcohol and Other Drugs

BEHAVIORAL HEALTH ACCESS

- ✓ *Is your life or the life of someone you love affected by the use of alcohol and other drugs?*
- ✓ *Are you looking for alcohol and drug abuse services, resources and information?*
- ✓ *Need information about PC1000 & DUI?*
- ✓ *Interested in Medication Assisted Treatment?*
- ✓ **Learn how to access outpatient counseling, residential treatment, detoxification, and support groups for men, women, families and youth**
- ✓ **Hablamos Español**

If you need alcohol and other drug abuse treatment information you can talk to a substance abuse counselor Monday through Friday during normal business hours:

Toll Free

1.800.846.1652

Outside of Contra Costa County

925.335.3310

Information Available 24/7 at:
www.cchealth.org/aod

All calls are completely confidential

Other Behavioral Health Division Resources

Mental Health Access: 1.888.678.7277

Suicide Crisis Hotline: 1.800.233.2900

Homeless Hotline: 1.800.799.6599





Medi-Cal Provides a Comprehensive Set of Health Benefits That May Be Accessed as Medically Necessary

Ambulatory Patient Services

- Physician services
- Hospital outpatient & outpatient clinic services
- Outpatient surgery (includes anesthesiologist services.)
- Podiatry
- Chiropractic
- Allergy care
- Treatment therapies (chemotherapy, radiation therapy, etc.)
- Dialysis/hemodialysis

Prescription Drugs

- Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class.
- Beneficiaries may receive up to a 100-day supply of many medications.

Emergency Services

- Emergency Room services
- All inpatient and outpatient services that are necessary for the treatment of an emergency medical condition, including dental services, as certified by the attending physician or other appropriate provider.
- Ambulance services

Rehabilitative & Habilitative Services and Devices

- Physical therapy
- Occupational therapy
- Speech therapy
- Acupuncture
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Skilled Nursing Facility services (90 days)
- Medical supplies, equipment, and appliances (including implanted hearing devices)
- Durable medical equipment
- Orthotics/prostheses
- Hearing aids
- Home Health Services

Hospitalization

- Inpatient hospital services
- Anesthesiologist services
- Surgical services (bariatric, reconstructive surgery, etc.)
- Organ & tissue transplantation

Laboratory Services

- Outpatient laboratory and X-ray services
  - Various advanced imaging procedures are covered based on medical necessity.

Maternity and Newborn Care

- Prenatal care
- Delivery and postpartum care
- Breastfeeding education
- Nurse midwife services
- Licensed midwife services

Preventive & Wellness Services and Chronic Disease Management

- Preventive services and vaccines recommended by:
  - United States Preventive Services Task Force (grade A & B)
  - Advisory Committee for Immunization Practices
  - Health Resources and Services Administration's Bright Futures
  - For women by the Institute of Medicine
- Family planning services
- Smoking cessation services
- Behavioral health treatment for children under 21

Mental health and Substance Use Disorder (SUD) Services, including Behavioral Health Treatment

- Outpatient Mental Health services
- Outpatient Specialty Mental Health services
- Inpatient Specialty Mental Health services
- Outpatient Substance Use Disorder services
  - Residential Treatment services
- Voluntary Inpatient Detoxification

Pediatric Services, Including Oral and Vision Care

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. EPSDT provides periodic screenings to determine health care needs and, in addition to the standard Medi-Cal benefits, a beneficiary under the age of 21 may receive extended services as medically necessary.

OTHER:

Dental	• Emergency dental services • Dentures • Dental implants and implant-retained prostheses • Basic preventive, diagnostic and repair services • EPSDT and pregnant women receive extended dental benefits.
Vision	• Routine eye exams once in 24 months • Eyeglasses for eligible individuals under the age of 21 and pregnant women through postpartum
Non-Emergency Medical Transportation Services	Ambulance, litter van, or wheelchair van only when ordinary public or private conveyance is medically contra-indicated and transportation is required for obtaining needed medical care for a Medi-Cal benefit.
Long Term Services and Supports	• Skilled Nursing Facility services (91+days) • Personal Care Services • Self-Directed Personal Assistance Services • Community First Choice Option • Home and Community Based Services

DHCS California Department of HealthCareServices

Contra Costa County
Employment and Human Services Department
Community Services Bureau

Report of Health Examination - Well Child Check

To protect the health of children, California law requires a health examination within 30 days of school entry.
Please have this report filled out by a health examiner and return it to the school. The school will keep and maintain it as confidential information.

To be filled out by Parent or Guardian

Child's Last Name First Middle Birth date

Street Address City Zip Code

I give my permission to share the results of this examination with Community Services Bureau.
Yo otorgo el permiso de compartir los resultados de los exámenes con el Buro de Servicios a la Comunidad.

Signature of Parent or Guardian Date

OFFICE USE ONLY

Center:

Phone: (
Fax:
Date Received:

HEALTH EXAMINATION DATE OF EXAM:

Please Check Exam Per Periodicity -

☐NB ☐3-5days ☐1m ☐2m ☐4m ☐6m ☐9m ☐12m ☐15m ☐18m ☐24m ☐30m ☐3y ☐4y ☐5y

PHYSICAL EXAMINATION	Value Pass/No Pass	Risk Assessment
HISTORY Initial/Interval (all)		
MEASUREMENTS		
Length/Height and Weight *(All Ages)*	**Length/Height**	**Weight**
Head Circumference *(NB-24m)*		
Weight for Length *(NB-18m)*		
Body Mass Index *(24m-5y)*		
Blood Pressure *(Screen 3-5y / Risk Assessment NB-30m)*		**Risk** Yes ☐ No ☐
SENSORY SCREENING		
Vision *(Screen 3y-5y / Risk Assessment 0-30m)*		**Risk** Yes ☐ No ☐
Hearing *(Screen NB, 4-5y / Risk Assessment 3-5 days-3y)*		**Risk** Yes ☐ No ☐
DEVELOPMENTAL/BEHAVIORAL HEALTH		
Developmental Screening *(9m, 18m, 30m)*		
Autism Screening *(18m, 24m)*		
Developmental Surveillance *(NB-6m,12m,15m,24m,3-5y)*		
Psychosocial/Behavioral Assessment *(all)*		
Maternal Depression Screening *(1m,2m,4m,6m)*		
PROCEDURES		
Newborn Blood *(NB – 2m)*		
Newborn Bilirubin *(NB)*		
Critical Congenital Heart Defect Screening *(NB)*		
Hematocrit or Hemoglobin (*Screen 12m / Risk Assessment 4m,15m - 5y)*		**Risk** Yes ☐ No ☐
Lead Screening *(Screen 12m, 24m / Risk Assessment 6m,9m,18m, 3-5y)*		**Risk** Yes ☐ No ☐
Tuberculosis Testing*(Risk Assessment* 1m,6m,12m,24m,3-5y) ***Date Given:*** _____ ***Date Read:*** _____		**Risk** Yes ☐ No ☐
Dyslipidemia Screening (*Risk Assessment 24m, 4y)*		**Risk** Yes ☐ No ☐
ORAL HEALTH *(Screen 6-9m / Risk Assessment 12m,18m-5y)*		**Risk** Yes ☐ No ☐
Fluoride Varnish *(6m-5y)*		
Fluoride Supplementation (*Risk Assessment 6m-9m, 18m-5y*		**Risk** Yes ☐ No ☐
ANTICIPATORY GUIDANCE *(All)*		

Name of Clinic/Physician: _____
Signature of Physician: _____
Address: _____
Phone Number: _____ ***Date:*** _____

Concerns Noted by Physician

Referred to: _____

Phone Number: _____

Staff Follow-Up

Please Attach a Copy of the Child's Immunization Record

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	Prenatal[2]	Newborn[3]	3-5 d[4]	By 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																																
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																				
Weight for Length		●	●	●	●	●	●	●	●	●	●																					
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																																
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★	★
Hearing		●[8]	●[9]	◄	►	★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	◄	►	●[17]	►	◄	●	►	◄	►	●	►
DEVELOPMENTAL/BEHAVIORAL HEALTH																																
Developmental Screening[11]								●			●		●																			
Autism Spectrum Disorder Screening[12]											●	●																				
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																						★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																							●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																									
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																																
Newborn Blood		●[19]	●[20]	►																												
Newborn Bilirubin[21]		●																														
Critical Congenital Heart Defect[22]		●																														
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			●		★		★	◄	►	►	★	★	★	★	★	◄	►	●	►
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	◄	●	►	★	★	★	
Cervical Dysplasia[31]																															●	
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★	★	★															
Fluoride Varnish[34]							◄	►	◄	►	●	►	►	►	►	►																	
Fluoride Supplementation[35]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ◄ ● ► = range during which a service may be provided

Content Revised: 6/27/17
Electronic Conversion: 03/26/2014

My Asthma Plan ENGLISH

Patient Name: _____

Medical Record #: _____

Provider's Name: _____ DOB: _____

Provider's Phone #: _____ Completed by: _____ Date: _____

Controller Medicines	How Much to Take	How Often	Other Instructions
		_____ times per day **EVERY DAY!**	❑ Gargle or rinse mouth after use
		_____ times per day **EVERY DAY!**	
		_____ times per day **EVERY DAY!**	
		_____ times per day **EVERY DAY!**	

Quick-Relief Medicines	How Much to Take	How Often	Other Instructions
❑ Albuterol (ProAir, Ventolin, Proventil) ❑ Levalbuterol (Xopenex)	❑ 2 puffs ❑ 4 puffs ❑ 1 nebulizer treatment	Take ONLY as needed (see below — starting in Yellow Zone or before excercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medications and discuss your treatment plan.

Special instructions when I am *doing well,* *getting worse,* *having a medical alert.*

GREEN ZONE

Doing *well.*

- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.

Peak Flow (for ages 5 and up):
is _____ or more. (80% or more of personal best)

Personal Best Peak Flow (for ages 5 and up): _____

PREVENT asthma symptoms every day:

- ☐ Take my controller medicines (above) every day.
- ☐ Before exercise, take _____puff(s) of _____
- ☐ Avoid things that make my asthma worse. (See back of form.)

YELLOW ZONE

Getting *worse.*

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

Peak Flow (for ages 5 and up):
_____ to _____(50 to 79% of personal best)

CAUTION. Continue taking every day controller medicines, AND:

- ☐ Take___puffs or___one nebulizer treatment of quick relief medicine. If I am not back in the *Green Zone* within 20-30 minutes take ___more puffs or nebulizer treatments. If I am not back in the *Green Zone* within one hour, then I should:
- ☐ Increase_____
- ☐ Add_____
- ☐ Call_____
- ☐ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in _____days.

RED ZONE

Medical Alert

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.

Peak Flow (for ages 5 and up):
less than _____(50% of personal best)

MEDICAL ALERT! Get help!

- ☐ Take quick relief medicine: _____puffs every _____minutes and get help immediately.
- ☐ Take _____
- ☐ Call _____

Danger! Get help immediately! Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or child doesn't respond normally.

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ❑ Yes ❑ No self administer asthma medications: ❑ Yes ❑ No (This authorization is for a maximum of one year from signature date.)

_____ _____

Healthcare Provider Signature Date

ORIGINAL (Patient) / CANARY (School/Child Care/Work/Other Support Systems) / PINK (Chart)

Asthma Action Plan

ENGLISH

PROVIDER INSTRUCTIONS

At initial presentation, determine the level of asthma severity

- Level of severity is determined by both impairment and risk and is assigned to the most severe category in which any feature occurs.

At subsequent visits, assess control to adjust therapy

- Level of control is determined by both impairment and risk and is assigned to the most severe category in which any feature occurs.
- Address adherence to medication, inhaler technique, and environmental control measures.
- Sample patient self-assessment tools for asthma control can be found at
  http://www.asthmacontrol.com/index.html
  http://www.asthmacontrolcheck.com

Stepwise approach for managing asthma:

- Therapy is increased (stepped up) if necessary and decreased (stepped down) when possible as determined by the level of asthma severity or asthma control.

Asthma severity and asthma control include the domains of current impairment and future risk.

Impairment: frequency and intensity of symptoms and functional limitations the patient is currently experiencing or has recently experienced.

Risk: the likelihood of either asthma exacerbations, progressive decline in lung function (or, for children, reduced lung growth), or risk of adverse effects from medication.

ASTHMA MANAGEMENT RECOMMENDATIONS:

— Ensure that patient/family receive education about asthma and how to use spacers and other medication delivery devices.

— Assess asthma control at every visit by self-administered standardized test or verbal history.

— Perform spirometry at baseline and at least every 1 to 2 years for patients ≥ 5 years of age.

— Update or review the Asthma Action Plan every 6 to 12 months.

— Perform skin or blood allergy tests for all patients with persistent asthma.

— Encourage patient/family to continue follow-up with their clinician every 1 to 6 months even if asthma is well controlled.

— Refer patient to a specialist if:

- there are difficulties achieving or maintaining control

OR

- step 4 care or higher is required (step 3 care or higher for children 0-4 years of age) OR
- immunotherapy or omalizumab is considered OR
- additional testing is indicated OR
- if the patient required 2 bursts of oral systemic corticosteroids in the past year or a hospitalization.

HOW TO USE THE ASTHMA ACTION PLAN:

Top copy (for patient):

- Enter specific medication information and review the instructions with the patient and/or family.
- Educate patient and/or family about factors that make asthma worse and the remediation steps on the back of this form.
- **Complete and sign the bottom of the form and give this copy of the form to the patient.**

Middle copy (for school, childcare, work, etc):

- Educate the parent/guardian on the need for their signature on the back of the form in order to authorize student self-carry and self-administration of asthma medications at school and also to authorize sharing student health information with school staff.
- **Provide this copy of the form to the school/childcare center/work/caretaker or other involved third party. (This copy may also be faxed to the school, etc.)**

Bottom copy (for chart):

- **File this copy in the patient's medical chart.**

FOR MORE INFORMATION:

To access the August 2007 full version of the NHLBI Guidelines for the Diagnosis and Treatment of Asthma (EPR-3) or the October 2007 Summary Report, visit **http://www.nhlbi.nih.gov/guidelines/asthma/index.htm.**

Controlling Things That Make Asthma Worse

❑ SMOKE

- Do not smoke. Attend classes to help stop smoking.
- Do not allow smoking in the home or car. Remaining smoke smell can trigger asthma.
- Stay away from people who are smoking.
- If you smoke, smoke outside.

❑ DUST

- Vacuum weekly with a vacuum with a high efficiency filter or a central vacuum. Try to make sure people with asthma are not home during vacuuming.
- Remove carpet if possible. Wet carpet before removing and then dry floor completely.
- Damp mop floors weekly.
- Wash bedding and stuffed toys in hot water every 1-2 weeks. Freeze stuffed toys that aren't washable for 24 hours.
- Cover mattresses and pillows in dust-mite proof zippered covers.
- Reduce clutter and remove stuffed animals, especially around the bed.
- Replace heating system filters regularly.

❑ PESTS

- Do not leave food or garbage out. Store food in airtight containers.
- Try using traps and poison baits, such as boric acid for cockroaches. Instead of sprays/bombs, use baits placed away from children, such as behind refrigerator.
- Vacuum up cockroach bodies and fill holes in with caulking or copper wool.
- Fix leaky plumbing, roof, and other sources of water.

❑ MOLD

- Use exhaust fans or open windows for cross ventilation when showering or cooking.
- Clean mold off hard surfaces with detergent in hot water and scrub with stiff brush or cleaning pad, then rinse clean with water. Absorbent materials with mold may need to be replaced.
- Make sure people with asthma are not in the room when cleaning.
- Fix leaky plumbing or other sources of water or moisture.

❑ ANIMALS

- Consider not having pets. Avoid pets with fur or feathers.
- Keep pets out of the bedroom of the person with asthma.
- Wash your hands and the hands of the person with asthma after petting animals.

❑ ODORS/SPRAYS

- Avoid using strongly scented products, such as home deodorizers and incense, and perfumed laundry products and personal care products.
- Do not use oven/stove for heating.
- When cleaning, keep person with asthma away and don't use strong smelling cleaning products.
- Avoid aerosol products.
- Avoid strong or extra strength cleaning products.
- Avoid ammonia, bleach, and disinfectants.

❑ POLLEN AND OUTDOOR MOLDS

- Try to stay indoors when pollen and mold counts are high.
- Keep windows closed during pollen season.
- Avoid using fans; use air conditioners.

❑ COLDS/FLU

- Keep your body healthy with enough exercise and sleep.
- Avoid close contact with people who have colds.
- Wash your hands frequently and avoid touching your hands to your face.
- Get an annual flu shot.

❑ WEATHER AND AIR POLLUTION

- If cold air is a problem, try breathing through your nose rather than your mouth and covering up with a scarf.
- Check for Spare the Air days and nights and avoid strenuous exercise at those times.
- On very bad pollution days, stay indoors with windows closed.

❑ EXERCISE

- Warm up before exercising.
- Plan alternate indoor activities on high pollen or pollution days.
- If directed by physician, take medication before exercise. (See Green Zone of Asthma Action Plan.)

Contra Costa County
Employment and Human Services Department
Community Services Bureau

Individualized Health Plan
Routine Care

Today's Date: ____ / ____ / _____ **Review No Later Than:** _____

Child Name: _____ **Birth Date:** _____

Parent(s) or Guardian(s): _____ **Phone #:** _____

Primary Health Plan Provider _____ **Phone #:** _____

Diagnosis: 1. _____ **2.** _____ **3.** _____

Regularly Scheduled Medications

Medication	Schedule (When)	Dose (How Much)	Duration (How Long)	Route (How)	Possible Side Effects

Accommodations the child needs in daily activities	Accommodations Needed At	
	Home	School
Diet or Feeding: _____	☐	☐
Classroom Activities: _____	☐	☐
Naptime / Sleeping: _____	☐	☐
Toileting: _____	☐	☐
Outdoor Activities / Field Trips: _____	☐	☐
Transportation: _____	☐	☐
Other: _____	☐	☐

Parent Signature: _____

Health Care Provider Signature/Stamp: _____

Contra Costa County
Community Services Department

Individualized Health Plan – Emergency Care

(To be completed by Medical Provider)

Child Name: _____ **Birth Date:** ____/____/____

Parent(s) or Guardian(s) _____ **Phone:** _____

Primary Health Care Provider: _____ **Phone:** _____

Diagnosis: 1. _____ **2.** _____ **3.** _____

Call Parents If: _____

_____

_____

Medication Indications:

Medication Name	Schedule (When/How Often)	Dose (How Much)	Duration (How Long)	Route (How)	Possible Side Effects

Call 911 (Emergency Medical Services) if:

_____

_____

While waiting for Parent(s) or Medical Help to Arrive: _____

_____

_____

I have helped develop this health plan. I understand it and will try my best to follow the plan. I will communicate any changes in the child's condition or treatment.

Plan Completed On: ____/____/____ **Plan to be Updated On or Before:** ____/____/____

Parent or Guardian Signature(s): _____

Head Start Staff Signature and Title: _____

Health Care Provider Signature/Stamp: _____

CONTRA COSTA COUNTY – COMMUNITY SERVICES BUREAU
MEDICAL STATEMENT TO REQUEST
SPECIAL MEALS AND/OR ACCOMMODATIONS

1. School / Agency Name	2. Site Name	3. Site Telephone Number
4. Name of Child or Adult Participant	5. CLOUDS #	6. Age or Date of Birth
7. Name of Parent or Guardian		8. Telephone Number

9. Description of Child or Participant's Physical or Mental Impairment Affected:

10. Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:

11. Indicate Food Texture for Above Child or Participant:

☐ **Regular** ☐ **Chopped** ☐ **Ground** ☐ **Pureed**

12. Foods to be Omitted and Appropriate Substitutions (please list specific foods to be omitted and suggested substitutions. You may attach a sheet with additional information as needed):

Foods To Be Omitted	Suggested Substitutions

13. Adaptive Equipment to be Used:

14. Signature of State Licensed Healthcare Professional*	15. Printed Name	16. Phone Number	17. Date

***For this purpose, a state licensed healthcare professional in California is a licensed physician, a physician assistant, or a nurse practitioner.**

18. To be completed by Parent/Guardian: I give my permission to Community Services Bureau to release and exchange the above information, and post it in the classroom to ensure my child's health and safety.

Parent/Guardian Signature: _____ **Date:** _____

The information on this form should be updated to reflect the current medical and/or nutritional needs of the participant.

INSTRUCTIONS

1. **School or Agency:** Print the name of the school or agency that is providing the form to the parent.

2. **Site:** Print the name of the site where meals will be served.

3. **Site Phone Number:** Print the phone number of site where meal will be served.

4. **Name of Child or Participant:** Print the name of the child or participant to whom the information pertains.

5. **CLOUDS ID #**: Print child's CLOUDS ID number.

6. **Age of Child or /Participant:** Print the age of the child or participant. For infants, please use date of birth.

7. **Name of Parent or Guardian:** Print the name of the person requesting the child or participant's medical statement.

8. **Phone Number:** Print the phone number of parent or guardian.

9. **Description of Child or Participant's Physical or Mental Impairment Affected:** Describe how the physical or mental impairment restricts the child or participant's diet.

10. **Explanation of Diet Prescription and/or Accommodation to Ensure Proper Implementation:** Describe a specific diet or accommodation that has been prescribed by the state healthcare professional.

11. **Indicate Texture:** If the child or participant does not need any modification, check "Regular".

12. **Foods to be Omitted:** List specific foods that must be omitted (e.g., exclude fluid milk).
    Suggested Substitutions: List specific foods to include in the diet (e.g., calcium-fortified juice).

13. **Adaptive Equipment to be Used:** Describe specific equipment required to assist the child or participant with dining (e.g., sippy cup, large handled spoon, wheel-chair accessible furniture, etc.).

14. **Signature of State Licensed Healthcare Professional:** Signature of state licensed healthcare professional requesting the special meal or accommodation.

15. **Printed Name:** Print name of state licensed healthcare professional.

16. **Phone Number:** Phone number of state licensed healthcare professional.

17. **Date:** Date state licensed healthcare professional signed form.

18. **Parent/Guardian Signature & Date:** Signature of Parent/Guardian and date parent/guardian signed form.

Citations are from Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act (ADA) of 1990, and ADA Amendment Act of 2008:

A person with a disability is defined as any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment.

Physical or mental impairment means (a) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory; speech; organs; cardiovascular; reproductive, digestive, genito-urinary; hemic and lymphatic; skin; and endocrine; or (b) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

Major bodily functions have been added to major life activities and include the functions of the immune system; normal cell growth; and digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

"Has a record of such an impairment" means a person has, or has been classified (or misclassified) as having, a history of mental or physical impairment that substantially limits one or more major life activities.

CONTRA COSTA HEALTH PLAN

A Division of Contra Costa Health Services

THIS PACKET CONTAINS AN OVERVIEW OF THE 3/23/2018 AD HOC MEETING OF THE CCHP PHARMACY & THERAPEUTICS COMMITTEE (DEDICATED TO PAIN MANAGEMENT)

Overview

CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

- On Friday 3/23/2018, an ad hoc meeting of the CCHP Pharmacy & Therapeutics committee was held, dedicated to pain management.
- >30 providers from the community & CCRMC attended the meeting and formulated a plan to address the opiate epidemic in Contra Costa County.
- Topics of major discussion included:
  - Background information on the opiate epidemic and CCHP data.
  - Individual presentations & discussions on each of the 3 major goals set by CCHP:
    1. Restricting opiate and benzodiazepine co-prescribing
    2. Placing quantity limits on immediate release opiates for new starts
    3. MME limitations and reporting metrics

AIM STATEMENT

By December 1, 2019 CCHP will improve the health of members by implementing measures that ensure that prescribed opiates are used for appropriate indications, at safe doses, and in conjunction with other treatment modalities as measured by a decrease in:

- **Total number of members on concurrent benzo/opiate**
- **Total number of opioid users on >120mg MME**
- **Total number of opioid users on >120mg MME on an escalating dose**
- **Duration of initial opioid prescriptions (PMPM)**

BACKGROUND INFORMATION

The Origins of the Epidemic

Historically
Chronic opioids reserved for patients with cancer or end-of-life pain

Mid to late 1980s
Shift to liberal use of opioids for chronic, non-cancer pain based on small studies

1990s-2003
Pain advocacy groups lobby state medical boards to change statues for more permissive use of opioids.
By 2003, only 5 states did not change statues.

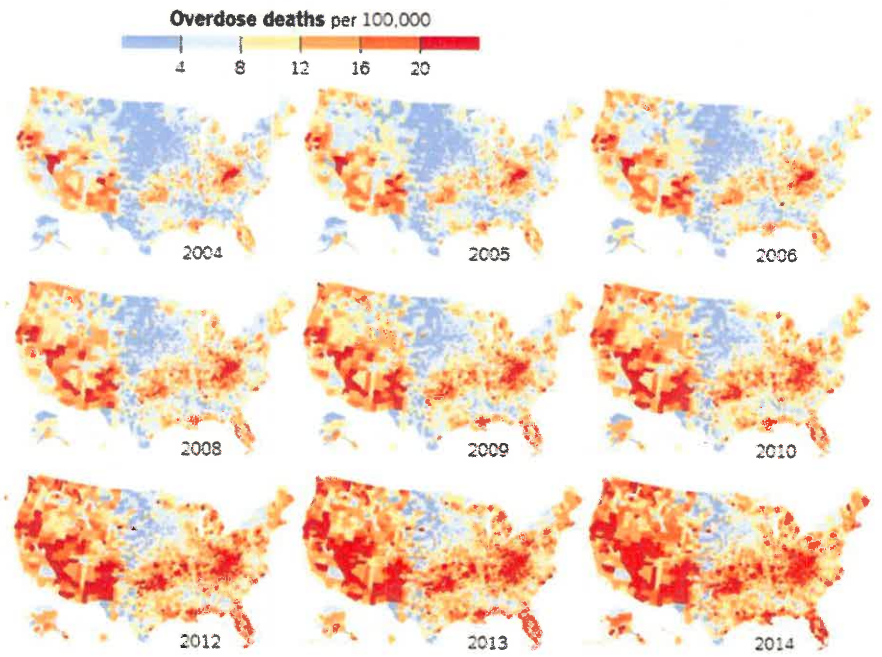
Joint Commission promotes increased opioid use inpatient and in ED
Numeric pain scale elevated to sole metric for evaluating "quality" pain care (Purdue sponsored guidelines from JC)

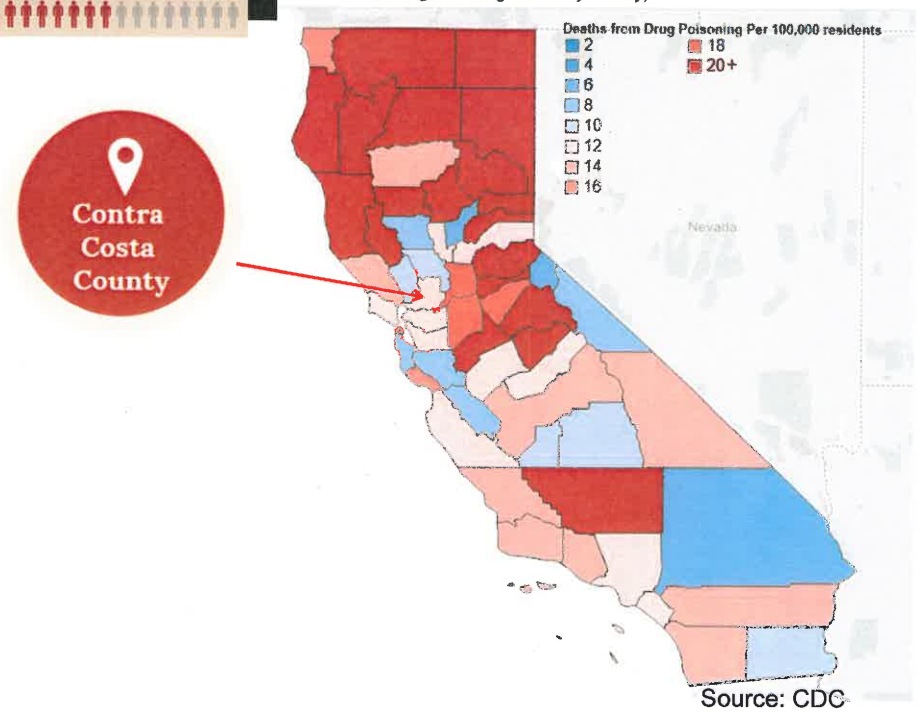
2004
OxyContin leading drug of abuse in US.
Due to aggressive OxyContin marketing.

2007
Washington pain experts develop 1st US opioid dosing guideline.
Developed in response to epidemic

2016
Obama and presidential candidates vow to fight the opioid epidemic.
Opioid overdose deaths gain attention

2016
CDC releases new pain guidelines





Opioid Related Deaths in Contra Costa County

Contra Costa County 2003 and 2013 Comparison			
	2003	2013	% Change
Deaths due to opioids	26	62	+138%
Nonfatal Hospital visits for opiate overdoses	110	174	+58%

Source: California Department of Public Health http://epicenter.cdph.ca.gov/ReportMenus/AlcoholDrugTable.aspx

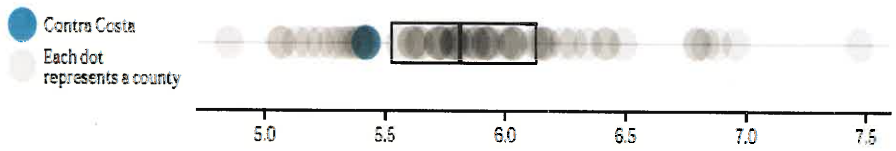
Contra Costa County 2014-2015 Coroner's Report	
Deaths due to prescription overdose	106
Deaths from single opioid overdose	32
Deaths from multiple opioid overdose	22
Total death due to opioid overdose	54
Deaths from illegal drugs used in combination with opioids	6

County Estimates of Opioid Use Disorder and Treatment Needs in California

California County Spotlight: Contra Costa County, February 19, 2018

- In 2016, an estimated 5.4 percent of people ages 12 and over (53,889 people) in Contra Costa had an opioid use disorder (OUD).
- The county had 50 opioid overdose deaths in 2016.
- Assuming 20% of people with OUD seek treatment, there are 4,639 to 7,675 people with OUD in the county without local access to opioid agonist treatment (i.e. buprenorphine or methadone). Since there are no regulatory barriers to naltrexone and counseling treatments, this snapshot focuses on agonists.

Percent of the Population 12 Years and Older with Opioid Use Disorder in California Counties, Highlighting Contra Costa[a]



Source: Urban Institute https://www.urban.org/sites/default/files/contra_costa.pdf

CCHP STATISTICS OF THE

OPIOID CRISIS

299 members
are on both an opioid and a benzodiazepine on a given day. Among them, 62 are also on a skeletal muscle relaxant.

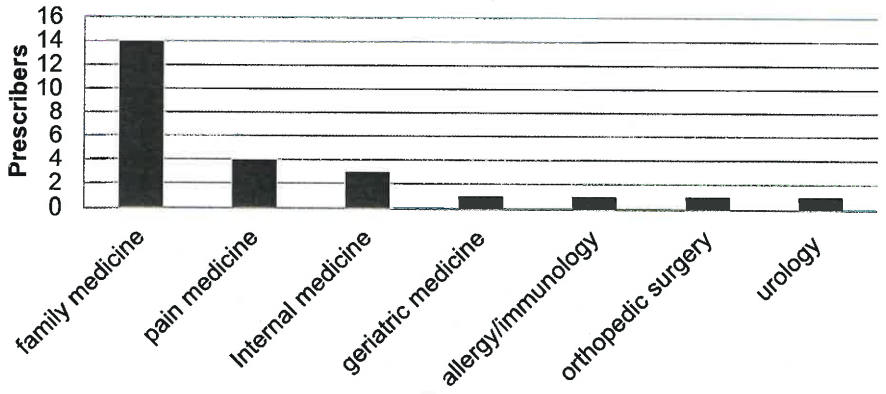
90 prescriptions
for controlled substances are prescribed **each month** by a single prescriber to 70 members.

4 physicians, 5 pharmacies
are seen by one patient to get 22 prescriptions for controlled substances in a quarter

23 prescriptions
for controlled substances are written for one individual over a 3 month period.

CCHP Prescriber Patterns

Top 25 Opiate Prescribers by Specialty



Include prescribers that write up to 75 prescriptions for opiates per month for up to 63 unique members.

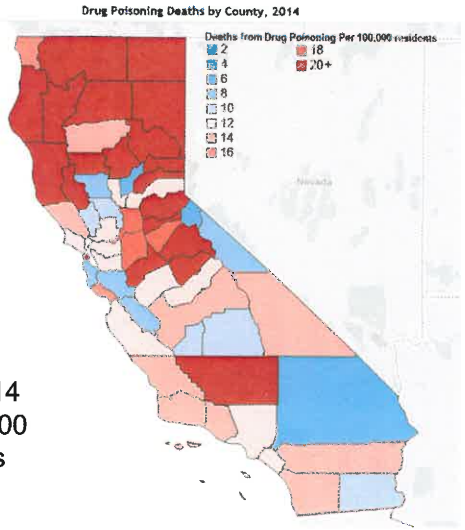
CCHP Prescriber Patterns

Prescribers ordering concurrent benzodiazepines and opioids

	RMC	CPN
■ Benzo+ Opioid	193	69
■ Benzo/opioid/muscle relaxant	19	22

RMC = regional medical center (CCRMC & CCC clinic providers)
CPN = community provider network (CCHP contracted community providers)

What have other successful healthplans done to tackle the opioid epidemic?



Partnership Health Plan comprised of 14 Northern California counties and 550,000 members represented the highest rates of opioid overdoses in the state

Partnership Health Plan Outcomes

- **In 2013, Partnership Health plan investigated internal and external opioid data and agreed drastic action was needed.**

- **Based on quality improvement practices and Southern Oregon Prescribing Guidelines, the Managing Pain Safely project launched in January 2014 with the following outcomes by December 2015:**
  - **48% reduction in total opiate fills per 100 members per month**
  - **43% reduction in total opioid users receiving >120mg MED**
  - **52% reduction in initial opiate fills per 100 members per month**

Partnership Health Plan: How they did it

Education

Content: Live CME, Webinars, Emails, Blogs, Project ECHO, toolkits

Audience: prescribers, internal Partnership staff, public, elected representatives

Formulary changes

Restrictions¥:
-High potency opioids placed non-formulary
- Quantities >120MED
-Justification required for high doses and escalations

Expanded Benefits:
-Podiatry, chiropractic, accupuncture, PT
-Alternatives to opioids added to formulary
-Incentivizing Buprenorphine providers

¥Claims based identification of members and providers for targeted interventions

Collaboration

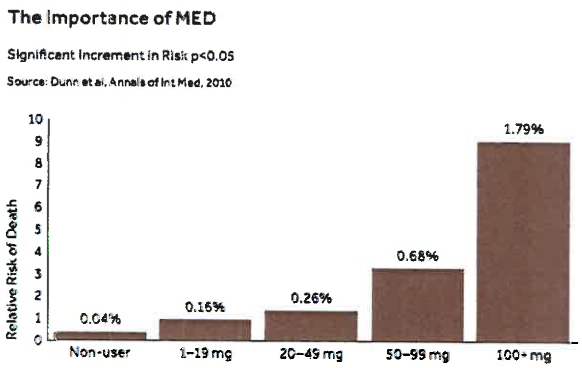
Locally:
Reached out to county coalitions to help disseminate information

Government:
Notified Medical Board, elected representatives and Department of Justice

Medically:
Integrated care teams and Rounds

Guideline Recommendations for Maximum doses

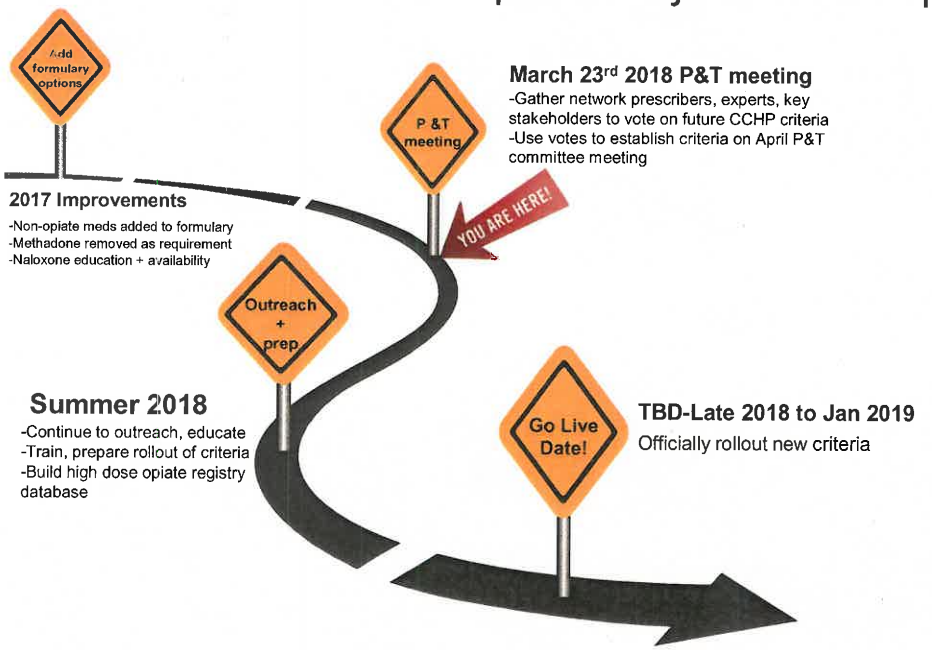
Guideline	Recommendation
CDC Opioid prescribing guidelines	Caution >50mg/day; avoid >90mg/day
American Pain Society	200mg/day MED requires monitoring
Canadian guidelines	200mg/day MED requires monitoring
Washington state	NTE >120mg/day MED without demonstration of functional improvement



CCHP ACTION PLAN

Alternative Therapies
Quantifiable Goals
Implementation Strategies
Proposed Criteria

CCHP Opiate Project Roadmap



Non-opioid Alternative Therapies

Formulary Changes

- **Currently available on formulary (no PA):**
  - Topical capsaicin
  - Topical lidocaine cream
  - Topical diclofenac gel
  - Duloxetine (Cymbalta)
  - Gabapentin
  - Multiple oral NSAIDs, anti-epileptics, corticosteroids, anti-depressants

Non Pharmaceutical Modalities

- Acupuncture
- Physical Therapy
- Chiropractic
- Cognitive Behavioral Therapy

Quantifiable Goals

- Reduce users on both opioids and benzos
- Reduce the duration of initial immediate release opioid prescriptions
- Reduce opioid users on >120 MED
  - Reduce opioid users (>120MED) on an escalating dose
  - Reduce the total opioid prescriptions (>120 MED) PMPM

Evidence for Proposed Criteria

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 65 / No. 1
March 18, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

- Proposed criteria is based on:
  - 2016 CDC guidelines for Prescribing Opioids for Chronic Pain
  - Medical Literature
  - Analysis of other successful healthplans such as Partnership, BCBSM, etc

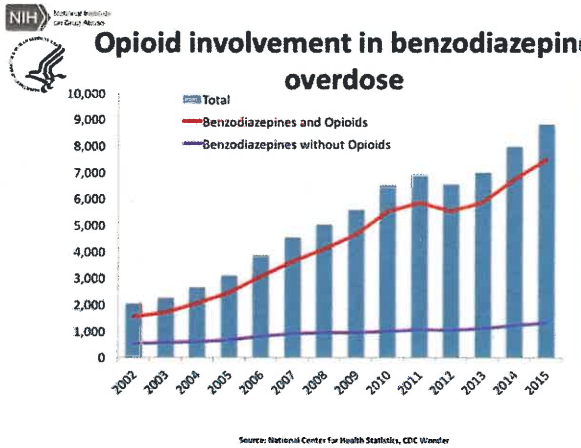
GOAL#1

Reduce users on both opioids and benzodiazepines

Proposed Criteria

- **Benzo-opioid report will identify prescribers to be notified**

Goal#1: Reduce users on both opioids and benzodiazepines



According to National Institute on Drug Abuse, ~8,000 deaths can be attributed to concurrent use of opioids and benzodiazepines in 2015

75% of deaths involving benzodiazepines also involve an opioid.[1]

Goal#1: Reduce users on both opioids and benzodiazepines

FDA Drug Safety Communication: FDA warns about serious risks and death when combining opioid pain or cough medicines with benzodiazepines; requires its strongest warning

- An FDA review found combined use of opioids and benzodiazepines resulted in difficulty breathing and deaths.
- FDA added *Boxed Warnings* (FDA strongest warning) to the drug labeling of prescription opioids and benzodiazepines.
- The FDA recommends health professionals avoid co-prescribing and if they are prescribed, to limit the doses and duration of each drug.
- 9-2017: Avoid combining benzodiazepines with medication-assisted treatment (buprenorphine, methadone). Providers should taper off benzodiazepines

Goal#1: Reduce users on both opioids and benzodiazepines

- Benzodiazepines should not be used chronically (i.e 1 month+) for the following reasons:
  - Benzodiazepines lose their efficacy when used chronically and are addictive
  - May worsen anxiety, insomnia with prolonged use
  - Accidental falls and injuries, especially in elderly cause increased hospital admissions
  - There are safer alternatives for anxiety and insomnia that can be used long term.

Goal#1: Reduce users on both opioids and benzodiazepines

- **What have other healthplans done to tackle co-prescribing of benzodiazepines and opioids?** Partnership healthplan has changed Alprazolam from formulary to non-formulary status.

Advantages	Disadvantages
• Easier to monitor • More difficult to prescribe benzodiazepines	• There are more benzodiazepines other than alprazolam. Making all benzodiazepines non-formulary would anger members, prescribers and increase workload for pharmacy dept. • Monitoring a taper plan would be labor-intensive. • Benzos are not very expensive, if denied, members are likely to pay out-of-pocket in cash.

Goal#1: Reduce users on both opioids and benzodiazepines

- Blue Cross Blue Shield of Michigan conducted DUR and notified providers

DUR
Report of all claims between a 6 mo time frame identified patients receiving concurrent opioids (>200MED)/benzos

Notification
Patients' prescription profiles faxed to prescribers and suggested to re-evaluate their prescribing

Results
-51% reduction in members co-prescribed. From 174 to 73 members.

-Among those who continued concurrent therapy, the **number of opioids prescribed fell** (2.26 down to 1.77, $p<0.001$)

- **CCHP** proposes a model similar to BCBSM.
  - A Tapestry report identifies co-prescribed opioids, benzodiazepines ± a muscle relaxant.
  - A letter alert providers

Goal #1: Reduce users on both opioids and benzodiazepines

Sample notification letter

Dear Dr,

Our records show that the following patients under your medical supervision are being prescribed both a benzodiazepine and an opioid prescription pain medication and that you have written for one or both of these prescriptions:

PATIENT NAME-TOTAL #RXs/MO

MEDICATIONS DOSE TABS (MME/DAY)

In summary, you have prescribed ___# patients __# of prescription(s) in the month of ____ 2018 that has resulted in their use of a dangerous combination of drugs and could lead to a potential overdose.

CCHP recommends that you contact your patient(s) and discuss reducing the opioid or the benzodiazepine to improving their safety.

Goal #1 P&T Outcomes

- **<u>CCHP will implement a model similar to BCBSM</u>:**
  - A Tapestry report will identify co-prescribed opioids, benzodiazepines ± Soma for ALL CCHP members & ALL CCHP providers.
  - A formal letter will be sent to providers on a monthly basis, clearly stating which of their CCHP patients is on this potentially deadly combination of drugs, and that the regimen should be re-considered immediately.
  - CCHP will monitor to monitor benzo/opiate co-prescriptions over time to evaluate the effectiveness of the reporting tool.

GOAL#2

Reduce duration of initial IR opiate prescriptions

Proposed Criteria

- Allow 7-day duration for immediate release opiates for acute non-cancer pain

Goal#2 :Reduce the duration of initial opioid prescriptions

- **CDC guidelines state: "when opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed."**
- **Aimed at significantly reducing the number of people newly dependent upon or addicted to opioids**

Goal#2: Reduce the duration of initial opioid prescriptions

- CDC MMWR Weekly Report Vol 66/No.10 March 17, 2017
  - Retrospective analysis of patients with an initial opioid prescription from 2006-2015
    - Researchers found that >1 week supply or a 2nd prescription approximately doubled the chances of opioid use 1 year later
    - Sharpest increases in chronic opioid use were observed after the fifth and thirty-first day of therapy, second prescription, 700 MME cumulative dose, and an initial 10 or 30 day supply

Goal#2: Reduce the duration of initial opioid prescriptions

- Published guidelines and literature support limitations on initial opioid prescription limitation
  - Interagency Guidelines on Prescribing Opioids for Pain-Washington State Agency Medical Directors' Group-June 2015
    - States that receiving a one week supply or 2 or more opioid prescriptions after an acute back sprain is associated with a doubling of the patient's risk for long-term disability
  - Guideline for Discharge Opioid Prescriptions after Inpatient General Surgical Procedures. Journal of the American College of Surgeons. 2017 Nov 8; pii: S1072-7515(17)32055-0
    - Concluded that 15 opioid pills satisfied the opioid needs of 88% of patients discharged on postoperative day 1

Goal#2: Reduce the duration of initial opioid prescriptions

- Over the past year, at least 9 states, many health plans, and several chain pharmacies have instituted voluntary initial opioid prescription limits
  - SFHP-7 day limit on initial opioid Rxs
  - New Jersey-state law prohibiting an initial Rx greater than **a 5 day supply** for treatment of acute pain
  - CVS Caremark plans limit dispensing to a 7 day supply for acute opioid prescriptions for patients who are new to therapy
  - Other examples of programs in place: FCHP, Anthem, Partnership Health Plan, Express Scripts

Goal #2 P&T Outcome:

- **CCHP will be implementing a formulary change that will limit all initial immediate release opioid prescriptions for acute pain treatment to a seven (7) day supply.**
  - Exceptions: patients with a paid claim for an opioid in the past 180 days (continuation of therapy), chronic pain patients, palliative care or hospice care patients, and cancer patients.

GOAL#3

Reduce opioid users on >120 MED

Proposed Criteria

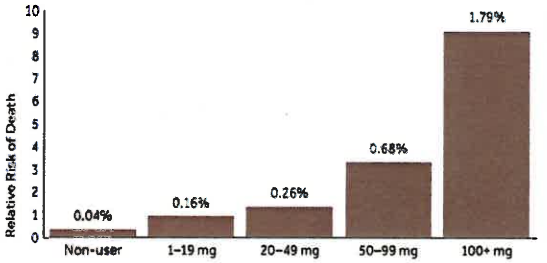
- **A quantity limit placed on all formulary extended release opioids for each single-dose strength, NTE 120 MED**
- **Creation of registry for all high-dose patients to track treatment plans. Requires an explanation for all stable, high-dose opioids and a "taper plan"**

Goal#3: Reduce opioid users on >120 MED

The Importance of MED

Significant Increment in Risk p<0.05

Source: Dunn et al. Annals of Int Med. 2010



Among 9,940 patients on 3+ opioids for chronic noncancer pain, 51 overdoses and 6 deaths occurred.

Risk assessment found that for those with 100+mg have 9x risk of overdose resulting in death over those <20mg MED.

Guideline	Recommendation
CDC Opioid prescribing guidelines	Caution >50mg/day; avoid >90mg/day
American Pain Society	200mg/day MED requires monitoring
Canadian guidelines	200mg/day MED requires monitoring
Washington state	NTE >120mg/day MED without demonstration of functional improvement

Goal#3: Reduce opioid users on >120 MED

CDC Recommendation: "Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day."(Recommendation category:A, evidence type:3)

If patients do not experience improvement in pain and function at ≥90 MME/day, or if there are escalating dosage requirements, clinicians should discuss other approaches to pain management with the patient, consider working with patients to taper opioids or to taper and discontinue opioids and consider consultation with a pain specialist.

Goal#3: Reduce opioid users on >120 MED

Modified approval message for continuation of therapy of >120MED stable dose:

"This request has been approved for a total of 3 months. National pain experts recommend that opioid doses should not be increased beyond a maximum daily dose of 120mg Morphine Equivalent Per Day (MED) for chronic non-cancer pain, since doses greater than 120mg do not provide more effective long-term analgesia. Risks outweigh benefits at doses >120mg Morphine Equivalent Per Day. These risks include tolerance, a multitude of opioid side effects and a higher risk of fatal overdose.

Contra Costa Health Plan strongly advises this patient be placed on a plan to gradually taper his/her narcotic dose down to a level less than 120 mg MED. A plan for tapering this patient's opioid has not been provided. Please provide a plan for tapering and/or an explanation with clinical documentation and rationale for continued high dose opioid prescription within the next 3 months. Please note, approval for continuation of therapy beyond 3 months is contingent upon submission of a plan for tapering and/or medical justification for continued high dose opioid treatment."

Goal#3: Reduce opioid users on >120 MED

Palliative Care

Appropriate medical justifications for continued therapy:

- Patient in palliative care or cancer therapy
- Diagnosis of substance abuse disorder being supervised by MD
- Opioid use monitored by pain specialist
- Plan to taper the opioid or concurrent benzodiazepine

Creation of a chronic pain registry:

- Tapestry report #4074 has been created by CCHP to calculate total MMEs for all CCHP members and link reports to PCP as well as the actual prescriber of each contributing medication:

- TAP4074 (DRAFT) report query tool:

Start Date	2/13/2018	End Date	3/14/2018
Minimum MME per Claim	0	Maximum MME per Claim	100000
Minimum MME Total per Member	0	Maximum MME Total per Member	100000
Enter PCP NPIs (or "ALL for all providers)	"ALL	Remove Page Header for export to Excel ?	No
Show Data Dictionary on Last Page?	No	When ready, press "View Report"	

Creation of a chronic pain registry:

- TAP4074 sample report:
  - This report would be used by CCHP clinical pharmacist staff to establish a registry of all CCHP members on chronic high dose opiates.

CONTRA COSTA BUSINESS INTELLIGENCE

Opiate Utilization Estimated MME (TAP4074) DRAFT

This report shows CCHP member pharmacy claims **for Service Dates 2/13/2018 through 3/14/2018**
Note: See data dictionary for definitions of Opioid claims and MME Multipliers
PCP NPI : **123456789**
Total # of Members : 2

Member + DOB + MRN	Total MME	Claim MME	Rx Date	Drug Name	Qty	Days	Claim #	Product Type	Network	Prescriber	PCP as of Rx Date
PATIENT EXAMPLE #1 1/2/1985 (123456789)	546	96	2/13/18	HYDROMORPHONE 8 MG TABLET	90	30	384443528821	Medicaid	RMC	PRESCRIBER NAME	PCP NAME
		450	3/1/18	METHADONE HCL 5 MG TABLET	189	21	184609363352	Medicaid	RMC	PRESCRIBER NAME	PCP NAME
		96	3/8/18	HYDROMORPHONE 8 MG TABLET	90	30	184670392841	Medicaid	RMC	PRESCRIBER NAME	PCP NAME
PATIENT EXAMPLE #2 2/3/1945 (789456123)	152	60	3/5/18	HYDROCODONE-ACETAMIN 10-325 MG	180	30	384643832331	SPD	RMC	PRESCRIBER NAME	PCP NAME
		32	3/5/18	HYDROMORPHONE 4 MG TABLET	60	30	384645484151	SPD	RMC	PRESCRIBER NAME	PCP NAME
		60	3/5/18	MORPHINE SULF ER 30 MG TABLET	60	30	384643832901	SPD	RMC	PRESCRIBER NAME	PCP NAME

Goal #3 P&T Outcome

- **CCHP will implement the following:**
  - Placing quantity limits on all formulary opioids for each single-dose strength to a maximum of 120 MME.
    - What does this mean? Single tablet doses that exceed, or that would exceed 120mg MME in typical dosing will be removed from the CCHP formulary completely:

Extended release morphine sulfate 100mg	Methadone 40mg
Extended release morphine sulfate 200mg	Extended release oxycodone 60mg
Extended release hydromorphone 32mg	Extended release oxycodone 80mg

  - Creation of registry (managed by CCHP clinical pharmacist staff) for all high-dose opiate patients to track treatment plans. Requires an explanation for all stable, high-dose opioids and a taper plan.

GOAL#3

Reduce opioid users on >120 MED, targeting dose escalation

Proposed Criteria

- **Denials for escalating doses (>120 MED) without medical justification**
- **Only 3 months of opioids are approved under any authorization**
- **For continuation of therapy, pain must be re-evaluated with a plan to either taper OR an explanation for continuation**

Goal#3: Reduce opioid users on >120 MED

- Denial message when requested dose results in dose escalation to MED>120

This request is denied because you do not meet **Contra Costa Health Plan Pharmacy PA Criteria** as follows:

The requested drug is denied because documentation submitted did not support medical necessity for dose escalation. National experts in pain management recommend a maximum daily dose of 120mg Morphine Equivalent Per Day (MED) for chronic non-cancer pain, since doses above 120mg do not provide more effective long-term analgesia. Additionally, it can lead to more problems, including tolerance, greater risk of long-term side effects including accidental overdose. The patient is currently on: **(insert morphine equivalent dose here.)**

Goal#3: Reduce opioid users on >120 MED

Why are approvals only for 3 months?

CDC recommendation

"Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids" (recommendation category A, evidence type 4)

Goal #3 P&T Outcome

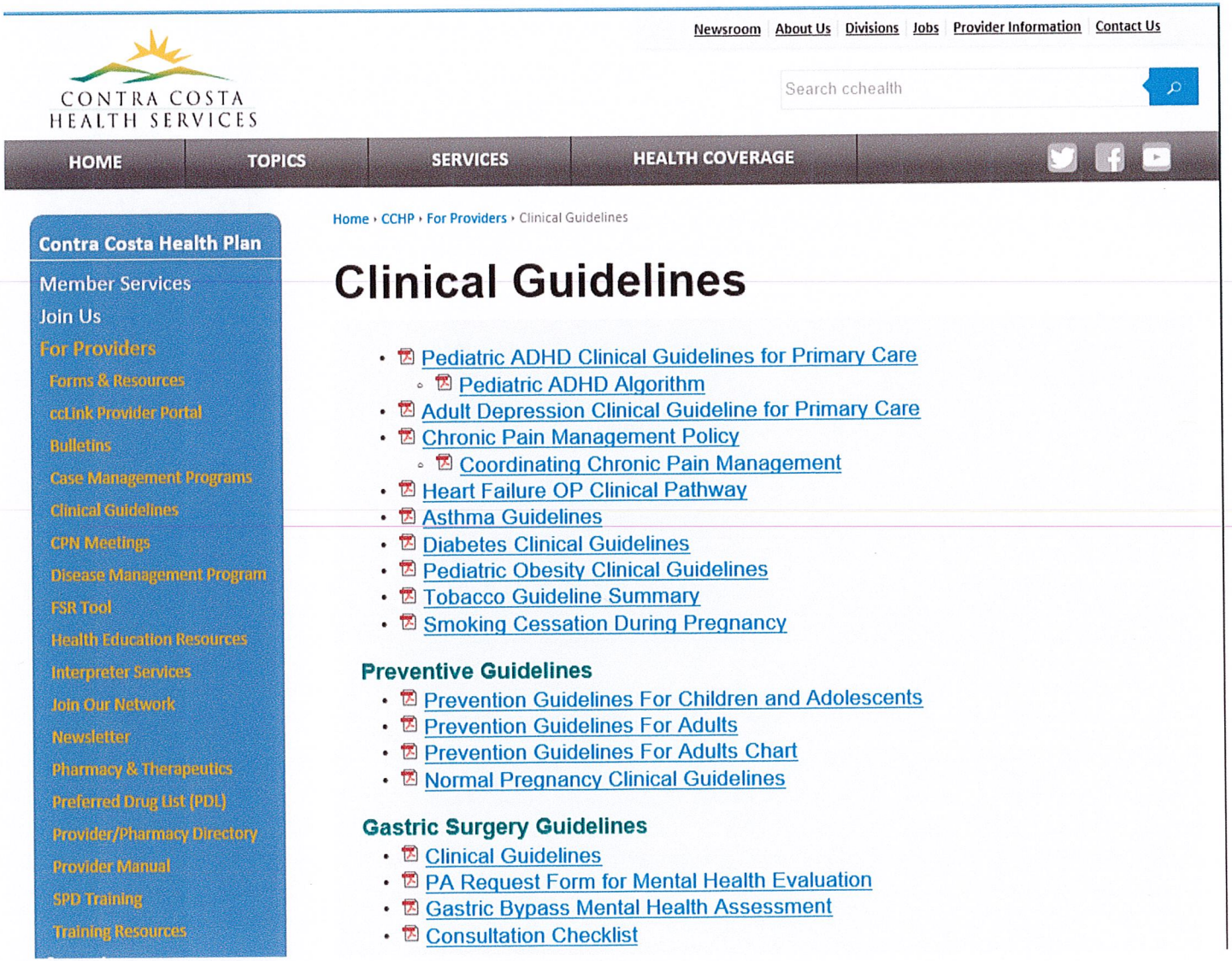
- **CCHP will implement the following:**
  - Prior authorization requests for escalating doses (>120 MED) without valid medical justification will be denied.
- **CCHP will implement the following procedural changes:**
  - No more than 3 months of opioids are approved under any authorization request.
  - For continuation of therapy (even at a stable, unchanged dose), pain must be re-evaluated with a plan to either taper OR an explanation for continuation.

Conclusions & next steps:

- CCHP will begin implementation of an opiate program with the following goals:
  - Decrease the # of CCHP members on concurrent benzo/opiate
  - Decrease the # of CCHP members on opioid doses >120mg MME
  - Decrease the # of CCHP members on opioid doses >120mg MME on an escalating dose
  - Decrease the duration of initial opioid prescriptions (PMPM)
- What does the timeline look like for implementation?
  - Claims processing coding changes will take a number of months to implement. Expect changes to begin to roll out in approximately 90 days.

Conclusions & next steps:

- Many of your colleagues may have questions about CCHP's opiate program – **PLEASE SHARE THIS INFORMATION WITH THEM** and contact CCHP with any questions.
- CCHP clinical pharmacist services are available for in-office education events – contact us to schedule!
- **Questions??**



http://cchealth.org/healthplan/clinical-guidelines.php

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HEALTH ADVISORY UPDATE
MARCH 16, 2018
ZIKA VIRUS

SUMMARY:
Zika virus infection during pregnancy continues to be of great concern due to the potential for Zika associated birth defects. But because of the declining incidence of new Zika virus infections in California, the California Department of Public Health (CDPH) has issued new guidelines for the management of pregnant women with possible Zika virus exposure. The declining rate of Zika virus infections, coupled with the inherent limitations of Zika virus testing, has lowered the pre-test probability of infection, further complicating test interpretation. Please see CDPH's "Updated Guidance for Health Care Providers Caring for Pregnant Women with Possible Zika Virus Exposure" for details and rationale. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/ZikaInformationforHealthProfessionals.aspx

UPDATE:
Zika virus testing by detection of viral RNA by PCR (nucleic acid testing, NAT) or serology (IgM antibody testing) is now widely available in commercial clinical laboratories throughout California. Please submit your specimens to commercial laboratories for processing using your regular clinical testing protocol. When needed, local public health laboratories and CDPH will conduct confirmatory Zika virus testing (plaque reduction neutralization testing, PRNT), which is not a commercially available test.

Actions Requested of Healthcare Professionals:

1. **Advise** pregnant patients ***not*** to travel to areas with Zika virus transmission. For non-pregnant patients and pregnant patients who cannot avoid travel, educate on how to avoid mosquito bites and potential sexual transmission. Refer travelers to CDC Travel Advisories for current information about Zika virus and prevention: http://wwwnc.cdc.gov/travel/notices
2. **Assess all pregnant women for possible Zika virus exposure** at each prenatal care visit. The following topics should be reviewed: 1) recent travel or residence in an area with active Zika transmission, and 2) unprotected sex (vaginal, anal or oral sex, or sharing of sex toys without using a barrier method) with a partner who has traveled to or lived in an area with active Zika transmission.
3. **Suspect Zika** (also consider Dengue and Chikungunya) in travelers with acute onset of fever, rash, arthralgia, myalgia or conjunctivitis within 2 weeks after: 1) return from an area with local Zika transmission or 2) unprotected sex with a partner who has traveled to or lives in an area with known Zika transmission.
4. **Report** non-negative (positive or indeterminate) cases of Zika virus infection and possible congenital exposure to Contra Costa Public Health by faxing the 'Zika Case History Form' (http://cchealth.org/cd/pdf/Zika-Case-History-Form.pdf) to 925-313-6465.
5. **Test** patients by sending appropriate specimens to your contracted clinical commercial laboratory. See below for details about testing and specimen collection.

WHO TO TEST:

TESTING BY EXPOSURE GROUPS

- **Pregnant women with symptoms of Zika virus disease (acute onset of fever, rash, arthralgia, or conjunctivitis).**
  - Testing should be done as soon as possible.
- **Asymptomatic pregnant women with ongoing possible Zika virus exposure**
  - Zika IgM antibody and PCR testing may be considered after pre-test counseling and individualized risk assessment for those with an appropriate exposure history (e.g., exposure limited to current pregnancy), but is not routinely recommended.
- **Asymptomatic pregnant women with recent but without ongoing exposure**
  - May not be routinely tested but instead should be assessed carefully for factors that increase the likelihood of Zika infection.
  - A patient's risk tolerance and decision-making regarding pregnancy may be sufficient justification to test for Zika virus infection.
- **Pregnant women who have recent possible Zika virus exposure and who have a fetus with prenatal ultrasound findings consistent with congenital Zika virus syndrome**
  - Should receive Zika virus testing to assist in establishing the etiology of the birth defects.
- **Infants/Neonates** with:
  - Exposure occurring at any time during mother's pregnancy,
  - Born to a mother with a positive or inconclusive laboratory result,
  - Possible congenital Zika virus infection (microcephaly at birth, intracranial calcifications detected prenatally or at birth, or other brain or eye abnormalities consistent with Zika virus infection or symptoms consistent with acute Zika virus infection within 2 weeks of birth).
- **Symptomatic non-pregnant travelers or sexual partners of travelers with possible Zika virus exposure**
  - Not high priority unless attempting pregnancy or sexual partner is pregnant or trying to become pregnant.

EXPOSURE IS DEFINED AS:

- Recent travel to an area with risk of Zika virus*
- Resident of an area with risk of Zika virus*
- Recent unprotected sexual contact with
  - a male who has traveled in the past 6 months to an area with risk of Zika virus
  - a female who has traveled in the past 8 weeks to an area with risk of Zika virus

* Map of Areas with Zika: (https://wwwnc.cdc.gov/travel/page/world-map-areas-with-zika)

How to Test for Zika Virus in Adults

	Pregnancy Status[1]	**Zika Virus RNA** [i.e. PCR, NAT, or NAA] (Serum & Urine)	**Zika Virus Antibody, IgM** (Serum)
Symptomatic (onset ≤12 weeks)	Pregnant	✓	✓
	Non-Pregnant	✓	✓
Asymptomatic*	Pregnant without Ongoing Exposure (not routinely tested – see text)	✓ (exposure ≤ 12 weeks ago)	✓
	Pregnant with Ongoing Exposure	✓	✓ (once a trimester)
	Pregnant with Abnormal Ultrasound Findings Suspicious for Zika Infection	✓	✓

* Prolonged IgM persistence may make it challenging to determine whether the infection occurred during the current pregnancy or prior to the current pregnancy.

How to Test for Zika Virus in Infants/ Neonates[2] (ideally, samples should be collected within 2 days of life)

	Status at Birth	**Zika Virus RNA** [i.e. PCR, NAT, NAA] (Serum & Urine)	**Zika Virus Antibody, IgM** (Serum)
Babies of Mothers Infected with Zika	Non-negative mother (positive or indeterminate for Zika)	✓	✓
Babies with Congenital Zika Infection	Abnormal findings consistent with Zika infection at Birth	✓	✓
	Zika Symptoms within 2 weeks of birth	✓ (consider testing CSF)	✓

[1] Update: Interim Guidance for Health Care Providers Caring for Pregnant Women with Possible Zika Virus Exposure — United States Including U.S. Territories. (MMWR, July 2017) (https://www.cdc.gov/mmwr/volumes/66/wr/mm6629e1.htm?s_cid=mm6629e1_w)

[2] Update: Interim Guidance for the Diagnosis, Evaluation, and Management of Infants with Possible Congenital Zika Virus Infection — United States, October 2017 (MMWR, October 2017) https://www.cdc.gov/mmwr/volumes/66/wr/mm6641a1.htm

TREATMENT

- There is no specific treatment for Zika infection; clinical guidance is to provide supportive care including rest, fluids, and use of analgesics and antipyretics (after Dengue has been ruled out).

PREVENTION

- Pregnant women ***should not*** travel to any area where Zika virus is spreading.
- Preventing mosquito bites is the main control measure to avoid becoming infected**.**
- Persons with Zika virus exposure can pass the infection to sex partners. A correctly used barrier method (condoms or dental dams) can reduce the risk of Zika transmission.
- Counsel patients about pregnancy planning and the timing of pregnancy after possible exposure to Zika virus.
    - Pregnant couples in which one or both partners have traveled to or live an area with Zika should **use a condom (or other barriers to prevent infection) every time** they have sex, should not share sex toys and/or should not have sex during the pregnancy.
    - Couples interested in conceiving should wait to get pregnant.
        - Women, regardless of symptom status, should wait **at least 8 weeks** from symptom onset (if symptomatic) or last possible exposure (if asymptomatic) to attempt conception.
        - Men, regardless of symptom status, wait **at least 6 months** from symptom onset (if symptomatic) or last possible exposure (if asymptomatic) before attempting conception with their partner. Zika virus can be detected in semen for a longer period of time than in blood.

RESOURCES:

- Zika Travel Information: (https://wwwnc.cdc.gov/travel/page/zika-travel-information)
- Practice Advisory: Zika Prevention Strategies and Clinical Management of Pregnant Women (American College of Obstetricians and Gynecologists [ACOG] and the Society for Maternal-Fetal Medicine [SMFM]) (https://www.acog.org/About-ACOG/ACOG-Departments/Zika-Virus)
- Update: Interim Guidance for Preconception Counseling and Prevention of Sexual Transmission of Zika Virus for Persons with Possible Zika Virus Exposure — United States (MMWR, September 2016) (http://www.cdc.gov/mmwr/volumes/65/wr/mm6539e1.htm)
- CDC Guidance For Healthcare Providers, Zika in Infants and Children, Evaluation and Testing (https://www.cdc.gov/pregnancy/zika/testing-follow-up/evaluation-testing.html)
- Interim Guidance for Interpretation of Zika Virus Antibody Test Results (MMWR, May 2016) (http://www.cdc.gov/mmwr/volumes/65/wr/mm6521e1.htm)
- CDC Roadmap for Babies of Mothers Infected with Zika During Pregnancy who Appear Healthy (https://www.cdc.gov/zika/pdfs/roadmap-for-parents-babies-infected-before-birth.pdf)
- CDC Roadmap for Babies with Congenital Zika Infection (https://www.cdc.gov/zika/pdfs/roadmap-for-parents.pdf)

Department of Health Care Services
SB 1004 Medi-Cal Palliative Care Policy
November 2017 – Update

This document provides an update on the Department of Health Care Services (DHCS) Medi-Cal palliative care policy as authorized by SB 1004 (Hernandez, Chapter 574, Statutes of 2014). This November 2017 version reflects minor updates, and is consistent with DHCS All Plan Letter 17-015, published October 19, 2017[1].

The DHCS Medi-Cal palliative care policy is applicable to both managed care and fee-for-service delivery systems. Due to the specific focus of SB 1004, this document is oriented toward Medi-Cal only beneficiaries enrolled in Medi-Cal managed care plans (MCPs). Further guidance will be provided for Medi-Cal only fee-for-service beneficiaries not enrolled in MCPs.

Section 1: SB 1004 Medi-Cal Palliative Care, and Overall Context

The Centers for Medicare and Medicaid Services (CMS) defines palliative care as: "patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice." Many physicians and practitioners note that palliative care is an overall approach to the practice of medicine that is broader than end-of-life care, and is for "any age and any stage" of illness.

For purposes of SB 1004 guidance, DHCS proposes a Medi-Cal palliative care policy that is guided by the CMS definition of palliative care and the substantial body of research on palliative care programs, and with specific definitions of eligible conditions, services, and providers. The purpose of defining Medi-Cal palliative care more narrowly for a specific set of conditions is to meet the specific requirements of SB 1004, and to recognize that long-term success in implementing a new program to improve end of life care for Medi-Cal beneficiaries is more likely to be achieved through an incremental approach.

At the same time, a number of Medi-Cal managed care health plans (MCPs), hospitals and health systems, and other providers are already incorporating broader palliative care principles and strategies into their models of care. DHCS encourages those strategies to improve patient satisfaction and outcomes for Medi-Cal beneficiaries at all stages of life and illness, and to help meet the goals of Let's Get Healthy California and the DHCS Quality Strategy.

Early Palliative Care

At initial diagnosis of serious illness, early palliative care may accompany disease modifying care (curative care or restorative intent). Early palliative care is often advance care planning and can include palliative care consultation or pain and symptom management as needed, but may not reflect the full array of services listed below for SB 1004 palliative care. Research indicates patients and families have higher satisfaction and alignment of care with treatment wishes when advance care planning conversations occur earlier in the disease process. For example, a patient with a recent diagnosis of Stage II cancer, who is proceeding with initial chemotherapy, does not have related emergency department visits or inpatient stays, and whose condition is stable, should be offered early palliative care, but may not be eligible for SB 1004 palliative care.

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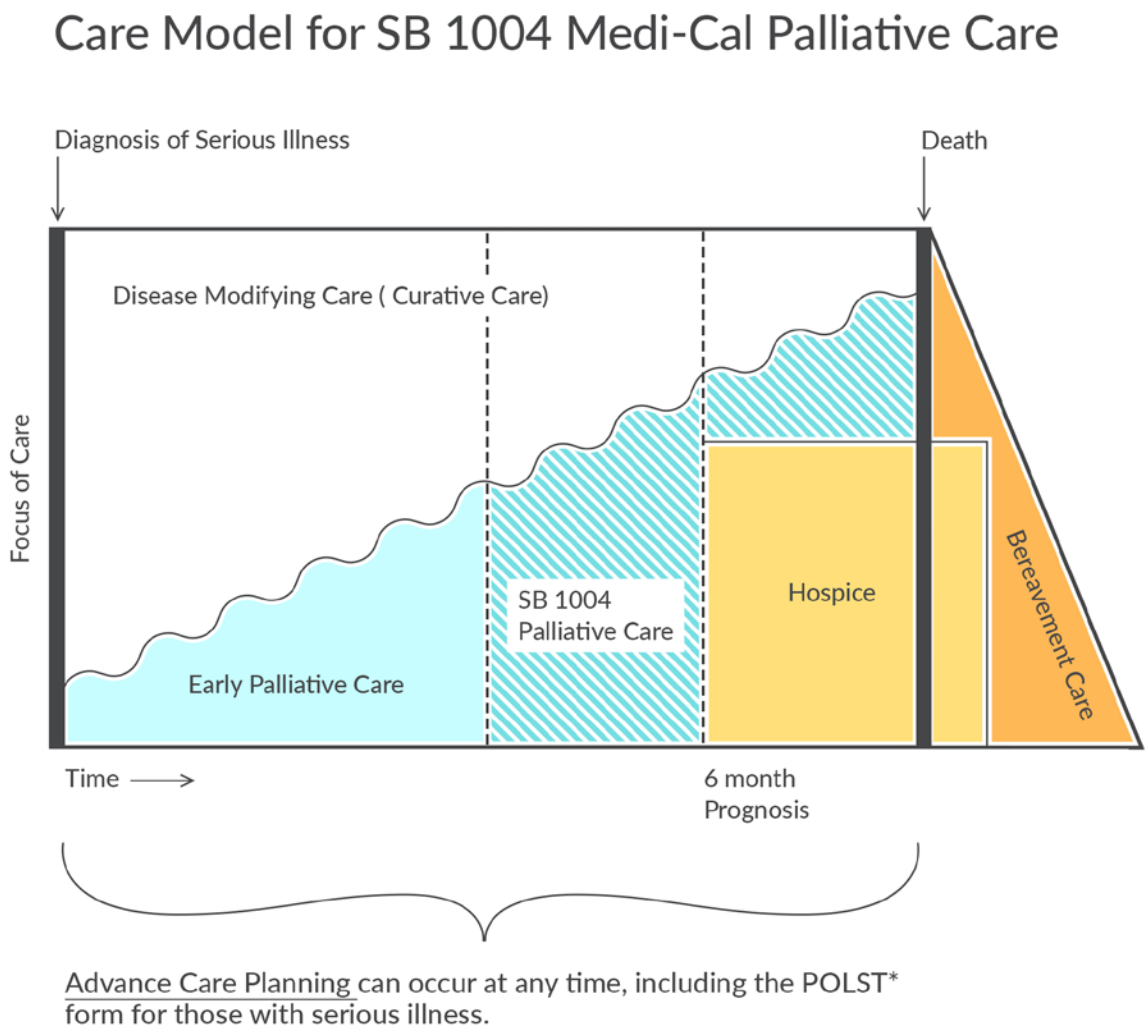
[1] APL 17-015 can be found at:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-015.pdf

Hospice Care

Note that hospice care also serves seriously ill patients, but is distinct from SB 1004 Medi-Cal palliative care. Hospice care is a Medi-Cal benefit that is available to both managed care and fee-for-service beneficiaries who have a medical prognosis of six months or less to live, and is provided in lieu of curative treatment for the terminal condition. Palliative care may be provided concurrently with curative care while hospice care may not, and palliative care is not limited to beneficiaries with a medical prognosis for life expectancy of six months or less. Further information about hospice care in Medi-Cal can be found in the DHCS All-Plan Letter 13-014 for managed care, and in Title 22 of the California Code of Regulations, Section 51349.

Figure 1



* Patients with serious illness can complete a Physicians Authorization for Life-Sustaining Treatment (POLST) form with their provider. The POLST is a statewide standard form for seriously ill patients to indicate to medical personnel whether the patient desires or declines resuscitation, intubation, feeding tubes and other interventions.

Figure 1 above provides an overview of the care model for SB 1004 Medi-Cal palliative care. The design is adapted from the National Consensus Project for Quality Palliative Care.

At initial diagnosis of serious illness, early palliative care may accompany disease modifying care (curative care or restorative intent). Early palliative care is often advance care planning and/or palliative care consultation, and can include pain and symptom management as needed. The wavy line indicates that the proportion of palliative care varies based on individual patient choices and needs. As the patient's illness progresses, those with serious illness who meet specific clinical eligibility criteria can enroll in SB 1004 palliative care programs and also continue to access disease modifying care. As the patient's illness progresses further, those who meet hospice eligibility criteria can disenroll from SB 1004 palliative care, and enroll in hospice to receive additional comfort care and forego further disease modifying care. Note that specific services for individual patients are based on medical necessity, and this figure is for general descriptive purposes only. Also, additional options are available for children.

Case Example: Provision of Palliative Care and Hospice through the Course of Illness[2]

Primary/Early Palliative Care

Patient A is a 55 year-old woman diagnosed with stage IIA breast cancer, who is being evaluated in oncology clinic for initial treatment with chemotherapy and hormone therapy. She has been working for several years, is a single mother of three adult children, including one about to enter college. She reports feeling stress and anxiety in juggling work, treatment, and support for her child entering college.

- Considerations for early palliative care:
  - Psychosocial and spiritual support in coping with the diagnosis
  - Practical assistance with paperwork for Family Medical Leave Act, disability, etc.
  - Education and support for family members
  - Symptom management during treatment
  - Introduction of advance care planning and identification of surrogate decision-maker

SB 1004 Palliative Care

Patient A underwent mastectomy, four cycles of chemotherapy and hormone therapy, and seemed to have no evidence of disease progression. She returned to work and had resumed her normal activities, with some modifications, for 18 months; however, she has recently become more fatigued and has had to take days off of work to rest. She returned to see her primary care doctor for progressive back pain, which she attributed to strain while moving furniture; unfortunately, x-rays of her spine showed a lesion suspicious for a metastasis, as well as lung nodules. Patient was diagnosed with advanced cancer and referred back to her oncologist for follow-up, who presents options of palliative radiation and chemotherapy to potentially extend and improve the quality of her life.

[2] Example developed by Anne Kinderman, MD, Director of the Supportive & Palliative Care Service Program at Zuckerberg San Francisco General and Associate Professor of Medicine at the University of California San Francisco.

- Considerations for palliative care
  - Psychosocial and spiritual support in coping with disease progression
  - Practical assistance with applying for disability and counseling regarding financial planning, insurance issues
  - Education and support for family members
  - Discussion of benefits/burdens of treatment options and goals of care
  - Symptom management during treatment
  - Focused advance care planning and designation of durable power of attorney for healthcare, if not already done

Hospice Care

Patient A chose to undergo both palliative radiation and chemotherapy for her stage IV breast cancer, and experienced some relief from her back pain. Unfortunately, she had difficulty tolerating the chemotherapy regimen, due to fatigue and nausea. Nevertheless, she completed an additional four cycles of chemotherapy in the hopes that this would provide her with more time with her family. Unfortunately, on follow-up CT scans, the metastatic disease in her lungs had continued to progress, in spite of treatment. Patient A's palliative care and oncology providers discuss this bad news with her, and inform her of options to try third line chemotherapy, or enroll in hospice. Based on the difficulty she had tolerating the second line chemotherapy, she decided to enroll in hospice care at home.

- Considerations for hospice:
  - Psychosocial and spiritual support in coping with end of life
  - Practical assistance with caregiving services, health aides, meal services, etc.
  - Counseling regarding financial planning, insurance issues
  - Education and support for family members
  - Transition to inpatient hospice or skilled nursing facility if needed
  - Symptom management through disease progression and end of life
  - Focused advance care planning and designation of durable power of attorney for healthcare, if not already done
  - Completion of POLST form

Palliative Care Options for Children

Additional options for children include the Section 1915(c) Home and Community Based Services waiver known as Partners for Children (PFC), to provide hospice-like services in addition to Medi-Cal State Plan services for seriously-ill children. Also, Section 2302 of the Patient Protection and Affordable Care Act (ACA) provides authority for hospice care concurrently with curative care for beneficiaries under age 21. Information regarding the concurrent care policy for children is available in DHCS All Plan Letter 13-014, California Children's Services Numbered Letter 06-1011, and Managed Care Policy Letter 11-004. Concurrent care for children is a statewide benefit, and PFC waiver enrollment is available in several counties in the state.

DHCS policy for SB 1004 is without regard to age, so beneficiaries under age 21 may be eligible for SB 1004 palliative care services if they meet the general and disease-specific eligibility criteria. However, both concurrent care under Section 2302 of the ACA and the PFC waiver provide additional services and broader eligibility criteria for children than SB 1004.

Section 2: Eligible Conditions

Eligible conditions for SB 1004 Medi-Cal palliative care include Cancer, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), or Liver Disease. Based on the significant body of national research on palliative care, and the results of existing palliative care programs, these four conditions are most promising for improved patient satisfaction and health outcomes, and permit cost-effective implementation.

Based on feedback from a panel of palliative care experts, beneficiary eligibility for SB 1004 Medi-Cal palliative care should be determined through a clinical review consisting of general eligibility criteria and disease-specific criteria.[3] Beneficiaries would need to meet all items in the general eligibility criteria in subsection A and at least one of the four disease-specific criteria in subsection B below.

A. **General Eligibility Criteria:**

1. The beneficiary is likely to or has started to use the hospital or emergency department as a means to manage his/her advanced disease. This refers to unanticipated decompensation and does not include elective procedures.
2. The beneficiary has an advanced illness, as defined in section B below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment.
3. The beneficiary's death within a year would not be unexpected based on clinical status.
4. The beneficiary has either received appropriate patient-desired medical therapy or is a beneficiary for whom patient-desired medical therapy is no longer effective.[4] Patient is not in reversible acute decompensation.
5. The beneficiary and, if applicable, the family/patient-designated support person, agrees to:
    a. Attempt, as medically/clinically appropriate, in-home, residential-based, or

[3] The SB 1004 palliative care criteria are based on the Sharp HealthCare Transitions Guidelines for Advanced Illness Management, developed by Daniel R. Hoefer, MD, Chief Medical Officer of Outpatient Palliative Care and Hospice for Sharp HealthCare, and guidelines for the Partnership Health Plan Partners in Palliative Care Program developed by Robert Moore, MD, Chief Medical Officer.

[4] This language is intended to distinguish between patients undergoing well-tolerated and effective treatment (early palliative care) and patients for whom treatment is not effective or well-tolerated (SB 1004 palliative care). Examples of this situation cited by the Advanced Illness Management (AIM) palliative care model include: ineffective chemotherapy or radiation for cancer; refractory fluid overload for CHF; severe or frequent exacerbations of COPD. Note that in lieu of "appropriate patient-desired medical therapy," the Sharp Transitions Guidelines indicate that "patients should have received maximum medical therapy," according to the Medicare definition of maximum medical therapy, which includes any of the following: "1) No further traditional therapy is available, 2) Patient is intolerant to further therapy, 3) Patient declines further therapy, 4) Patient repeatedly decompensates due to severe non-compliance." This criteria is also permissible under SB 1004.

outpatient disease management/palliative care instead of first going to the emergency department; and

b. Participate in Advance Care Planning discussions.

B. **Disease-Specific Eligibility Criteria**

1. Congestive Heart Failure (CHF): Must meet (a) and (b)
   a. The beneficiary is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned or meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher;[5] and
   b. The beneficiary has an Ejection Fraction of less than 30 percent for systolic failure or significant co-morbidities.

2. Chronic Obstructive Pulmonary Disease (COPD): Must meet (a) or (b)
   a. The beneficiary has a Forced Expiratory Volume (FEV)1 less than 35 percent of predicted and a 24-hour oxygen requirement of less than three liters per minute; or
   b. The beneficiary has a 24-hour oxygen requirement of greater than or equal to three liters per minute.

3. Advanced Cancer: Must meet (a) and (b)
   a. The beneficiary has a stage III or IV solid organ cancer, lymphoma, or leukemia; and
   b. The beneficiary has a Karnofsky Performance Scale (KPS) score less than or equal to 70[6] or has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

4. Liver Disease: Must meet (a) and (b) combined or (c) alone
   a. The beneficiary has evidence of irreversible liver damage, serum albumin less than 3.0, and International Normalized Ratio (INR) greater than 1.3, and
   b. The beneficiary has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices; or
   c. The beneficiary has evidence of irreversible liver damage and has a Model for End Stage Liver Disease (MELD) score of greater than 19.[7]

Beneficiaries with serious illness who are receiving services under SB 1004 palliative care may choose to transition to hospice care if they meet the medical prognosis for hospice, or, if they also continue to meet the medical eligibility criteria for SB 1004, may remain in SB 1004 palliative

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[5] NYHA classifications are available at: http://www.heart.org/HEARTORG/Conditions/HeartFailure/AboutHeartFailure/Classes-of-Heart- Failure_UCM_306328_Article.jsp#.WefN7rpFxxo

[6] "Performance Scales: Karnofsky and ECOG Scores," http://oncologypro.esmo.org/Guidelines-Practice/Practice- Tools/Performance-Scales

[7] MELD score calculator is available at: https://optn.transplant.hrsa.gov/resources/allocation-calculators/meld- calculator

care until their death. Beneficiaries with medical conditions that improve or stabilize, but still meet the eligibility criteria for SB 1004, may have palliative care services reduced as determined by medical necessity, but should continue to receive periodic assessments to monitor for a change in condition or needed services.

Note that research supports additional conditions for palliative care referral, and some MCPs are already authorizing palliative care consults and services for patients with other medical conditions. This policy reflects the minimum eligibility criteria for SB 1004 palliative care patients; MCPs would continue to have discretion to authorize palliative care services for patients with other medical conditions in addition to the four listed

Further, across existing palliative care programs in California, clinical eligibility criteria varies, and several approaches have been successful in improving patient satisfaction and health outcomes in a cost-effective manner for patients with serious illness. As a result, MCPs may propose alternative eligibility protocols for DHCS review. Those protocols may be no more restrictive, in terms of the eligible conditions, than the criteria listed above.

In addition, as noted on page 1 above, research indicates that beneficiaries diagnosed with serious illness have improved patient satisfaction and receive care better aligned with their preferences when they have early palliative care services, such as advance care planning, early in the disease progression. As a result, MCPs should consider working with specialists in targeted practice areas such as oncology and cardiology, so that early palliative care, particularly advance care planning, is offered to beneficiaries diagnosed with serious illness but who are not enrolled in SB 1004 palliative care.

Section 3: Services

DHCS policy provides that Medi-Cal palliative care include the eight services listed below, when reasonable and necessary for the palliation or management of a qualified serious illness and related conditions, when provided by a qualified provider, and when provided according to existing Medi-Cal regulations, Provider Manuals, Provider Bulletins, or All-Plan Letters for the specific service. All of the services below, except for chaplain services, are included in existing Medi-Cal benefits.

A. Palliative Care Services:

Effective January 1, 2018, when a beneficiary meets the minimum eligibility criteria for palliative care, MCPs must authorize palliative care without regard to age.
Palliative care must include, at a minimum, the following seven services when medically necessary and reasonable for the palliation or management of a qualified serious illness and related conditions:

1. Advance Care Planning: Advance care planning for beneficiaries enrolled in Medi-Cal palliative care under SB 1004 includes documented discussions between a physician or other qualified healthcare professional and a patient, family member, or legally-recognized decision-maker. Counseling that takes place during these discussions addresses, but is not limited to, advance directives, such as Physician Orders for Life-Sustaining Treatment (POLST)

forms.[8] Please refer to the section on Advanced Care Planning in the Provider Manual for further details.[9]

2. Palliative Care Assessment and Consultation: Palliative care assessment and consultation services may be provided at the same time as advance care planning or in subsequent patient conversations. The palliative care consultation aims to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include, but are not limited to:
    - Treatment plans, including palliative care and curative care
    - Pain and medicine side effects
    - Emotional and social challenges
    - Spiritual concerns
    - Patient goals
    - Advance directives, including POLST forms
    - Legally recognized decision maker

3. Plan of Care: A plan of care should be developed with the engagement of the beneficiary and/or his/her representative(s) in its design. If a beneficiary already has a plan of care, that plan should be updated to reflect any changes resulting from the palliative care consultation or advance care planning discussion. A beneficiary's plan of care must include all authorized palliative care, including but not limited to pain and symptom management and curative care. The plan of care must not include services already received through another Medi-Cal funded benefit program.[10]

4. Palliative Care Team: The palliative care team is a group of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of beneficiaries and their families and are able to assist in identifying sources of pain and discomfort of the beneficiary. This may include problems with breathing, fatigue, depression, anxiety, insomnia, bowel or bladder, dyspnea, nausea, etc. The palliative care team will also address other issues such as medication services and allied health. The team members must provide all authorized palliative care. DHCS recommends that the palliative care team include, but is not limited to the following team members, a doctor of medicine or osteopathy (Primary Care Provider if MD or DO), a registered nurse, a licensed vocational nurse or nurse practitioner (Primary Care Provider if NP), and a social

[8] POLST forms are available at: http://capolst.org/
[9] Medi-Cal Provider Manual "Evaluation and Management (E&M)." Available at https://www.google.com/url?q=https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/eval_m00o03.doc&sa=U&ved=0ahUKEwi1w7-e2KPPAhVV7GMKHclmCkUQFggEMAA&client=internal-uds-cse&usg=AFQjCNH1-XcVgZ-oocK-OzJhLYgZ1sMslA. Accessed September 22, 2016.
[10] Examples include, but are not limited to, APL 13-014; California Children's Services Numbered Letter 06-1011; Managed Care Policy Letter 11-004.

worker. Chaplain Services: DHCS recommends that MCPs provide access to chaplain services as part of the palliative care team. Chaplain services provided as palliative care are not reimbursable through the Medi-Cal program.

5. Care Coordination: A member of the palliative care team should provide coordination of care, ensure continuous assessment of the beneficiary's needs, and implement the plan of care.

6. Pain and Symptom Management: Adequate pain and symptom management is an essential component of palliative care. Prescription drugs, physical therapy and other medically necessary services may be needed to address beneficiary pain and other symptoms. The beneficiary's plan of care must include all services authorized for pain and symptom management.

7. Mental Health and Medical Social Services: Counseling and social services must be available to the beneficiary to assist in minimizing the stress and psychological problems that arise from a serious illness, related conditions, and the dying process. Counseling services facilitated by the palliative care team may include, but are not limited to: psychotherapy, bereavement counseling, medical social services, and discharge planning as appropriate. Provision of medical social services shall not duplicate specialty mental health services (SMHS) provided by county Mental Health Plans (MHPs) and does not change the MCP's responsibilities for referring to, and coordinating with, county MHPs as delineated in APL 13-021.[11]

8. Recommended Service: **24/7 Telephonic Palliative Care Support** (separate from a routine advice line).

   Many palliative care programs include specialized telephonic support. This service is recommended, but not required for MCPs, due to initial program development constraints.

Additional notes on palliative care services:

- Identification of the specific palliative care services needed for an individual beneficiary is dependent on a palliative care consult and/or needs assessment process. Palliative care services should be aligned with the needs and decisions of the beneficiary.

- Research and discussions with palliative care experts indicate that the full range of palliative care services (physical, social, spiritual, and emotional) should be available

[11] APL "Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services" available at: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-021.pdf

to achieve the intended results in quality and cost-effectiveness measures.

- DHCS encourages MCPs and providers to provide palliative care consultations and services in a manner that meets beneficiaries' cultural needs. Resources and technical assistance on culturally sensitive palliative care is an emerging field, and DHCS supports further training and development in this area.

B. Curative Care/Disease Modifying Care:

As specified in SB 1004, beneficiaries electing not to enroll in hospice care but who meet the eligibility criteria for SB 1004 Medi-Cal palliative care may access both palliative care and curative care services that are medically necessary, as specified in current Medi-Cal statute and regulation. Essential to care coordination, the palliative care team and a plan of care will ensure coordination between curative care and palliative care services, particularly including the beneficiary's Primary Care Provider.

Section 4: Providers

MCPs may authorize palliative care to be provided in a variety of settings, including, but not limited to, inpatient, outpatient, or community-based settings. MCPs must utilize qualified providers for palliative care based on the setting and needs of a beneficiary so long as the MCP ensures that its providers comply with existing Medi- Cal contracts and policy. DHCS recommends that MCPs use providers with current palliative care training and/or certification to conduct palliative care consultations or assessments.

MCPs may contract with hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and other types of community-based providers that include licensed clinical staff with experience and/or training in palliative care. MCPs may contract with different types of providers depending on local provider qualifications and the need to reflect the diversity of their membership. Community-Based Adult Services (CBAS) facilities may be considered as a palliative care partner for facilitating advance care planning or palliative care referrals. Palliative care provided in a beneficiary's home must comply with existing Medi-Cal requirements for in-home providers, services, and authorization, such as physician assessments and care plans. MCPs must inform and educate providers regarding availability of the palliative care benefit.

Also, DHCS is authorized to expend up to $244,000 for palliative care provider training, and will provide further guidance on this funding and training to Medi-Cal providers. In particular, DHCS recommends that providers of palliative care consultations or assessments have current palliative care training or certification.

Further, results from existing palliative care programs highlight the importance of developing provider referral and education processes, as well as consumer information about palliative care. DHCS recommends that MCPs develop provider and consumer outreach plans when implementing SB 1004 palliative care programs.

Section 5: Monitoring Outcomes and Performance Measures

To track results from SB 1004, DHCS will require MCPs to periodically provide lists of SB 1004 palliative care beneficiary participants to the Department. Further guidance will be provided on any MCP requirements for additional data reporting, such as inpatient stays, emergency department visits, or hospice enrollment, as well as quality measures.

Skin Cancer Prevention Behavioral Counseling
Release Date March 2018

Skin Cancer Prevention: Behavioral Counseling

Release Date: March 2018

Recommendation Summary

Population	Recommendation	Grade (What's This?)
Young adults, adolescents, children, and parents of young children	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.	B
Adults older than 24 years with fair skin types	The USPSTF recommends that clinicians selectively offer counseling to adults older than 24 years with fair skin types about minimizing their exposure to UV radiation to reduce risk of skin cancer. Existing evidence indicates that the net benefit of counseling all adults older than 24 years is small. In determining whether counseling is appropriate in individual cases, patients and clinicians should consider the presence of risk factors for skin cancer. See the Clinical Considerations section for information on risk assessment.	C
Adults	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of counseling adults about skin self-examination to prevent skin cancer. See the Clinical Considerations section for suggestions for practice regarding the I statement.	I

https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/skin-cancer-counseling2?ds=1&s=skin%20cancer

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Behavioral Counseling to Prevent Skin Cancer
US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

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IMPORTANCE Skin cancer is the most common type of cancer in the United States. Although invasive melanoma accounts for only 2% of all skin cancer cases, it is responsible for 80% of skin cancer deaths. Basal and squamous cell carcinoma, the 2 predominant types of nonmelanoma skin cancer, represent the vast majority of skin cancer cases.

OBJECTIVE To update the 2012 US Preventive Services Task Force (USPSTF) recommendation on behavioral counseling for the primary prevention of skin cancer and the 2009 recommendation on screening for skin cancer with skin self-examination.

EVIDENCE REVIEW The USPSTF reviewed the evidence on whether counseling patients about sun protection reduces intermediate outcomes (eg, sunburn or precursor skin lesions) or skin cancer; the link between counseling and behavior change, the link between behavior change and skin cancer incidence, and the harms of counseling or changes in sun protection behavior; and the link between counseling patients to perform skin self-examination and skin cancer outcomes, as well as the harms of skin self-examination.

FINDINGS The USPSTF determined that behavioral counseling interventions are of moderate benefit in increasing sun protection behaviors in children, adolescents, and young adults with fair skin types. The USPSTF found adequate evidence that behavioral counseling interventions result in a small increase in sun protection behaviors in adults older than 24 years with fair skin types. The USPSTF found inadequate evidence on the benefits and harms of counseling adults about skin self-examination to prevent skin cancer.

CONCLUSIONS AND RECOMMENDATION The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to UV radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer. (B recommendation) The USPSTF recommends that clinicians selectively offer counseling to adults older than 24 years with fair skin types about minimizing their exposure to UV radiation to reduce risk of skin cancer. Existing evidence indicates that the net benefit of counseling all adults older than 24 years is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the presence of risk factors for skin cancer. (C recommendation) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of counseling adults about skin self-examination to prevent skin cancer. (I statement)

Author/Group Information: The US Preventive Services Task Force (USPSTF) members are listed at the end of this article.

JAMA. 2018;319(11):1134-1142. doi:10.1001/jama.2018.1623

The US Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific clinical preventive services for patients without obvious related signs or symptoms.

It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.

Summary of Recommendations and Evidence

The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to UV radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer (B recommendation) (**Figure 1**).

The USPSTF recommends that clinicians selectively offer counseling to adults older than 24 years with fair skin types about minimizing their exposure to UV radiation to reduce risk of skin cancer. Existing evidence indicates that the net benefit of counseling all adults older than 24 years is small. In determining whether counseling is appropriate in individual cases, patients and clinicians should consider the presence of risk factors for skin cancer. (C recommendation)

See the Clinical Considerations section for information on risk assessment.

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of counseling adults about skin self-examination to prevent skin cancer. (I statement)

See the Clinical Considerations section for suggestions for practice regarding the I statement.

Rationale

Importance

Skin cancer is the most common type of cancer in the United States and is generally categorized as melanoma or nonmelanoma skin cancer. Melanoma is the fifth-leading type of incident cancer, and 2.2% of adults will be diagnosed with it in their lifetime.[1] Although invasive melanoma accounts for only 2% of all skin cancer cases, it is responsible for 80% of skin cancer deaths.[1] Basal and squamous cell carcinoma, the 2 predominant types of nonmelanoma skin cancer, represent the vast majority of skin cancer cases. There were an estimated 3.3 million new cases of nonmelanoma skin cancer in 2012 and an estimated 91 270 new cases of melanoma skin cancer in 2018.[1]

Recognition of Risk Status

Exposure to UV radiation during childhood and adolescence increases the risk of skin cancer later in life, especially when more severe damage occurs, such as with severe sunburns. Persons with fair skin types (ivory or pale skin, light hair and eye color, freckles, or those who sunburn easily) are at increased risk of skin cancer. Persons who use tanning beds and those with a history of sunburns or previous skin cancer are also at substantially increased risk of skin cancer. Other factors that further increase risk include an increased number of nevi (moles) and atypical nevi, family history of skin cancer, HIV infection, and history of receiving an organ transplant. Most studies of interventions to increase sun protection behaviors have been limited to persons with fair skin types.[2-4]

Benefits of Behavioral Counseling Interventions

Behavioral counseling interventions target sun protection behaviors to reduce UV radiation exposure. UV radiation is a known carcinogen[5] that damages DNA and causes most skin cancer cases.[6] A substantial body of observational evidence demonstrates that the strongest connection between UV radiation exposure and skin cancer results from exposure in childhood and adolescence. Sun protection behaviors include the use of broad-spectrum sunscreen with a sun-protection factor of 15 or greater; wearing hats, sunglasses, or sun-protective clothing; avoiding sun exposure; seeking shade during midday hours (10 AM to 4 PM); and avoiding indoor tanning bed use.

The USPSTF found adequate evidence that behavioral counseling interventions available in or referable from a primary care setting result in a moderate increase in the use of sun protection behaviors for persons aged 6 months to 24 years with fair skin types.

The USPSTF found adequate evidence that behavioral counseling interventions available in or referable from a primary care setting result in a small increase in the use of sun protection behaviors for persons older than 24 years with fair skin types.

The USPSTF found insufficient evidence regarding the benefits of counseling adults about skin self-examination to prevent skin cancer.

Harms of Behavioral Counseling Interventions

The USPSTF found adequate evidence that the harms related to behavioral counseling interventions and sun protection behaviors in young persons or adults are small. The USPSTF found inadequate evidence regarding the harms of counseling adults about skin self-examination.

USPSTF Assessment

The USPSTF concludes with moderate certainty that behavioral counseling interventions have a moderate net benefit for young adults, adolescents, and children aged 6 months to 24 years with fair skin types.

The USPSTF concludes with moderate certainty that behavioral counseling interventions have a small benefit in adults older than 24 years with fair skin types.

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of counseling adults about skin self-examination.

Clinical Considerations

Patient Population Under Consideration

This recommendation applies to asymptomatic persons without a history of skin cancer (**Figure 2**). Because most trials of skin cancer

Figure 1. US Preventive Services Task Force (USPSTF) Grades and Levels of Certainty

What the USPSTF Grades Mean and Suggestions for Practice

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the Clinical Considerations section of the USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as the number, size, or quality of individual studies. inconsistency of findings across individual studies. limited generalizability of findings to routine primary care practice. lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of the limited number or size of studies. important flaws in study design or methods. inconsistency of findings across individual studies. gaps in the chain of evidence. findings not generalizable to routine primary care practice. lack of information on important health outcomes. More information may allow estimation of effects on health outcomes.
The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.	

USPSTF indicates US Preventive Services Task Force.

counseling predominantly include persons with fair skin types, the USPSTF limited its recommendation to this population.

Assessment of Risk

Persons with fair skin types (ivory or pale skin, light eye color, red or blond hair, freckles, those who sunburn easily) are at increased risk of skin cancer and should be counseled. Other factors that further increase risk include a history of sunburns, previous use of indoor tanning beds, and a family or personal history of skin cancer. Persons with an increased number of nevi and atypical nevi are at increased risk of melanoma. Persons with a compromised immune system (eg, persons living with HIV, persons who have received an organ transplant) are at increased risk of skin cancer.

Behavioral Counseling Interventions

All studies conducted in children and adolescents focused on sun protection behaviors; most were directed at parents, and some provided child-specific materials or messages. Half of the interventions included face-to-face counseling, and all included

Figure 2. Clinical Summary: Behavioral Counseling to Prevent Skin Cancer

Population	Young adults, adolescents, children, and parents of young children with fair skin type	Adults older than 24 years with fair skin type	Skin self-examination in adults
Recommendation	Counsel about minimizing exposure to UV radiation. Grade: B	Selectively offer counseling about minimizing exposure to UV radiation. Grade: C	No recommendation. Grade: I (insufficient evidence)
Risk Assessment	Ultraviolet radiation exposure during childhood and adolescence increases risk of skin cancer later in life, especially when more severe damage occurs. Persons with fair skin type (light hair and eye color, freckles, those who sunburn easily) are at increased risk of skin cancer. Persons who use tanning beds and those with a history of sunburns or previous skin cancer are also at greatly increased risk of skin cancer. Other factors that increase risk include an increased number of nevi (moles) and atypical nevi, family history of skin cancer, HIV infection, and history of receiving an organ transplant.		
Behavioral Counseling Interventions	Behavioral counseling interventions target sun protection behaviors to reduce UV radiation exposure, including use of broad-spectrum sunscreen with a sun-protection factor of 15 or greater; wearing hats, sunglasses, or sun-protective clothing; avoiding sun exposure; seeking shade during midday hours (10 AM to 4 PM); and avoiding indoor tanning use.		
Other Relevant USPSTF Recommendations	The USPSTF has issued a recommendation on screening for skin cancer in adults.		

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to https://www.uspreventiveservicestaskforce.org.

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USPSTF indicates US Preventive Services Task Force.

print materials. Three studies provided the intervention in conjunction with well-child visits. The majority of studies conducted in young adults and adults focused on improving sun protection behaviors, and 2 studies used "appearance-focused" messages. The mode of delivery varied and included mail-based, face-to-face or telephone counseling, and technology-based (text messages, online programs and modules, personal UV facial photographs) interventions.[2]

Suggestions for Practice Regarding the I Statement

Potential Preventable Burden

Counseling adults about performing skin self-examination appears to result in an increase of such examinations. The potential benefit of behavioral counseling about skin self-examination is uncertain because of the lack of evidence on the link between behavior change and skin cancer or other health outcomes. In addition, there is no evidence about the incremental benefit that might occur with skin self-examination above the benefit from counseling for sun protection behaviors and from current levels of skin examinations being performed by clinicians.

Potential Harms

Skin self-examination is performed by the patient and is noninvasive. Psychosocial harms, such as anxiety or cancer worry, are possible. If skin self-examination leads to biopsy, procedural harms such as pain, bleeding, scarring, or infection could occur.[7]

Current Practice

The frequency of behavioral counseling for skin self-examination in the asymptomatic population is not well known.

Additional Approaches to Prevention

The Community Preventive Services Task Force recommends child care center–based, primary and middle school–based, and multicomponent community-wide interventions for the prevention of skin cancer.[8] These interventions combine school- and community-based communications and policy to increase preventive behaviors (eg, covering up, using shade, or avoiding the sun during peak UV hours) among certain populations in specific settings.

The US Food and Drug Administration (FDA) provides information to help guide patients and clinicians regarding sun protection and the use and effectiveness of broad-spectrum sunscreen.[9] The FDA has determined that broad-spectrum sunscreens with a sun-protection factor of 15 or greater, reapplied at least every 2 hours, protect against both UVA and UVB radiation and reduce the risk of skin cancer and early skin aging. The FDA also provides consumer education materials on the dangers of indoor tanning.[10]

The Environmental Protection Agency provides a variety of educational tools regarding sun safety, including state-specific information, and interactive widgets and smartphone applications that forecast UV exposure by zip code or city. It also provides sun safety fact sheets and handouts, including age-appropriate materials.[11]

Useful Resources

The USPSTF has issued a recommendation on screening for skin cancer in adults.[12]

Other Considerations

Implementation

Interventions included tailored mailings, print materials, and in-person counseling by health professionals. Interventions for children were directed mostly toward parents; some materials were child-specific. Counseling interventions for children, their parents, or both provided messages focused on increasing sun protection behaviors (eg, using sunscreen, avoiding midday sun, wearing sun-protective clothing). Some print-based interventions included materials tailored to the child's risk level, barriers to change, self-efficacy, or other factors. Health professionals providing in-person counseling included primary care clinicians and health educators.

One trial of an intervention involving children 3 years and younger used clinician counseling and print materials for parents promoting child sun protection with sun protection aids (sunscreen samples and hat).[13] Several trials in children aged 3 to 10 years used standard or tailored mailings over 1 to 36 months.[14-17] One study also included a DVD in addition to a standard mailing promoting sun protection. One trial used a 1-day, in-person parent education session with a children's video, print materials, and sun protection aids (shirt, hat, and sunscreen). For the single study in adolescents, clinicians directly counseled participants, with 4 follow-up telephone counseling sessions by a health educator over 18 months; mailed materials and sunscreen samples were also used.

In the 16 trials among adults, interventions included a variety of messages and components, conducted in a range of settings.[2,4] Technology-based interventions included an interactive web program and tailored text messages on sun protection, as well as appearance-focused print materials. The web program study reported reduced sunburns after the intervention, which provided information on topics such as indoor tanning, UV radiation exposure and health, skin cancer, sunscreen, and skin examination. Each module took about 10 minutes to complete and included a goal-setting section. Other interventions that increased sun protection behaviors in adults included mailed print materials containing personalized risk feedback and recommendations, self-monitoring aids for UV exposure, and skin cancer prevention and detection information; individualized computer reports; and an interactive educational computer program on skin cancer prevention that provided individual feedback on personal risk of skin cancer.

Research Needs and Gaps

A better understanding of the effectiveness of counseling on the use of sun protection behaviors in adults 25 years and older is needed to address the key evidence gap on counseling for this age group. Research that evaluates the association between UV exposure during adulthood and skin cancer risk would also be valuable.

In addition, studies regarding the effectiveness of counseling persons without a fair skin type are lacking. Ideally, research studies would provide measurements of sun exposure, sunburn, precursor skin lesions, and cancer among large trial populations, with an emphasis on behaviors and health outcomes among persons who receive an intervention focused on sun protection behaviors. Such studies would also assess whether these behaviors continue after trial completion. These cohorts should include populations with diverse skin colors and should include adolescents, young adults, and preschool-aged children and their parents. These studies may be used to further develop technologies and vehicles for administering relevant interventions for behavior change in the primary care setting, especially among nonwhite persons, young adults, and persons who practice indoor or outdoor tanning. Further evidence is needed to assess the balance of benefits and harms of counseling adults about skin self-examination to prevent skin cancer and premature death.

Discussion

Burden of Disease

Skin cancer is the most common type of cancer. Melanoma is less common than basal or squamous cell carcinoma but has a much higher death rate. In 2018, an estimated 91 270 new cases of melanoma are expected, representing 5.2% of all new cancer cases.[1] An estimated 9730 persons will die of the disease, representing 1.6% of all cancer deaths.[18] Although age-adjusted incidence rates have increased from 1989 to 2014 (from 13.7 to 25.2 cases per 100 000 persons), the death rate has remained fairly stable over the same period (from 2.7 to 2.6 deaths per 100 000 persons).[18] Adults older than 50 years; men; and persons with fair skin types are at increased risk. Melanoma is most frequently diagnosed among adults aged 65 to 74 years; death rates are highest among the middle-aged and elderly. Melanoma is 5 times more common among Hispanic adults and 25 times more common among white than African American adults.[18]

Nonmelanoma skin cancer, of which most cases are basal and squamous cell skin cancer, is associated with a substantial burden to the patient but rarely results in death. Basal cell skin cancer constitutes about 80% of nonmelanoma skin cancer cases, and squamous cell skin cancer constitutes about 20%.[6] In general, nonmelanoma skin cancer accounts for a small percentage of all cancer deaths, mostly in older adults or persons with a compromised immune system. An estimated 2000 persons die from nonmelanoma skin cancer each year.[6] The true prevalence of nonmelanoma skin cancer is difficult to estimate because it is not a required cancer for registry entry; an estimated 5.4 million cases were diagnosed in 3.3 million persons in 2012.[6]

Scope of Review

The USPSTF commissioned a systematic evidence review to update its 2012 recommendation on behavioral counseling for the primary prevention of skin cancer[19] and its 2009 recommendation on screening for skin cancer with skin self-examination.[20] The review[2,4] focused on direct evidence that counseling patients about sun protection reduces intermediate outcomes (eg, sunburn or precursor skin lesions) or skin cancer. The review also sought evidence on the link between counseling and behavior change, the link between behavior change and skin cancer incidence, and the harms of counseling or changes in sun protection behavior. In addition, the review

examined evidence regarding counseling patients to perform skin self-examination and skin cancer outcomes and the harms of skin self-examination.

Effectiveness of Behavioral Counseling Interventions to Change Behavior

Many counseling interventions were found to be moderately effective in modifying sun protection behaviors among children, adolescents, and young adults but less effective in adults. Both traditional cancer prevention and appearance-focused messages (ie, stressing the aging effects of UV radiation on the skin) increased sun protection behaviors compared with control groups.

Of the 6 trials that evaluated the effect of interventions on sun protection behaviors among children and adolescents, 5 reported a statistically significant improvement in parent-reported composite scores of child sun protection behaviors compared with control groups.[13,15,17,21,22] Four of the 6 trials specifically targeted children aged 3 to 10 years, 1 trial focused on children from birth to 3 years, and 1 trial focused on adolescents aged 11 to 15 years. Among the 4 trials in children aged 3 to 10 years, 3 showed statistically significant differences in changes in sun protection behavior and sunscreen use at 3 months to 3 years of follow-up.[14-16]

A cluster randomized clinical trial[13] that provided counseling to parents of newborns in a series of 4 well-child visits showed statistically significant improvement in composite sun protection scores in the intervention group. However, most individual measures were not statistically significant, and it was difficult to determine the clinical relevance of the small improvements. An in-person counseling intervention targeting adolescents and involving clinicians and health educators showed that sun protection scores were higher in the intervention group than in the control group at 2 years of follow-up.[21]

Adequate evidence of the effectiveness of counseling interventions was found in 2 of the 3 fair-quality trials conducted among young adults. In a web-based study of 18- to 25-year olds, participants viewed an interactive 12-module web program featuring 10-minute topics such as indoor tanning, UV exposure and health, skin cancer, and skin examination.[22] At 3 months of follow-up, there was a significant improvement in past-month UV exposure and sun protection behaviors, sunscreen use, outdoor tanning, and skin self-examination. Another study (a randomized clinical trial) used a video intervention, with or without UV facial photography; the intervention showed no effect on composite sun protection scores.[23] In the third young adult study, women who used indoor tanning were given a 24-page booklet that detailed the effects of UV radiation and indoor tanning and appearance-enhancing alternatives to indoor tanning. At 6 months of follow-up, there was a significantly smaller increase in indoor tanning sessions in the past 3 months in the intervention group than in the control group.[24]

Evidence of the effectiveness of counseling interventions in adults older than 24 years is mixed. Six of 12 trials that addressed sun protection behavior composite scores in adults found an increase in such behaviors compared with control groups.[2,4] Three of these interventions promoted sun protection with tailored mailings, 2 used interactive online programs, and 1 used tailored text messages. Four of 7 trials assessing sunscreen use found an increase in this outcome. Of 3 trials of self-reported indoor tanning behavior, only 1 trial using an appearance-focused intervention among young female adults noted a significant improvement compared with the control group.[24] Effective interventions were more often of longer duration or had more frequent contacts with participants during the study period.

Trials of counseling interventions that focused on counseling patients to perform skin self-examination as a means of reducing skin cancer risk were inconclusive. A trial with more than 1300 participants showed that those who received a skin self-examination counseling intervention did not have significant differences in the incidence of skin cancer cases or atypical nevi compared with those in the control group at 12 months of follow-up.[25] Several studies showed that skin self-examination interventions increase the likelihood of participants reporting that they perform skin self-examination.[2,4] Additional studies are needed to determine the direct effect of skin self-examination on skin cancer risk.

Link Between Behavior Change and Cancer Risk

Sun Exposure

Total and recreational sun exposure during childhood is associated with increased melanoma risk. Studies that measured long-term or total sun exposure showed mixed association between increased sun exposure and skin cancer risk. Several fair- to good-quality studies demonstrated a link between adult recreational exposure to UV radiation and increased melanoma risk.[3] One large population-based study showed increased risk of both melanoma incidence and melanoma death with higher quartiles of UV exposure.[26] Two recent meta-analyses and 2 cohort studies also showed an increased risk of nonmelanoma skin cancer in persons with increased exposure to ambient UV radiation.[2]

Indoor Tanning

Indoor tanning is associated with increased melanoma risk, and younger age at first indoor tanning exposure increases this risk.[27] A meta-analysis provided evidence of a dose-response relationship between melanoma risk and indoor tanning in women younger than 50 years.[28] Four studies found that increasing indoor tanning frequency was associated with increased melanoma risk. Two systematic reviews, 1 cohort study, and 1 case-control study found evidence that having ever used indoor tanning was associated with increased risk of squamous cell and basal cell carcinoma compared with never having used indoor tanning.[29-32]

Sunscreen Use

Two studies in adults provided new evidence of a protective effect of sunscreen use. One study, which was considered by the USPSTF for its previous recommendation statement, analyzed long-term follow-up data from a randomized clinical trial. In this study, intervention group participants applied sunscreen daily, while control group participants continued their usual behavior. At 4.5 years, the intervention group had a decreased risk of squamous cell carcinoma.[33] Ten years after conclusion of the trial, the intervention group had half as many incident melanomas as the control group. Overall, melanoma risk was reduced in the intervention group compared with the control group and was most pronounced for invasive melanoma compared with in situ melanoma.[34] A large US case-control study also demonstrated a lower likelihood of melanoma in persons routinely using sunscreen compared with those who do not.[29]

Skin Self-Examination and Health Outcomes

Evidence on the effectiveness of skin self-examination in reducing death or illness is lacking. One 20-year follow-up study showed no association between skin self-examination and skin cancer death.[35]

Potential Harms of Behavioral Counseling Interventions

Potential harms of interventions promoting sun protection behaviors include skin reactions to sunscreen lotion, vitamin D deficiency, reduced physical activity due to avoiding the outdoors, and a paradoxical increase in sun exposure from a false reassurance of protection from sunscreen use. Sunscreen use can be associated with numerous transient skin reactions, including allergic, irritant, and photoallergic contact dermatitis. Although vitamin D deficiency is a hypothetical harm of sun avoidance, recent studies have not shown an association between sunscreen use and decreased vitamin D levels. Among the sparse evidence available, 1 study suggested that sun protection behaviors do not lead to decreased physical activity or increased body mass index.[36] Older studies reported that sunscreen use did not result in an intentional increase in sun exposure, but 2 recent studies showed that sunscreen use was associated with higher likelihood of multiple sunburns.[37,38]

Persons who performed skin self-examination were more likely to subsequently undergo a skin procedure compared with those who did not, as evidenced by 1 trial, indicating a potential harm of skin self-examination. Although melanoma death rates have remained stable, the increasing number of skin biopsies and rising melanoma incidence over recent decades provide evidence for overdiagnosis.[39]

Estimate of Magnitude of Net Benefit

The USPSTF determined that behavioral counseling interventions are of moderate benefit in increasing sun protection behaviors in children, adolescents, and young adults with fair skin types. The link of behavior change to outcomes is supported by several trials and a substantial body of observational evidence showing that the strongest connection between UV radiation exposure and skin cancer stems from exposure in childhood and adolescence. Evidence of a connection between sun exposure in adulthood and melanoma is less robust than in childhood. The USPSTF found adequate evidence that the harms related to counseling or sun protection behaviors are small. The USPSTF concludes with moderate certainty that the net benefit of counseling to decrease UV exposure and reduce skin cancer risk is moderate in children, adolescents, and young adults aged 6 months to 24 years.

The USPSTF found adequate evidence that behavioral counseling interventions result in a small increase in sun protection behaviors in adults older than 24 years. The harms of counseling are small. The USPSTF determined that the evidence supporting a link between decreased UV exposure in adulthood and skin cancer risk is adequate. The USPSTF concludes with moderate certainty that the net benefit of counseling to decrease UV exposure and reduce skin cancer risk is small in adults older than 24 years.

The USPSTF found inadequate evidence on the benefits and harms of counseling adults about skin self-examination to prevent skin cancer. Therefore, the USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of counseling adults about skin self-examination to prevent skin cancer.

How Does Evidence Fit With Biological Understanding?

UV radiation from both solar and artificial sources has been classified as a human carcinogen by national and international organizations. Epidemiologic evidence suggests that the effect of UV radiation exposure from typical doses of sunlight varies over the life span, with some evidence of a window of biological vulnerability in childhood and adolescence that translates into increased skin cancer risk later in life. Much of the available evidence concerns the most common skin lesions, nonmalignant neoplasia and basal cell and squamous cell cancer. It remains unclear whether the same mechanisms apply to melanoma risk. For all 3 types of cancer, increasing intermittent or recreational sun exposure and total sun exposure are linked to increased risk. Artificial UV radiation, specifically indoor tanning, is also associated with an increased risk of skin cancer. Indoor tanning before age 35 years, for more than 10 tanning sessions over a lifetime, and for longer than 1 year have been linked to increased cancer risk.

Response to Public Comments

A draft version of this recommendation statement was posted for public comment on the USPSTF website from October 10 to November 6, 2017. In response to public comments, the USPSTF clarified the definition of fair skin type for the purposes of this recommendation. Comments requested more details about the behavioral counseling interventions, and the USPSTF provided additional information on implementation strategies. Several comments requested clarification about why skin self-examination is included in this recommendation; the USPSTF clarified that this recommendation addresses several preventive counseling interventions, including evidence about primary care clinicians counseling patients to perform skin self-examination. The USPSTF also added suggestions for practice regarding the I statement, information on newer technologies, and further information on the evidence for the different age ranges in the recommendations.

Update of Previous USPSTF Recommendation

This recommendation replaces the 2012 USPSTF recommendation on counseling about skin cancer prevention[19] and the skin self-examination portion of the 2009 USPSTF recommendation on screening for skin cancer.[20] In this updated recommendation, the USPSTF expanded the age range for behavioral counseling interventions to include persons aged 6 months to 24 years with fair skin types (the previous recommendation applied to persons aged 10 to 24 years, based on the evidence available at that time). Recent studies in children younger than 10 years resulted in the USPSTF extending the lower end of the age range to 6 months, the minimum age recommended for sunscreen use. Based on additional evidence since the prior recommendation, the USPSTF now also recommends that clinicians consider selectively offering counseling to adults older than 24 years with fair skin types. As in 2012, the evidence on persons without a fair skin type remains insufficient for this population to be included in the recommendation statement. The evidence continues to be insufficient to assess the balance of benefits and harms of counseling adults about skin self-examination to prevent skin cancer, as it was in 2009.

Recommendations of Others

The US Surgeon General,[40] American Cancer Society,[41] American College of Obstetricians and Gynecologists,[42] American Academy of Pediatrics,[43] Royal Australian College of General Practitioners,[44] and the World Health Organization's International Agency for Research on Cancer[45] endorse the involvement of clinicians in counseling patients about skin cancer prevention.

The Community Preventive Services Task Force recommends education and policy approaches to encourage sun protection behaviors in child care centers, schools, recreational sites, and occupational settings. In addition, it recommends community-wide interventions that may or may not involve health care settings to increase protection behavior from UV radiation. Interventions include mass media campaigns and environmental and policy changes across multiple settings within a defined geographic area or an entire community.[8]

The American Academy of Dermatology encourages everyone to perform skin self-examination to check for signs of skin cancer.[46] The American Cancer Society[47] and the Skin Cancer Foundation[48] recommend monthly skin self-examination.

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Accepted for Publication: February 8, 2018.

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Author Contributions: Dr Grossman had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. The USPSTF members contributed equally to the recommendation statement.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported. Authors followed the policy regarding conflicts of interest described at https://www.uspreventiveservicestaskforce.org/Page/Name/conflict-of-interest-disclosures. All members of the USPSTF receive travel reimbursement and an honorarium for participating in USPSTF meetings.

Funding/Support: The USPSTF is an independent, voluntary body. The US Congress mandates that the Agency for Healthcare Research and Quality (AHRQ) support the operations of the USPSTF.

Role of the Funder/Sponsor: AHRQ staff assisted in the following: development and review of the research plan, commission of the systematic evidence review from an Evidence-based Practice Center, coordination of expert review and public comment of the draft evidence report and draft recommendation statement, and the writing and preparation of the final recommendation statement and its submission for publication. AHRQ staff had no role in the approval of the final recommendation statement or the decision to submit for publication.

Disclaimer: Recommendations made by the USPSTF are independent of the US government. They should not be construed as an official position of AHRQ or the US Department of Health and Human Services.

Additional Contributions: We thank Ernest Sullivent, MD, MPH (AHRQ), who contributed to the writing of the manuscript, and Lisa Nicolella, MA (AHRQ), who assisted with coordination and editing.

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USPSTF A and B Recommendations

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	June 2014*
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013*
Aspirin preventive medication: adults aged 50 to 59 years with a ≥10% 10-year cardiovascular risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	B	April 2016*
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening: adults	The USPSTF recommends screening for high blood	A	October 2015*

	pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.		
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	B	December 2013*
Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B	September 2013*
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination,	B	September 2002†

	every 1 to 2 years for women age 40 years and older.		
Breastfeeding interventions	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.	B	October 2016*
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012*
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.	A	June 2016*
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.	B	May 2014*

Depression screening: adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	February 2016*
Depression screening: adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	January 2016*
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B	October 2015*
Falls prevention: older adults	The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.	B	April 2018*
Folic acid supplementation	The USPSTF recommends that all women who are planning or capable of	A	January 2017*

	pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.		
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011*
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	B	August 2014*
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.	B	May 2014
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for	A	June 2009

	hepatitis B virus infection in pregnant women at their first prenatal visit.		
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	June 2013
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	April 2013*
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013*
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	B	January 2013
Lung cancer screening	The USPSTF recommends annual screening for lung	B	December 2013

	cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.		
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012*
Obesity screening: children and adolescents	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.	B	June 2017*
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	January 2012*
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in	B	March 2008

	newborns.		
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	B	September 2014
Preeclampsia: screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.	B	April 2017
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.	B	September 2014*
Skin cancer behavioral counseling	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.	B	March 2018*

Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.	B	November 2016*
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.	A	September 2015*
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.	A	September 2015*

Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Tuberculosis screening: adults	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.	B	September 2016
Syphilis screening: nonpregnant persons	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.	A	June 2016*
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
Vision screening: children	The USPSTF recommends vision screening at least once in all children ages 3 to 5 years to detect amblyopia or its risk factors.	B	September 2017*

†The Department of Health and Human Services, under the standards set out in revised Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2016 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening1.
*Previous recommendation was an “A” or “B.”

Current as of: March 2018

Internet Citation: *USPSTF A and B Recommendations*. U.S. Preventive Services Task Force. April 2018.
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

USPSTF A and B Recommendations

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.

Topic	Description	Grade	Release Date of Current Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.	B	June 2014*
Alcohol misuse: screening and counseling	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.	B	May 2013*
Aspirin preventive medication: adults aged 50 to 59 years with a ≥10% 10-year cardiovascular risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	B	April 2016*
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.	A	July 2008
Blood pressure screening: adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A	October 2015*
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.	B	December 2013*

Breast cancer preventive medications	The USPSTF recommends that clinicians engage in shared, informed decisionmaking with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.	B	September 2013*
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.	B	September 2002†
Breastfeeding interventions	The USPSTF recommends providing interventions during pregnancy and after birth to support breastfeeding.	B	October 2016*
Cervical cancer screening	The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.	A	March 2012*
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.	A	June 2016*
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.	B	May 2014*
Depression screening: adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	February 2016*
Depression screening: adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	B	January 2016*
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B	October 2015*
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.	B	May 2012

Folic acid supplementation	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.	A	January 2017*
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.	B	January 2014
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.	A	July 2011*
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.	B	September 2014*
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.	B	August 2014*
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.	A	September 2007
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.	B	May 2014
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.	A	June 2009
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.	B	June 2013
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.	A	April 2013*
HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.	A	April 2013*
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.	A	March 2008
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.	B	January 2013

Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.	B	December 2013
Obesity screening and counseling: adults	The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.	B	June 2012*
Obesity screening: children and adolescents	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.	B	June 2017*
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year-old white woman who has no additional risk factors.	B	January 2012*
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.	B	March 2008
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.	B	September 2014
Preeclampsia: screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.	B	April 2017
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.	A	February 2004
Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.	B	February 2004
Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.	B	September 2014*
Skin cancer behavioral counseling	The USPSTF recommends counseling children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.	B	May 2012

Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.	B	November 2016*
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Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.	B	August 2013
Tuberculosis screening: adults	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.	B	September 2016
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Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.	A	May 2009
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†The Department of Health and Human Services, under the standards set out in revised Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act, utilizes the 2002 recommendation on breast cancer screening of the U.S. Preventive Services Task Force. To see the USPSTF 2016 recommendation on breast cancer screening, go to http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/breast-cancer-screening1.

*Previous recommendation was an “A” or “B.”

Current as of: April 2017

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/