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: July 17, 2018

Where: **West County Health Center**
13601 San Pablo Ave, Room A, San Pablo, CA.
***Attention!* Please enter through the side door (on San Pablo Ave.)**

The agenda for the meeting is as follows:

I.	**CALL TO ORDER and INTRODUCTIONS**	Christine Gordon, BSN, PHN, DHCS-MT
II.	**REVIEW and APPROVAL of Previous Meeting Minutes**	Jose Yasul, MD Medical Director, CCHP
III.	**NEW BUSINESS & REMINDERS**	

	• **Online Access to Clinical and Preventive Guidelines**
	• **Initial Health Assessment (IHA)**
	• **Behavioral Health - how to access**
	• **USPSTF Current Recommendations/Updates**
	  ➢ **Fall Prevention in Community-Dwelling Older Adults**
	  ➢ **Osteoporosis Screening to Prevent Fractures**
	• **HPV-related Oropharyngeal Cancer (OPC)**
	• **CAIR**
	Shingrix Vaccine
		Christine Gordon, BSN, PHN, DHCS-MT
		
		Kristin Burnett, Immunization Program Mgr./Public Health, Communicable Disease Programs

IV.	**DISCUSSION ITEMS**	

	• **CCHP Updates**
	  ➢ **Legislative Update – Hep C treatment**
	  ➢ **CCHP Benefits Update - Concussion pilot**
	  ➢ **Quality - HEDIS**
	  ➢ **Utilization Management - New GBS form / Eating disorder clinic**
		Jose Yasul, MD
		Medical Director, CCHP

V.	**CLAIMS Q&A**	Claims Unit Staff

Our next scheduled meeting is October 16, 2018

**** CPN meeting reimbursement will be prorated based on length of time attendee is present in the meeting.**

CONTRA COSTA HEALTH PLAN

West County

Quarterly Community Provider Network (CPN)

Meeting Minutes – July 17, 2018

Attending:

CCHP Staff: Jose Yasul, MD, Medical Director (conference call); Christine Gordon, RN, BSN, DHCS-MT; Delaina Gillaspy, Secretary

CPN Providers: Sarah Bottomley, NP; Sam Chatteron-Kirchmeier, MD; Olga Eaglin, PA; Damara Luce, PA; Kate O'Hearn, CPNP; Mimi Ogawa, MD; Martha Rea, PA; Ashley Ro, NP; Katherine Roller, MD; Jeff Ritterman, MD; Laurie Trombla, FNP; Andrew Wallach, MD; Katherine Winter, MD; Nancy Saldivar, NP; Christine Salera, NP

Guests: Kristin Burnett, Immunization Program Mgr./Public Health, Communicable Disease Program

Discussion	Action	Accountable
I. Meeting called to order at 7:40 A.M.		Christine Gordon, BSN, DHCS-MT
II. Agenda was approved with no revisions.		Jose Yasul, MD Medical Director, CCHP
III. **New Business & Reminders** ➢ Online Access to Clinical and Preventive Guidelines • Reviewed how to access Clinical Guidelines on Contra Costa Health plan website and provided handout to providers. ○ http://cchealth.org/healthplan/clinical-guidelines.php ➢ Initial Health Assessment (IHA) • IHA must be completed within 120 days of member being assigned to the provider's panel. ○ If there is any reasons why the IHA cannot be completed providers should document the reason why. ○ DHCS will be looking for this during audits. ➢ DHCS Audit • CCHP Community Liaisons will come out to provider offices to help prepare for DHCS audits. • Community Liaisons will do FSR, MRR, etc. to help provider prepare. • DHCS will be looking for completed Initial Health Assessments, Staying Healthy assessments, immunizations, up to date USPSTF vaccinations. ➢ Behavioral Health • Mental Health access line: 1-888-678-7277 • Behavioral Health How to Access: 1-925-5150 ○ 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. ➢ USPSTF Current Recommendations/Update • USPSTF A and B recommendations handout provided during meeting.		Christine Gordon, BSN, DHCS-MT

- Fall Prevention in Community-Dwelling Older Adults
    - Importance: Falls are the leading cause of injury-related morbidity and mortality among older adults in the United States. In 2014, 28.7% of community-dwelling adults 65 years or older reported falling, resulting in 29 million falls (37.5% of which needed medical treatment or restricted activity for a fay or longer) and an estimated 33,000 deaths in 2015.
- Osteoporosis Screening to Prevent Fractures
    - Importance: By 2020, approximately 12.3 million individuals in the United States older than 50 years are expected to have osteoporosis. Osteoporotic fractures, particularly hip fractures, are associated with limitations in ambulation, chronic pain and disability, loss of independence and decreased quality of life, and 21% to 30% of patients who experience a hip fracture die within 1 year. The prevalence of primary osteoporosis (i.e., osteoporosis without underlying disease) increases with age and differs by race/ethnicity. With the aging of the US population, the potential preventable burden is likely to increase in future years.

HPV – Related Oropharyngeal Cancer (OPC)

- Overview
    - 79 million people are infected with HPV
    - 14 million new infections each year.
    - 50% of new infections are within the age range of 15-24 years old.
    - HPV can cause:
        - Cervical, vaginal and vulvar cancers in women.
            - Rates have been decreasing due to pap screening and treatments of precancerous lesions.
        - Penile cancers in men.
        - Oropharyngeal and anal cancers in both men and women.
            - Oropharyngeal cancer rates have been increasing, and have surpasses cervical cancer rate.
            - Anal cancer rates have been increasing.
    - Common high risk types are HPV 16 and 18.
    - Est. 19,200 women and 11,600 men are diagnosed with cancer caused by HPV.
    - HPV vaccinations prevent 90% of HPV-related cancers. HPV vaccination prevents 29,000 cancers per year.
    - HPV vaccination
        - Best tool to prevent HPV-associated cancers.
        - Routinely recommended for 11-12 year old boys and girls.
        - Rationale:
            - Before sexual debut.
            - Better immune response in 11-15 year olds.
            - Pair with Tdap immunization (required for 7th grade in CA).
    - ACIP HPV Vaccination Recommendations
        - Licensed for ages 9-26.
        - Routinely recommended at age 11-12.
    - Mission
        - American Cancer Society launched campaign on June 8, 2018.
        - Goal: 80% of 13 year olds fully vaccinated for HPV by 2026.
    - Estimated Vaccination Coverage Among Adolescents – Ages 13-17, National Immunization Survey-Teen, CA, 2011-2016

Kristen Burnett, Immunization Program Mgr./Public Health, Communicable Disease Program

- 82% ≥ 1 Tdap, 80% ≥ 1 MenACWY, 73% ≥ 1 HPV, 49% HPV up to date (UTD)
- Contra Costa- CCHP HPV Vaccination Rate- 35158 Total Patients
  - 7.51% Vaccinated, 24.62% Untimely follow-up, 15.47% Not enough shots, and 52.40% No shots at all.
- Contra Costa- Network HPV Vaccination Rate
  - CPN- 3.99% Vaccinated, 16.16% Untimely follow-up, 10.64% Not enough shots, and 69.21% No shots at all.
  - RMC- 10.50% Vaccinated, 31.82% Untimely follow-up, 19.58% Not enough shots, and 38.10% No shots at all.
- Why is HPV vaccine coverage so low?
  - Providers expectations
    - Expects parents to schedule appointment.
    - Reluctant to give multiple shots at one visit.
    - Introduces HPV vaccine at age 11 but does not recommend it strongly.
  - Parents expectations
    - Not offered vaccination
    - Perceive vaccination as optional or unnecessary at that time.
    - Do not understand the reasoning to vaccinate at 11-12 years of age.
  - ** Delaying vaccination leads to non-vaccination.
- Structure of an effective recommendation
  - 1. Mention child's age
  - 2. Announce that child is due for 3 vaccinations at this age.
  - 3. Phrasing order matters: meningococcal, HPV, Tdap (HPV always in the middle of list).
  - 4. Say you will vaccinate today.
  - Frame as a **cancer prevention** vaccine.
  - HPV is a "sensitive service" and minors age 12 and up can get vaccine without parental consent in CA.

➢ Shingrix Vaccine
- New zoster/shingles vaccine for age 50 years old and up.
- ACIP preferentially recommends over Zostavax.
- If previously received Zostavax, should revaccinated with Shingrix.
- Differences
  - 2 shot series (2-6 months apart)
  - Refrigerated
  - Intramuscular injection
- Zostavax vs. Shringrix
  - Prevention of herpes zoster
    - 50-59 – Zostavax 70%, Shringrix 97%
    - 60-69 – Zostavax 64%, Shringrix 97%
    - 70-79 – Zostavax 41%, Shringrix 91%
    - 80+ – Zostavax 18%, Shringrix 91%
  - Prevention of PHN
    - 60-69 – Zostavax 66%, Shringrix 91%
    - 70+ – Zostavax 97%, Shringrix 89%

➢ CAIR- California Immunization Registry
- Vision
  - Any authorized use anywhere in CA can immediately obtain comprehensive immunization information on any CA child.
- Mission
  - To create and maintain a fully-populated and full-utilized

	interactive, confidential and secure immunization information system that improves immunization coverage to protect all Californians from vaccine-preventable diseases.		
IV.	**Discussion Items** ➢ Legislative Update • Hepatitis C Treatment ○ As of July 1, 2018 treatment for all patients ages 12 and above with Hepatitis C, regardless of liver fibrosis stage or co-morbidity, accepting patients with shortened life expectancy, will be available as a Medi-Cal benefit. ➢ CCHP Benefits Update • Concussion Pilot ○ Objective-To provide clarity to providers regarding the Concussion Pilot with STATMED. ○ Purpose-To ensure a member who sustains a head injury has access to an appropriate concussion evaluation and, if necessary, follow up in a timely fashion. ○ If a patient has a concussion the patient should be send to the Advice Nurse to get process started. The Advice Nurse will be tracking all referrals and with provide authorization to STATMED. ○ Transportation Issues ▪ Call Case Management to set up transportation for member. ➢ Quality • HEDIS ○ HEDIS spreadsheet provided to providers. ○ CPN Network/RMC ▪ Improvements on Physical activity counseling for children, Cervical cancer screening, Diabetes eye exam, Well Child Visits 3-6yrs old. ○ Breast Cancer screening is better than last year, but is still at less than 25%. ○ Generally pleased with results. ➢ Utilization Management • GBS form/ Eating disorder Clinic- Handout Provided ○ Family Based Treatment for Eating Disorders (FBT) ○ Based on treatment needs the model "Family Bases Treatment for Anorexia Nervosa" has been selected as the treatment model. ○ There are 5 Mental Health Clinical Specialist within the 3 Children's Behavioral Health Clinics (West, Central and East) providing FBT as a part of their clinical practice. Referrals can be made through the Access Line (888) 678-7277.		Jose Yasul, MD Medical Director, CCHP
V.	**Adjournment:** Meeting adjourned at 9:00 A.M.		

Oropharyngeal Cancer (OPC) and HPV Prevention in Children

5 Key Points that **Dental Professionals** Need to Know

1

OPC is also known as squamous cell carcinoma of the pharynx, including the base of the tongue and tonsils.

The incidence of OPC has overtaken that of cervical cancer. Be sure to screen your patients for oral cavity and oropharyngeal cancers.

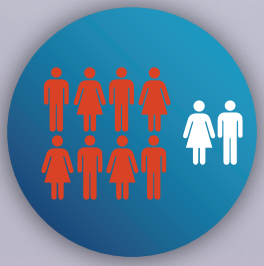
2

OPC incidence is rapidly increasing. This cancer is hard to detect before it spreads.

Everyone is at risk for OPC, but middle-aged white men are at higher risk. Unlike oral cavity cancers, smoking and drinking are not common risk factors for OPC.

3

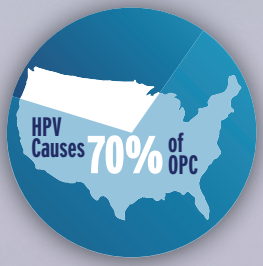
8 out of 10 people will contract the Human Papillomavirus (HPV) at some point in their lives and some will develop cancer. Everyone is at risk.



Although OPC is highly treatable, the treatment and the side effects are severe.

4

HPV causes 70% of OPCs in the US. HPV type 16 (which is covered by HPV vaccine) causes 60% of all OPCs.



HPV vaccine safely and effectively prevents infection by the major cancer-causing HPV types.

5

You are the key to cancer prevention.

Recommend the HPV vaccine to boys and girls ages 11 – 12. Every visit on or after the 9th birthday is an opportunity to recommend the vaccine.

HPV YOU ARE THE KEY TO CANCER PREVENTION

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

Dental professionals should recommend the HPV vaccine and refer patients to their pediatrician to get vaccinated.

For More Information: aap.org/oralhealth • aap.org/hpvtoolkit • email: HPV@aap.org

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Title: Concussion Pilot
Medical Director

DATE ACTIVE: Draft

OBJECTIVES:

To provide clarity to providers regarding the Concussion Pilot with STATMED

PURPOSE:

To ensure a member who sustains a head injury has access to an appropriate concussion evaluation and, if necessary, follow up in a timely fashion.

Who:

STATMED is an Urgent Care with offices in Concord, Pleasanton, and Lafayette. STAT MED offers the full spectrum of concussion services: evaluation, diagnosis, treatment, final assessment and, when needed, authorization to return to play, school or work.

PROCESS:

- Member suffers a head injury with concern for concussion and would like to be evaluated
- Member calls Advice Nurse for triage.
- If triage shows patient needs to be seen, but not at an ED, advise nurse authorizes to STATMED
- STATMED may do a Brainscope EEG to determine if the patient needs to go to an ED for a Head CT
- STATMED evaluates patient and determines that follow up for concussion is needed
- STATMED may schedule up to 2 follow up visits with the member that can be authorized retroactively.
- Additional visits may be requested by STATMED as needed for the next 2-4 weeks

CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Children's Behavioral Health Programs

May 11, 2018

Family Based Treatment for Eating Disorders (FBT)

Due to a steady stream of referrals for youth suffering from eating disorders and recognizing the need to provide specialized treatment for this vulnerable population, in 2015, Contra Costa Children's Mental Health made plans to implement an evidence-based treatment aimed at providing outpatient treatment for youth struggling with eating disorders.

Based on the treatment needs of our clients we selected "Family Based Treatment for Anorexia Nervosa" (FBT) as the treatment model of choice. FBT was developed by James Lock, MD (Stanford) and Daniel LeGrange, PhD (UCSF), and is based on treatment approaches that originated at the Maudsley Hospital in London (Maudsley Method). It can be adapted to the treatment of Bulimia.

FBT is a structured 20 session model that treats the eating disorder in the context of the family. FBT has three distinct phases: in Phase 1 parents are put in charge of weigh restoration; in Phase 2 parents hand over eating back to the adolescent; and in Phase 3 therapist and client process topics of adolescent development.

In September of 2016, Contra Costa Behavioral Health conducted a 2 day training with Daniel LeGrange for mental health clinicians, child psychiatrists, and primary care providers. The training was followed by on-going consultation with an expert from Dr. Le Granges training institute, which is still going on.

Between the 3 Children's Behavioral Health Clinics (West, Central, and East) we currently have 5 Mental Health Clinical Specialists providing FBT as part of their clinical practice. Referrals can be made through the **Access Line (888-678-7277).**

CONTRA COSTA HEALTH PLAN

Prior Authorization Request Form for Mental Health Evaluation [Prior to Gastric Bypass Surgery (GBS) Consultation]

(This form is valid for the Mental Health evaluation, which is required prior to GBS consult. GBS consult **may be** approved if there are no significant findings from the Mental Health evaluation)

Patient's Name: _____ Date of Request: _____

ID#: _____ Birthdate: _____

HEIGHT: _____ WEIGHT (most recent): _____ Date weighed _____ BMI: _____

Requesting Provider Name (Print): _____ Date Last Seen: _____

SIGNATURE: _____

Morbid obesity can be a health danger because of the associated increased prevalence of cardiovascular risk factor such as hypertension, hypertriglyceridemia, hyperinsulinemia, diabetes mellitus and low levels of high-density lipoprotein (HDL) cholesterol. Conservative and dietary treatments include low (800-1200) calorie and very low (400-800) calorie diets, behavioral modification, exercise and pharmacologic agents. When these less drastic measures have failed or are not appropriate, providers may request, (upon meeting the criteria listed below) a consultation for obesity surgery.

Must meet 1 or 2 (see Table 1 for BMI values)

1. ☐ BMI over 40 with or without comorbidities
2. ☐ BMI 35-39.9 with presence of any of the following severe obesity-related comorbidities likely to be alleviated by surgery:
   a. Life-threatening cardiovascular disease.
   b. Life-threatening pulmonary disease.
   c. Clinical significant obstructive sleep apnea.
   d. Uncontrolled diabetes mellitus.
   e. Severe neurological or musculoskeletal problems.

Life-threatening comorbidities include documented sleep apnea, cardiomyopathy of obesity, and Pickwickian syndrome. Other obesity-related comorbidities include symptomatic degenerative joint disease demonstrated on x-ray with orthopedic recommendation for weight loss, symptomatic ventral hernia, difficult to control diabetes or hypertension, some cases of lower back pain, severe lower extremity edema with ulceration, stress incontinence, amenorrhea, etc.

	Date
1.	
2.	
3.	
4.	
5.	
6.	
7.	

MUST MEET ALL CRITERIA BELOW*

Indicate date completed for each item, attach supporting documentation of meeting EACH criteria and fax packet to: CCHP Authorization Unit Fax- (925) 313-6058

1. Weight control efforts within the past year documented by PCP, which indicates member has made a serious effort to change eating and lifestyle in the last year, as shown by documented participation in a weight loss program, including exercise. **Patient or PCP must also provide a narrative summary of weight control efforts.**
2. A dietary consultation and at least one follow up visit 30-90 days after initial consult, performed within the last 6 months by an approved Health Plan Registered Dietician, are required to assess present eating patterns (binge eating, bulimia, etc.) and ability to comprehend and cope with the post-surgical dietary restrictions. *Purpose of both the dietary assessment and the weight loss program include educating members in healthy eating styles, assessing if they can lose weight without surgery, counseling on the effects of surgery, and connecting them to their PCP who can follow them after surgery.*
3. **Verification** from a program or participation in a support program, such as Overeaters Anonymous (www.oa.org) or WeightWatchers (www.weightwatchers.com) , within the past 6 months for a period of at least 3 months of regular attendance (> 3 meetings per month).
4. Documented failure to sustain weight loss from more conservative methods, such as diet management programs or other similar programs within the past year.
5. Labs: Fasting Blood Glucose or hemoglobin A_1C within the past 6 months _____, TSH and lipids within the past year _____
6. Obesity for a duration of at least 5 years.
7. Monthly weight checks for the past 6 months.

Confirm the following:

8. Yes ☐ No ☐ Presence of active peptic ulcer disease (PUD).
9. Yes ☐ No ☐ Presence of advanced kidney or liver disease,
10. Yes ☐ No ☐ Has attained full growth (at least 18 years of age or documentation of completion of bone growth).
11. Yes ☐ No ☐ Uses illegal drugs, abuses prescription medications, or drinks excessive amounts of alcoholic beverages.
12. Yes ☐ No ☐ Presence of endocrinologic, psychiatric/Mental Health or substance abuse disorder.
13. Yes ☐ No ☐ Client has a clear and realistic understanding of available alternatives and how their lives will be changed after surgery, including the possibility of morbidity and eventually mortality, and a credible commitment to make the life changes necessary to maintain the body size and health achieved.
14. Yes ☐ No ☐ Presence of contraindications to the surgery including major life-threatening disease not susceptible to alleviation by the surgery, uncontrolled substance abuse, severe psychiatric/Mental Health impairment and demonstrated lack of compliance and motivation.
15. Yes ☐ No ☐ **Client and provider understand that, in general, surgery to remove excess skin resulting from weight loss (e.g., panniculectomy, abdominoplasty) is not a covered benefit.**

***After meeting above criteria, Contra Costa Health Plan (CCHP) will authorize a Mental Health evaluation to rule out any mental disease or disorder and to determine the patient's ability to comply with post-op dietary and/or physical limitations and restrictions. Based on the findings of the Mental Health evaluation, CCHP will determine if an initial GBS consult is appropriate.**

Table 1

Body Weights in Pounds According to Height and Body Mass Index

*Each entry gives the body weight in pounds (lbs.) for a person of a given height and body mass index. Pounds have been rounded off. To use the table, find the appropriate height in the left-hand column. Move across the row to a given weight. The number at the top of the column is the body mass index for the height and weight.

Body Mass Index														
	25	30	35	36	37	38	39	40	41	42	43	44	45	50
Ht. (in)	Body Weight (lbs)													
58	119	143	167	172	176	181	186	191	195	200	205	210	214	238
59	124	149	174	179	184	188	193	198	203	208	213	218	223	248
60	127	153	178	183	188	194	199	204	209	214	219	224	229	255
61	132	159	185	191	196	201	207	212	217	222	228	233	238	265
62	136	163	190	196	201	206	212	217	223	228	234	239	245	272
63	141	169	198	203	209	214	220	226	231	237	243	248	254	282
64	146	176	205	211	217	223	228	234	240	246	252	258	264	293
65	150	180	210	216	222	228	234	240	246	252	258	264	270	300
66	154	187	218	224	230	236	243	249	255	261	268	274	280	311
67	159	191	223	229	236	242	248	255	261	268	274	280	287	319
68	165	198	231	238	244	251	257	264	271	277	284	290	297	330
69	169	203	236	243	250	257	263	270	277	284	290	297	304	338
70	175	210	244	251	258	265	272	279	286	293	300	307	314	349
71	179	214	250	257	264	271	279	286	293	300	307	314	321	357
72	185	221	258	266	273	281	288	295	303	313	317	325	332	369
73	189	226	264	272	279	287	294	302	309	317	324	332	340	377
74	195	234	273	281	288	296	304	312	319	327	335	343	351	390
75	199	239	279	287	294	302	310	318	326	334	342	350	358	398
76	205	246	287	296	304	312	320	328	337	345	353	361	370	411

Adapted from Bray, G.A. Gary, D.S.. Obesity, Part 1. Pathogenesis. West J. Med 1988; 149:429-41

	CCHP Medi-Cal HEDIS Measures	2017 RMC	**2018 RMC**	2015 CPN	2016 CPN	2017 CPN	**2018 CPN**	2015 KSR	2016 KSR	2017 KSR	**2018 KSR**	MPL	HPL	**2016 Medi-Cal Mean**	**2017 Medi-Cal Weighted Averages**
WCC	Nutrition counseling given for children	75.47%	86.79%	44.31%	64.08%	56.64%	64.90%	88.89%	87.32%	90.74%	92.08%	51.84%	79.52%	69.98	**76.48%**
	Physical activity counseling for children	76.10%	86.16%	41.92%	60.56%	52.45%	65.56%	88.89%	87.32%	90.74%	92.08%	45.09%	71.58%	60.19	**68.79%**
W34	*Yearly well child visit 3-6 yr.	71.02%	69.94%	75.61%	63.33%	63.09%	71.92%	89.66%	92.21%	87.95%	88.04%	64.72%	82.97%	72.28	**73.90%**
CIS	*Combo 3 immunizations	78.33%	80.00%	72.00%	70.90%	65.93%	72.22%	89.66%	82.72%	89.77%	80.00%	64.30%	79.81%	70.98	**70.70%**
PPC	*First trimester prenatal	92.79%	87.44%	85.39%	88.71%	89.69%	82.86%	69.01%	92.00%	89.13%	87.91%	74.21%	91.00%	81.9	**81.95%**
	Postpartum visit 21-56 days	75.68%	73.02%	58.43%	56.45%	64.95%	60.95%	76.06%	74.67%	85.87%	75.82%	55.47%	73.61%	61.29	**63.77%**
LBP	Avoiding Use of Imaging for Low Back Pain	75.74%	77.60%	83.57%	81.29%	73.10%	80.66%	99.51%	89.67%	79.22%	83.62%	69.88%	81.42%	80.3	**72.87%**
BCS	Breast Cancer Screening	58.29%	58.01%			46.18%	47.82%			84.76%	83.13%	52.24%	71.52%		
CCS	*Cervical cancer screening	53.31%	62.41%	53.92%	53.42%	51.81%	62.67%	87.50%	87.14%	80.49%	84.29%	48.14%	69.95%	58.96	**56.26%**
CDC	Diabetes Eye Exam 2 yrs.	45.55%	61.75%	52.22%	41.18%	48.10%	59.18%	78.38%	82.35%	75.00%	69.05%	44.53%	68.11%	53.98	**57.06%**
	*Diabetes HbA1c testing	89.32%	91.58%	85.56%	84.71%	93.67%	78.57%	86.49%	94.12%	97.22%	100.00%	82.98%	92.88%	86.98	**86.82%**
	Diabetes HbA1c(>9%) (lower is better)	30.25%	30.53%	56.67%	61.18%	41.77%	67.35%	37.84%	41.18%	22.22%	38.10%	52.31%	29.23%	40	**37.75%**
	Diabetes HbA1c (<8%)	54.45%	55.44%	35.56%	34.12%	50.63%	26.53%	45.95%	52.94%	75.00%	52.38%	39.80%	58.39%	49.76	**51.67%**
	Diabetes Nephropathy screen or treatment	87.90%	88.07%	84.44%	88.24%	86.08%	87.76%	94.59%	94.12%	94.44%	92.86%	88.32%	93.56%	83.72	**90.35%**
	Diabetes BP <140/90	61.21%	68.77%	45.56%	62.35%	64.56%	61.22%	72.97%	70.59%	75.00%	83.33%	52.26%	75.73%	64.74	**63.38%**
AAB	Avoidance of Antibiotics in Adults With Acute Bronchitis	45.19%	47.28%	33.68%	37.32%	41.35%	41.81%	54.05%	58.62%	68.13%	53.54%	22.12%	38.91%	29.77	**31.00%**
IMA-2	Immunizations for Adolescents: Combo 2	23.20%				26.14%				37.00%					
AMR	Asthma Medication Ratio	31.77%	35.86%			40.28%	49.59%			86.95%	90.07%	54.55%	70.00%		60.60%
CBP	*Controlling High Blood Pressure	59.47%	71.91%	50.63%	39.71%	45.65%	54.26%	79.25%	74.42%	80.00%	86.00%	46.87%	70.69%	60.73	**62.68%**
CDF	Screening for Depression and follow up--Screening		22.67%				0.93%				19.20%				
	Screening for Depression and follow up--Follow Up		43.06%				40.74%				29.14%				
ACR	All-Cause Readmissions (lower is better)	14.22%	16.42%	14.52%	13.78%	12.56%	13.36%	7.14%	11.76%	0.00%	11.56%				
	All-Cause Readmission, SPDs	17.75%	20.36%	15.96%	19.15%	15.34%	17.85%	4.76%	9.09%	0.00%	6.73%				
	All-Cause Readmission, Non SPDs	11.42%	13.76%	11.70%	7.83%	9.20%	10.26%	14.29%	13.04%	0.00%	13.43%				
MPM	Monitoring for Patients on persistent Medications - ACE or ARB	88.11%	86.82%	83.57%	84.36%	86.83%	86.34%	94.33%	91.95%	92.72%	93.98%	85.63%	92.13%	86.15	**87.59%**
	Monitoring for Patients on persistent Medications - Diuretics	87.35%	86.58%	81.49%	81.15%	83.64%	86.23%	92.20%	90.84%	91.08%	92.61%	85.18%	92.28%	86.3	**87.09%**
AMB	Ambulatory Care - Outpatient Visits per 1000 Member Months	141.70	142.42	259.32	258.25	68.24	74.36	259.08	364.45	77.27	78.85	303.4	450.33	311.54	
	Ambulatory Care - Emergency Department Visits per 1000 Member Months	32.21	30.89	49.26	48.46	12.71	12.56	41.89	44.93	8.13	8.02	53.23	87.57	47.25%	
CAP	Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months	93.58%	92.39%	92.57%	93.52%	91.39%	90.71%	98.90%	98.13%	97.72%	98.33%	93.14%	97.85%	94.26	
	Children and Adolescents' Access to Primary Care Practitioners - 25 Months-6 Years	81.11%	82.52%	82.31%	80.71%	77.49%	80.30%	90.13%	89.75%	87.45%	89.92%	84.83%	93.34%	86.86	
	Children and Adolescents' Access to Primary Care Practitioners - 7-11 Years	82.44%	83.60%	86.07%	84.90%	83.34%	83.14%	94.46%	92.34%	91.55%	92.61%	87.91%	96.10%	88.67	
	Children and Adolescents' Access to Primary Care Practitioners - 12-19 Years	78.65%	80.75%	81.44%	79.67%	75.80%	76.94%	93.41%	91.80%	90.14%	91.98%	85.84%	94.69%	86.51	

below Minimum Performance Level (MPL), national Medicaid 25th

above High Performance Level (HPL), national Medicaid 90th percentile

Note: shadings are based on 2017 HPL and MPL, sc

*included in default algorithm

	CCHP Medi-Cal HEDIS Measures	2015 CCHP	2015 RMC	2015 CPN
WCC	BMI %ile calculated for children	69.34%	85.29%	41.32%
	Nutrition counseling given for children	67.64%	79.41%	44.31%
	Physical activity counseling for children	66.67%	79.41%	41.92%
W34	*Yearly well child visit 3-6 yr.	79.81%	78.75%	75.61%
CIS	*Combo 3 immunizations	77.86%	72.25%	72.00%
PPC	*First trimester prenatal	85.89%	90.36%	85.39%
	Postpartum visit 21-56 days	67.15%	67.47%	58.43%
LBP	Avoiding Use of Imaging for Low Back Pain	87.31%	84.60%	83.57%
CCS	*Cervical cancer screening	55.47%	50.78%	53.92%
CDC	Diabetes Eye Exam 2 yrs.	55.10%	52.90%	52.22%
	*Diabetes HbA1c testing	83.98%	83.33%	85.56%
	Diabetes HbA1c(>9%) (lower is better)	41.26%	36.23%	56.67%
	Diabetes HbA1c (<8%)	44.17%	47.10%	35.56%
	Diabetes Nephropathy screen or treatment	82.52%	80.43%	84.44%
	Diabetes BP <140/90	60.44%	64.13%	45.56%
AAB	Avoidance of Antibiotics in Adults With Acute Bronchitis	47.06%	52.36%	33.68%
IMA-1	Immunizations for Adolescents: Combo 1	72.51%	70.21%	69.75%
CBP	*Controlling High Blood Pressure	64.23%	65.23%	50.63%
MMA	Medication Management for People with Asthma 50%	59.10%	54.97%	44.54%
MMA	Medication Management for People with Asthma 75%	37.92%	34.41%	21.26%
ACR	All-Cause Readmissions (lower is better)	16.98%	17.58%	14.52%
	All-Cause Readmission, SPDs	21.17%	22.58%	15.96%
	All-Cause Readmission, Non SPDs	10.68%	10.48%	11.70%
AMB	Ambulatory Care - Outpatient Visits per 1000 Member Months	257.12	133.81	75.00
AMB	Ambulatory Care - Emergency Department Visits per 1000 Member Months	56.21	34.17	14.25
MPM	Monitoring for Patients on persistent Medications - ACE or ARB	85.55%	84.50%	83.57%
MPM	Monitoring for Patients on persistent Medications - Digoxin	77.11%	82.46%	63.64%
MPM	Monitoring for Patients on persistent Medications - Diuretics	84.60%	83.96%	81.49%
CAP	Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months[2]	93.94%	92.47%	92.57%
CAP	Children and Adolescents' Access to Primary Care Practitioners - 25 Months-6 Years[2]	84.21%	82.88%	82.31%
CAP	Children and Adolescents' Access to Primary Care Practitioners - 7-11 Years[2]	86.56%	84.20%	86.07%
CAP	Children and Adolescents' Access to Primary Care Practitioners - 12-19 Years[2]	83.80%	81.90%	81.44%

*included in default algorithm

**Minimum Performance Level: National Medicad 25th percentile.

2015 KSR	2015 **MPL
92.59%	41.85%
88.89%	50.00%
88.89%	41.67%
89.66%	65.97%
89.66%	66.67%
69.01%	77.80%
76.06%	56.18%
99.51%	72.15%
87.50%	54.50%
78.38%	46.25%
86.49%	80.18%
37.84%	53.76%
45.95%	38.20%
94.59%	75.67%
72.97%	53.28%
54.05%	20.20%
79.63%	61.70%
79.25%	48.53%
87.94%	47.88%
67.73%	24.55%
7.14%	
4.76%	
14.29%	
48.11	314.03
7.78	52.33
94.33%	85.76%
66.67%	88.89%
92.20%	85.69%
98.90%	95.92%
90.13%	86.07%
94.46%	87.78%
93.41%	85.83%

0.0542	0.074318
0.0639	0.089109
0.0118	0.016487
0.0022	0.002869
-0.0487	-0.05338
-0.056	-0.07424
0.0275	0.036099
0.077	0.131669
0.13	0.266721
-0.0147	-0.01617
-0.0809	-0.25424
-0.0744	-0.13391
0.006	0.006808
0.0541	0.085696
-0.0011	-0.00236
0.1072	0.182096
-0.0125	-0.08961
-0.0143	-0.08304
-0.0192	-0.17407
-0.0115	-0.01299
	0
0.0002	0.000229
0.96%	-0.01%
0.2008	-0.0019

How Dentists Can Help Prevent Cancer

Did You Know?

- In the last 20 years, oral cancers have more than **tripled** in the US?
- The rate of oral-pharyngeal cancer has now **surpassed** that of cervical cancer?
- Over **70%** of oral-pharyngeal cancers are attributed to the Human Papilloma Virus (HPV)?
- Oral HPV is about three times as common in men than in women?

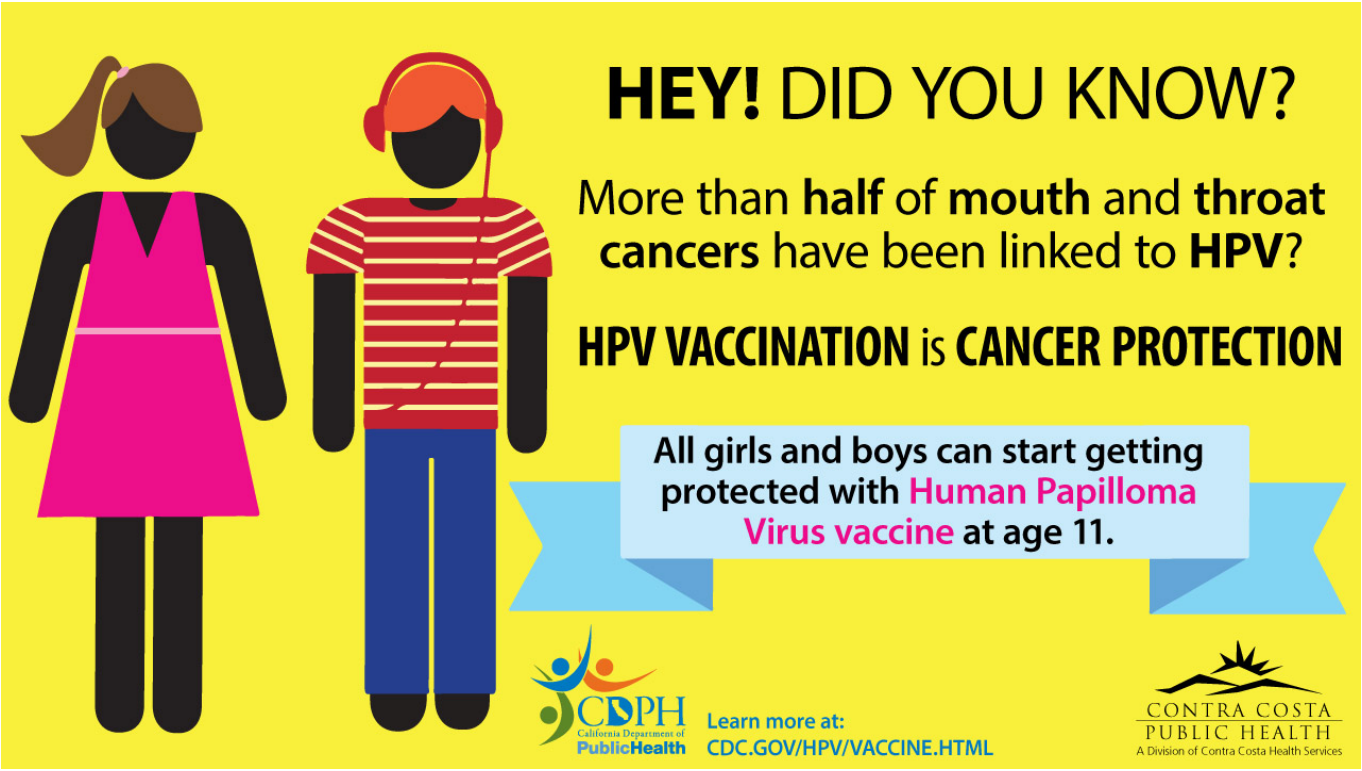
How Dentists Can Help

- Recommend **HPV vaccination** to all boys and girls starting at age 11
- Men and women can be vaccinated for HPV up to age 26
- **Examine** your patients for oral/pharyngeal cancer at each visit

Please refer patients to their primary care physician for HPV vaccination, or to the Contra Costa Public Health Immunization Program at (925) 313-6767 for free or low-cost immunization options.

Together we can prevent cancer!

For more information:
CDC: https://www.cdc.gov/cancer/hpv/basic_info/hpv_oropharyngeal.htm
Download the Team Maureen Dental Toolkit: https://teammaureen.org/about/materials/c/680



HPV Vaccine Information for Clinicians

CDC recommends HPV vaccination for girls and boys at ages 11 or 12 years to protect against cancers caused by HPV infections. CDC encourages clinicians to recommend HPV vaccination the same way and same day they recommend other routinely recommended vaccines for adolescents.

Background

Human papillomaviruses (HPV) are a very common family of viruses that infect epithelial tissue. More than 120 HPV types have been identified. Most HPV types infect cutaneous epithelial cells and cause common warts, such as those that occur on the hands and feet. Approximately 40 HPV types can infect mucosal epithelial cells, such as those on the genitals, mouth, and throat. Although most HPV infections are asymptomatic and resolve spontaneously or become undetectable, some HPV infections can persist and lead to cancer.

Persistent infections with high-risk (oncogenic) HPV types can cause cervical, vaginal and vulvar cancers in women; penile cancers in men; and oropharyngeal and anal cancers in both men and women. The most common high-risk types are HPV 16 and 18.

Infection with low-risk (non-oncogenic) HPV types can cause genital warts and rarely laryngeal papillomas. These types can also cause benign or low-grade cervical cell abnormalities. The most common low-risk types are HPV 6 and 11.

About 79 million Americans are infected with genital HPV. Approximately 14 million people become newly infected each year, mostly teens and young adults. Almost every person will acquire an HPV infection at some time in their life.

Every year in the United States, an estimated 19,200 women and 11,600 men are diagnosed with a cancer caused by HPV infection.

Of women diagnosed with an HPV cancer, cervical cancer is the most common with almost 12,000 women diagnosed annually in the United States; subsequently about 4,400 women die every year from cervical cancer in the country.

Of the men in the United States diagnosed with an HPV cancer, oropharyngeal cancer is the most common. Around 9,100 U.S. men each year are diagnosed with oropharyngeal cancer caused by HPV infection. There is no screening test for oropharyngeal cancers, making prevention of infection a priority.

HPV Vaccines

Three HPV vaccines have been licensed by the U.S. Food and Drug Administration (FDA) since 2006. HPV vaccine is recommended for routine vaccination of adolescents (including girls and boys) at age 11 or 12 years, and can be started at age 9 years.

	Bivalent/2vHPV (Cervarix)	Quadrivalent/4vHPV (Gardasil)	9-valent/9vHPV (Gardasil 9)
Manufacturer	GlaxoSmithKline	Merck	Merck
Year Licensed	October 2009 - females	June 2006 - females; October 2009 - males	December 2014 - males and females
HPV types in vaccine	16 and 18	6, 11, 16, and 18	6, 11, 16, 18, 31, 33, 45, 52, and 58
Adjuvant in vaccine	AS04: 500 µg aluminum hydroxide 50 µg 3-*O*-desacyl-4′-monophosphoryl lipid A	AAHS: 225 µg amorphous aluminum hydroxyphosphate sulfate	AAHS: 500 µg amorphous aluminum hydroxyphosphate sulfate
Recommended for…	• Females ages 11-12 (can start at age 9 years) • Females ages 13 through 26 who were not adequately vaccinated previously	• Females and males ages 11-12 (can start at age 9 years) • Females ages 13 through 26 and males ages 13 through 21 who were not adequately vaccinated previously • Males ages 22 through 26 with certain immunocompromising conditions; gay, bisexual, and other men who have sex with men (MSM); and transgender persons who were not adequately vaccinated previously	• Females and males ages 11-12 (can start at age 9 years) • Females ages 13 through 26 and males ages 13 through 21 who were not adequately vaccinated previously • Males ages 22 through 26 with certain immunocompromising conditions; gay, bisexual, and other men who have sex with men (MSM); and transgender persons who were not adequately vaccinated previously
Contraindicated for…	People with anaphylaxis caused by latex	People with immediate hypersensitivity to yeast	People with immediate hypersensitivity to yeast

National Center for Immunization and Respiratory Diseases
Office of the Director

Bivalent HPV vaccine protects against two types of HPV, quadrivalent HPV vaccine protects against four types of HPV, and 9-valent HPV vaccine protects against nine types of HPV. Bivalent, quadrivalent, and 9-valent HPV vaccine all protect against HPV 16 and 18, the HPV types that cause about 66% of cervical cancers and the majority of other HPV-attributable cancers in the United States. Quadrivalent and 9-valent HPV vaccine also protect against HPV 6 and 11, the HPV types that cause anogenital warts. In addition, 9-valent HPV vaccine targets five additional cancer-causing types, which account for another 15% of cervical cancers (12).

The additional five types in 9-valent HPV vaccine account for a higher proportion of HPV-associated cancers in women compared with men, and also cause cervical precancers in women. Therefore, the additional protection from 9-valent HPV vaccine will mostly benefit women.

After the end of 2016, only 9-valent HPV vaccine will be available in the United States.

HPV Vaccine Recommendations

HPV vaccine is routinely recommended for adolescents at age 11 or 12 years. Vaccination is also recommended for females ages 13 through 26 years and males ages 13 through 21 years who were not adequately vaccinated when they were younger. Vaccination is also recommended for gay, bisexual, and other men who have sex with men, transgender people, and persons with certain immunocompromising conditions ages 22 through 26 years who were not adequately vaccinated when they were younger.

Ideally, adolescents should be vaccinated before they are exposed to HPV. However, people who have already been infected with one or more HPV types can still get protection from other HPV types in the vaccine.

HPV vaccines *can* safely be given to…

- Patients with minor acute illnesses, such as diarrhea or mild upper respiratory tract infections, with or without fever.
- Women who have had an unclear or abnormal Pap test, a positive HPV test, or genital warts. However, these patients should be advised that the vaccine may not have any therapeutic effect on existing Pap test abnormalities, HPV infection, or genital warts.
- Patients with immunocompromising conditions, including certain diseases or medications. However, the immune response to vaccination and effectiveness of the vaccine might be less than in people with a normally functioning immune system.
- Women who are breastfeeding.

HPV vaccines should *not* be given to…

- Patients with a history of allergies to any vaccine component. Quadrivalent vaccine (4vHPV) and nine-valent vaccine (9vHPV) are not recommended for people with immediate hypersensitivity to yeast. Bivalent vaccine (2vHPV) is not recommended for people with anaphylaxis caused by latex.
- Patients with moderate or severe acute illnesses. In these cases, patients should wait until the illness improves before getting vaccinated.
- Pregnant women. However, HPV vaccines have not been shown to cause any adverse pregnancy outcomes or adverse events for the mother or her developing fetus.
  - If a woman is found to be pregnant after starting the HPV vaccine series, second and/or third doses should be delayed, and given after she is no longer pregnant.
  - Pregnancy testing is not needed before vaccination. If a pregnant woman does receive HPV vaccine, no intervention is needed.
  - Exposure to 9vHPV vaccine during pregnancy can be reported to the manufacturer. Pregnancy registries for 4vHPV and 2vHPV were closed after >6 years, with FDA concurrence.

HPV Vaccine Safety

HPV vaccines are very safe. Scientific research shows the benefits of HPV vaccination far outweigh the potential risks. Like all medical interventions, vaccines can have some side effects. Nearly 90 million doses of HPV vaccines have been distributed in the United States since the first HPV vaccine was introduced in 2006. The most common side effects associated with HPV vaccines are mild, and include pain, redness, or swelling in the arm where the shot was given.

All vaccines used in the United States, including HPV vaccines, are required to go through years of extensive safety testing before they are licensed by the U.S. Food and Drug Administration (FDA). During clinical trials conducted before they were licensed:

- 9-valent HPV vaccine was studied in more than 15,000 males and females
- Quadrivalent HPV vaccine was studied in more than 29,000 males and females
- Bivalent HPV vaccine was studied in more than 30,000 females
- Each HPV vaccine was found to be safe and effective.

Syncope (fainting) can occur after any medical procedure, including vaccination. Recent data suggest that syncope after any vaccination is more common in adolescents. Adolescents and adults should be seated or lying down during vaccination, and remain that way for 15 minutes after vaccination, under clinician observation. This is to prevent any injuries that could occur from a fall during a syncopal event.

Adverse events occurring after administration of any vaccine should be reported to the Vaccine Adverse Event Reporting System (VAERS). Additional information about VAERS is available by telephone (1-800-822-7967) or online (https://vaers.hhs.gov).

HPV Vaccine Effectiveness

HPV vaccines work extremely well. HPV vaccine was first recommended in 2006 in the United States, and by 2010, quadrivalent type HPV infections in teen girls decreased by 56%, and decreases in prevalence were also observed in women in their early 20s. Research has also shown that fewer U.S. teens are getting genital warts since HPV vaccines have been in use. Also, decreases in vaccine-type prevalence, genital warts, and cervical dysplasia have been observed in other countries with HPV vaccination programs.

There are no data to suggest HPV vaccines will treat existing diseases or conditions caused by HPV. However, people who already have HPV-associated diseases or conditions can still get protection from other HPV types covered by the vaccines.

Cervical cancer screening is recommended for women beginning at age 21 years and continuing through age 65 years for both vaccinated and unvaccinated women. Women who have received any HPV vaccine should still be screened for cervical cancer beginning at age 21 years, in accordance with currently published cervical cancer screening guidelines. There are no screening recommendations for other cancers caused by HPV.

Duration of Vaccine Protection

Studies suggest that HPV vaccines offer long-lasting protection against HPV infection and therefore disease caused by HPV infection. Studies of the bivalent and quadrivalent vaccines have followed vaccinated individuals for around ten years, and so far have found no evidence of protection decreasing over time. Duration of protection provided by HPV vaccination will continue to be studied.

HPV Vaccine Dosing Schedules

- If the first dose of any HPV vaccine is given before the 15th birthday, vaccination should be completed according to a 2-dose schedule. In a 2-dose series, the second dose is recommended 6–12 months after the first dose (0, 6–12 month schedule).
- If the first dose of any HPV vaccine is given on or after the 15th birthday, vaccination should be completed according to a 3-dose schedule. In a 3-dose series, the second dose is recommended 1–2 months after the first dose, and the third dose is recommended 6 months after the first dose (0, 1–2, 6 month schedule).
- In a 2-dose schedule of HPV vaccine, the minimum interval is 5 months between the first and second dose. If the second dose is administered at a shorter interval, a third dose should be administered a minimum of 12 weeks after the second dose and a minimum of 5 months after the first dose.
- In a 3-dose schedule of HPV vaccine, the minimum intervals are 4 weeks between the first and second dose, 12 weeks between the second and third dose, and 5 months between the first and third dose. If a vaccine dose is administered at a shorter interval, it should be re-administered after another minimum interval has been met since the most recent dose.

Although minimum intervals are stated in the dosing schedule, there is no maximum interval. There is no reason to restart the vaccine series if the HPV vaccine schedule is interrupted; patients who have exceeded the minimum interval for the next dose by months or even years, may be given the next dose needed. 9-valent HPV vaccine may be used to continue or complete a vaccination series started with quadrivalent or bivalent HPV vaccines.

There is no ACIP recommendation regarding additional 9-valent HPV vaccine doses for persons who have been adequately vaccinated with bivalent or quadrivalent HPV vaccine.

HPV vaccine can safely be administered at the same visit as other vaccines recommended for adolescents at ages 11 or 12 years, such as tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) vaccine, quadrivalent meningococcal conjugate (MenACWY) vaccine, and influenza vaccine. Administering all indicated vaccines at a single visit at ages 11 or 12 years increases the likelihood that patients receive their vaccinations on schedule.

As mentioned previously, patients should be observed for 15 minutes after receiving any shot, including HPV vaccine.

Paying for HPV Vaccine

As with all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), HPV vaccines are covered by insurance. For patients that need assistance paying for HPV vaccine, the Vaccines for Children (VFC) program may be able to help. VFC provides vaccines for children ages 18 years and younger who are uninsured, Medicaid-eligible, or American Indian/Alaska Native. Learn more about the VFC program at www.cdc.gov/Features/VFCprogram.

Related Resources

Petrosky E, Bocchini JA, Jr., Hariri S, Chesson H, Curtis CR, Saraiya M, et al. Use of 9-valent human papillomavirus (HPV) vaccine: updated HPV vaccination recommendations of the advisory committee on immunization practices. MMWR Morb Mortal Wkly Rep. 2015 Mar 27;64(11):300-4. 304. Print version [24 pages}

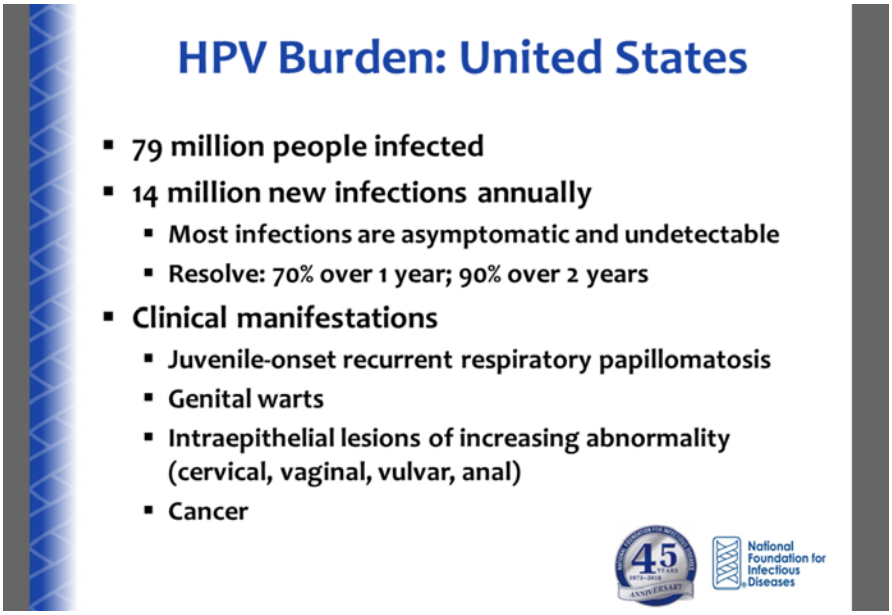
Markowitz LE, Dunne EF, Saraiya M, Chesson HW, Curtis CR, Gee J, Bocchini JA Jr, Unger ER. Human papillomavirus vaccination: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep 2014;63(RR-05):1-30.

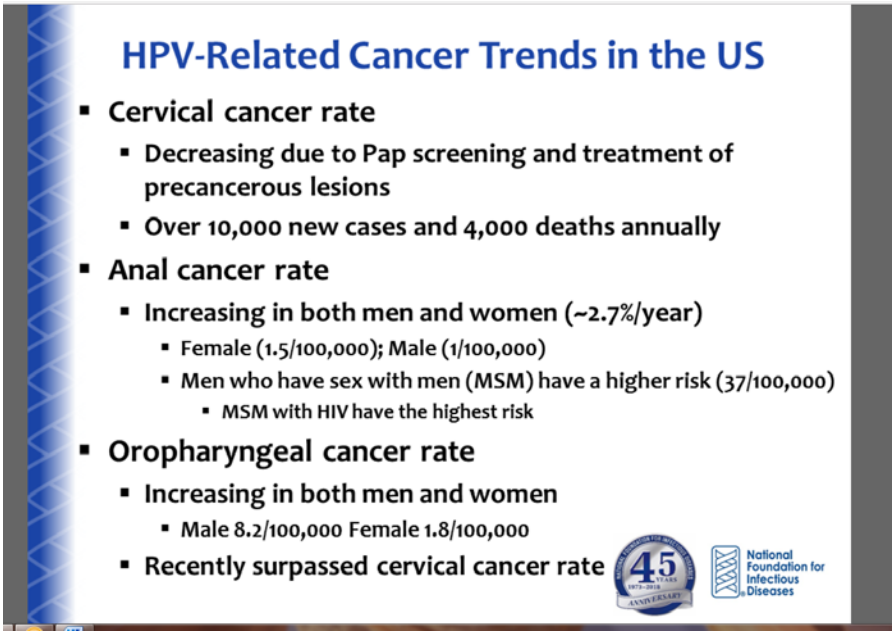
Food and Drug Administration. Prescribing information [Package insert]. Gardasil 9 [Human Papillomavirus 9-valent Vaccine, Recombinant], Merck & Co., Inc. Silver Spring, MD: U.S. Department of Health and Human Services, Food and Drug Administration; 2016; Available from: http://www.fda.gov/downloads/BiologicsBloodVaccines/Vaccines/ApprovedProducts/UCM426457.pdf.

Meites E, Kempe A, Markowitz LE. Use of a 2-Dose Schedule for Human Papillomavirus Vaccination — Updated Recommendations of the Advisory Committee on Immunization Practices. MMWR Morb Mortal Wkly Rep 2016;65: 1405–1408. http://dx.doi.org/10.15585/mmwr.mm6549a5.

Abbreviated slides and notes form NFID Webinar **HPV Vaccination: Recommendations and Strategies for Improving Coverage** March 21, 2018

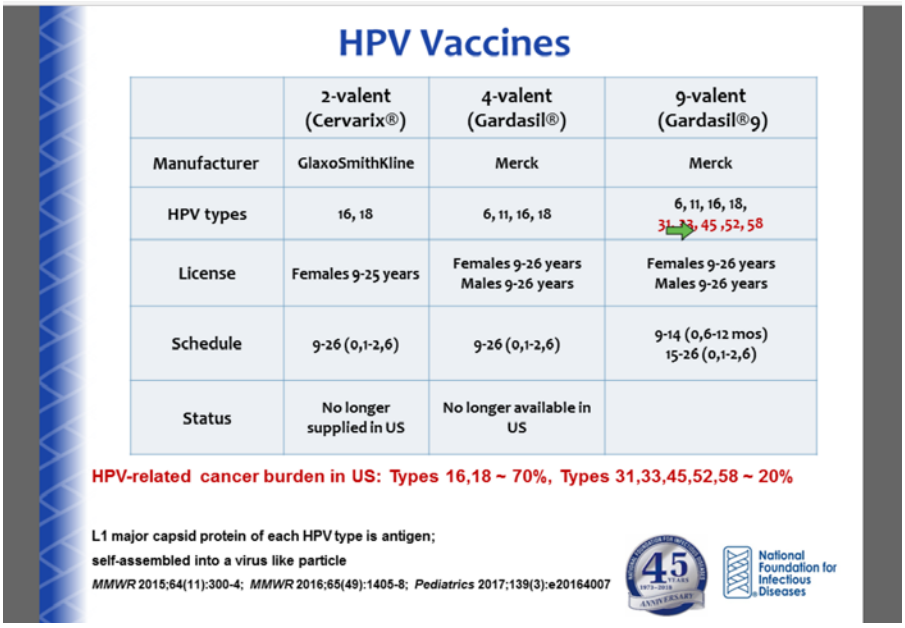
For recorded webinar and full slide deck
visit: https://cc.readytalk.com/cc/s/meetingArchive?eventId=fo1v0wcrkrzb

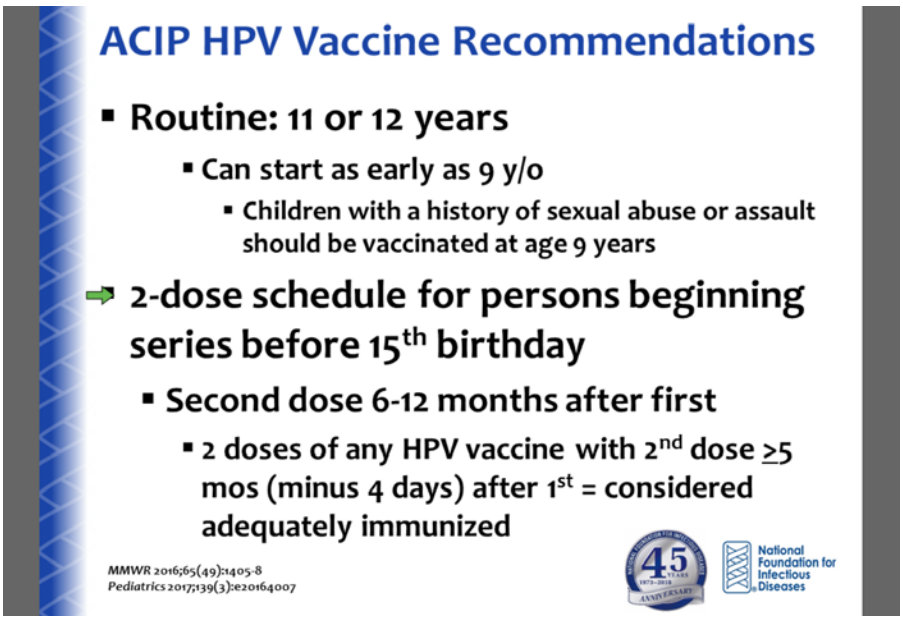




Oral/pharyngeal most common in MSM particularly HIV+

9 valent vaccine has potential to reduce cancer by **90%**





Only 2 doses if begin series before 15th birthday.

3 dose series if ages 15-26.

Anti-HPV 16 cLIA GMTs in PPI Population 1 Month after Last Dose

Population	N	n	GMT (mMU/mL)	GMT ratio relative to 3-dose regimen in 16-26 y/o females (95% CI)
9-14 y/o girls (0,6)	301	272	8004.9	2.54 (2.12,3.00)
9-14 y/o boys (0-6)	301	273	8474.8	2.69 (2.29,3.15)
9-14 girls and boys (0,12)	300	264	14,329.3	4.54 (3.84,5.37)
9-14 y/o girls (0,2,6)	300	269	6996.0	2.22 (1.89,2.61)
16-26 y/o women (0,2,6)	314	249	3154.0	1

From JAMA 2016;316(22):2411-21 and Table 11, GARDASIL 9 Package Insert, 10/ 2016 version

PPI population = received all assigned vaccinations within pre-defined day ranges, did not have major deviations from protocol, met interval criteria for blood draws

45 YEARS 1973–2018 ANNIVERSARY

National Foundation for Infectious Diseases

Antibody response much higher for younger group.

Also delaying 2nd dose to 12 months in younger group increases antibody response.

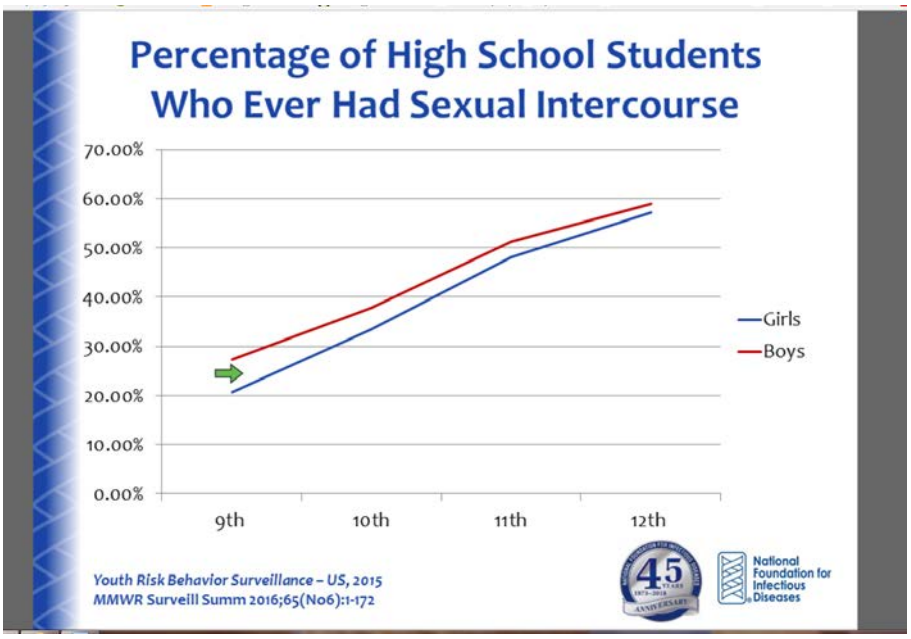
Rationale for Recommendation for Immunization of 11-12 Year Olds

- Modeling shows greater impact if given universally before onset of sexual activity
- Antibody response in 11-15 year olds is greater than 16-26 year olds
  - Protection has persisted for >12 years
  - Kinetics 3-5 years after 2-dose schedule are similar
- Vaccine is well-tolerated in this age group
- Implementation advantage: visit at age 11-12 already scheduled as immunization visit

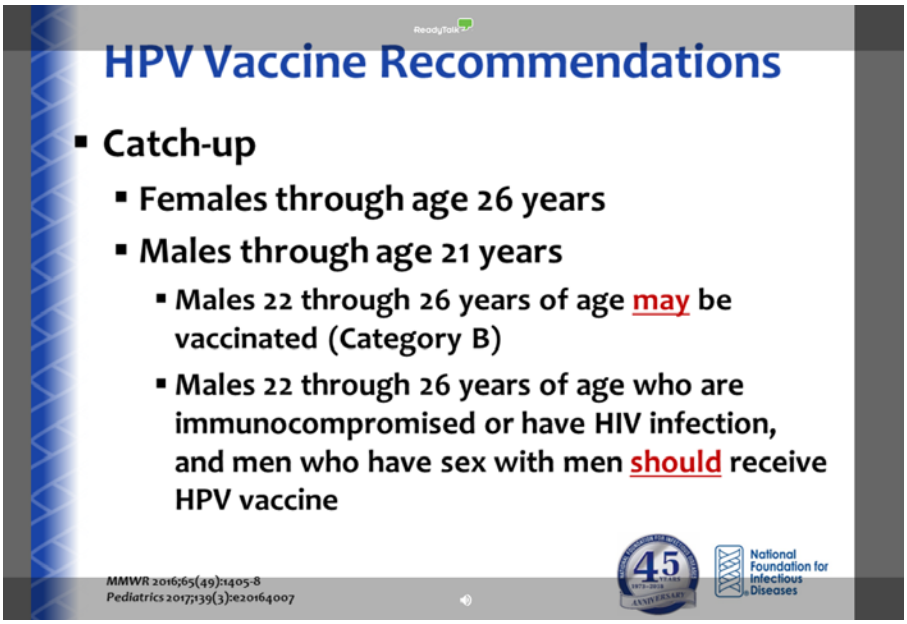
MMWR 2016;65(49):1405-8
Pediatrics 2017;139(3):e20164007

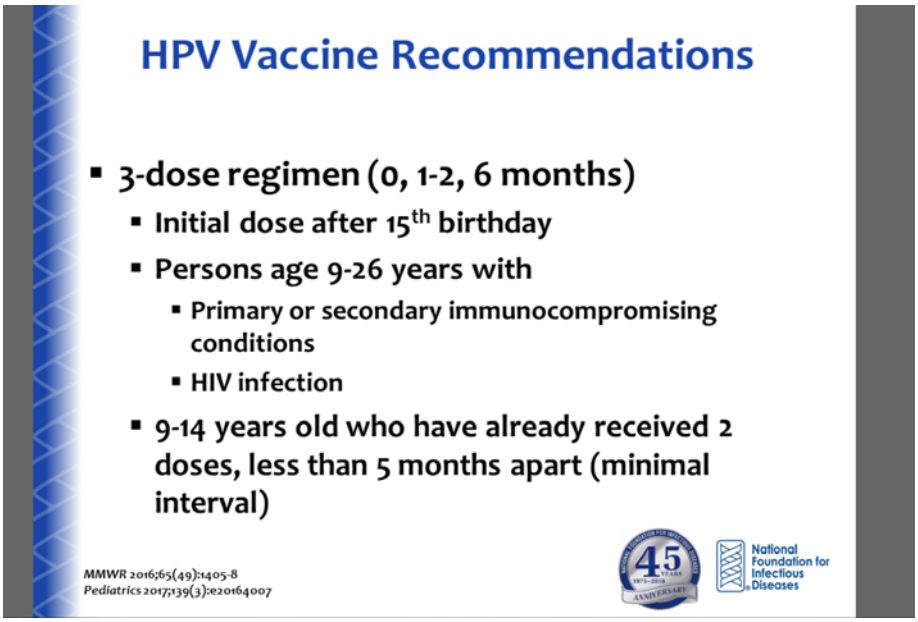
45 YEARS 1973–2018 ANNIVERSARY

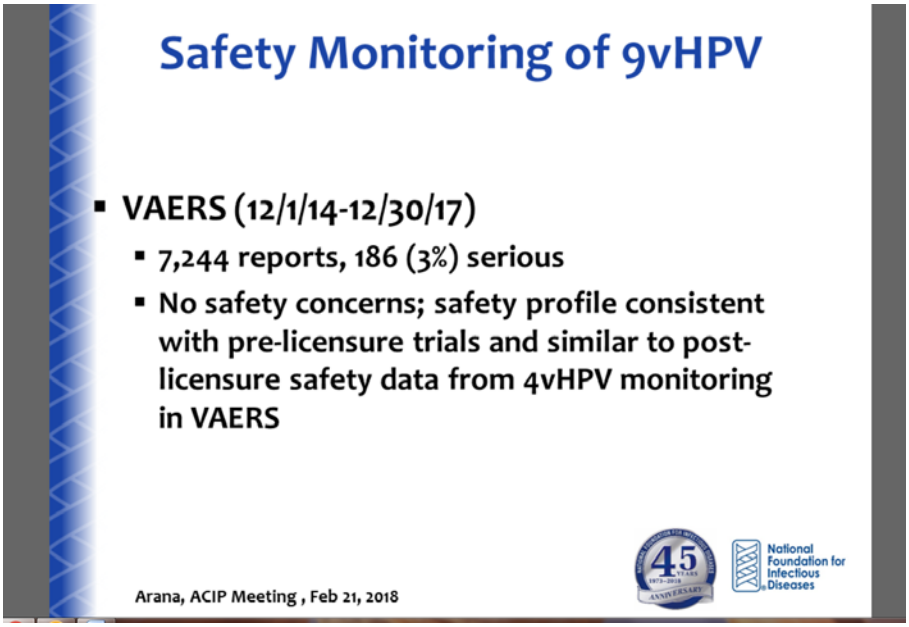
National Foundation for Infectious Diseases



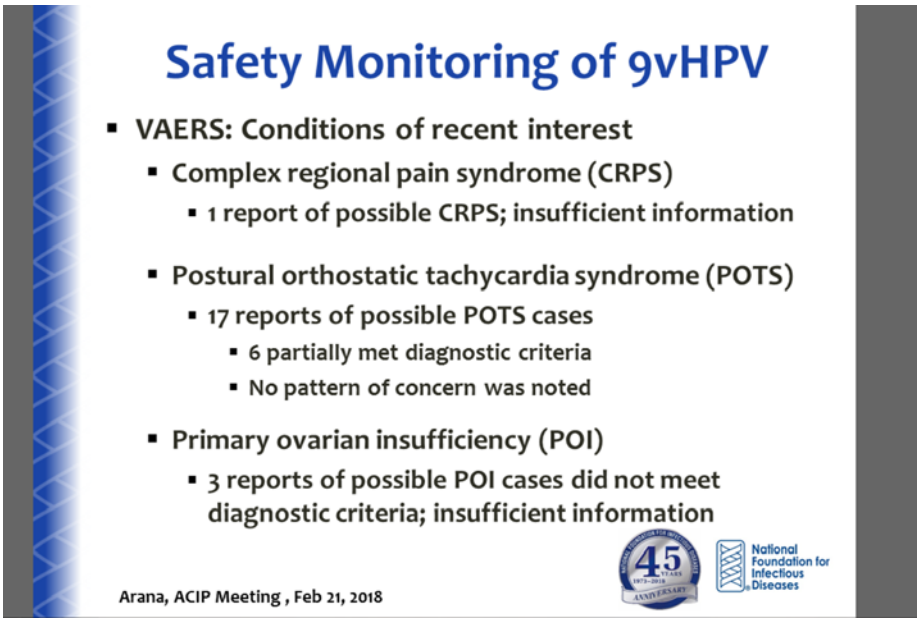
However they experiment with other types of sexual contact before intercourse, which still puts them at risk for HPV (mucous membrane contact)



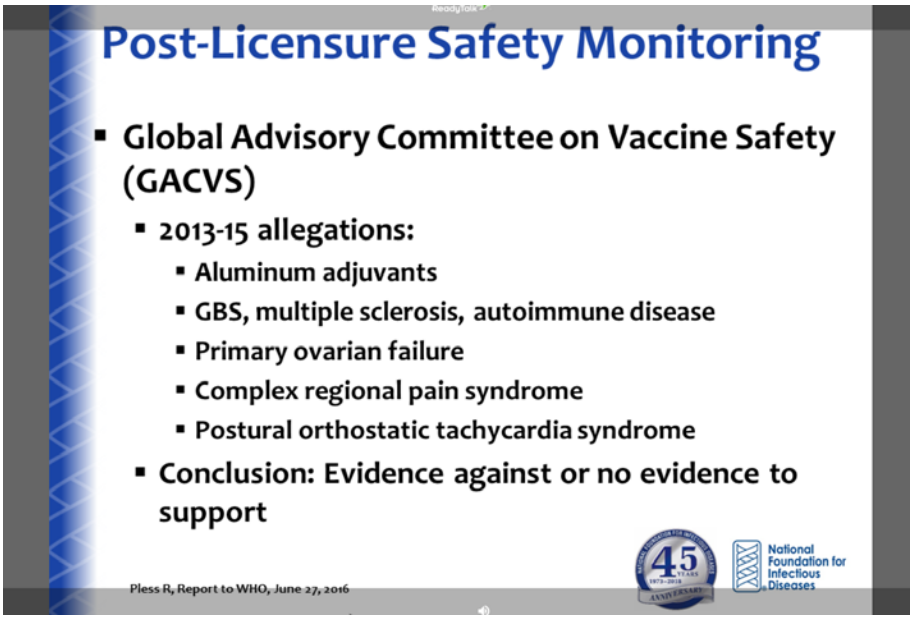




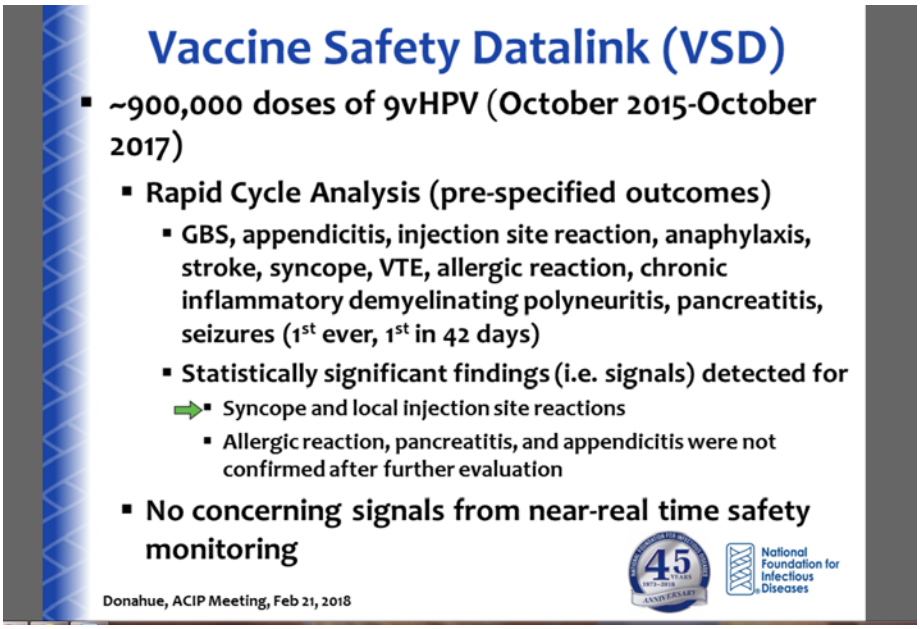
Very similar to every other vaccine that has been licensed



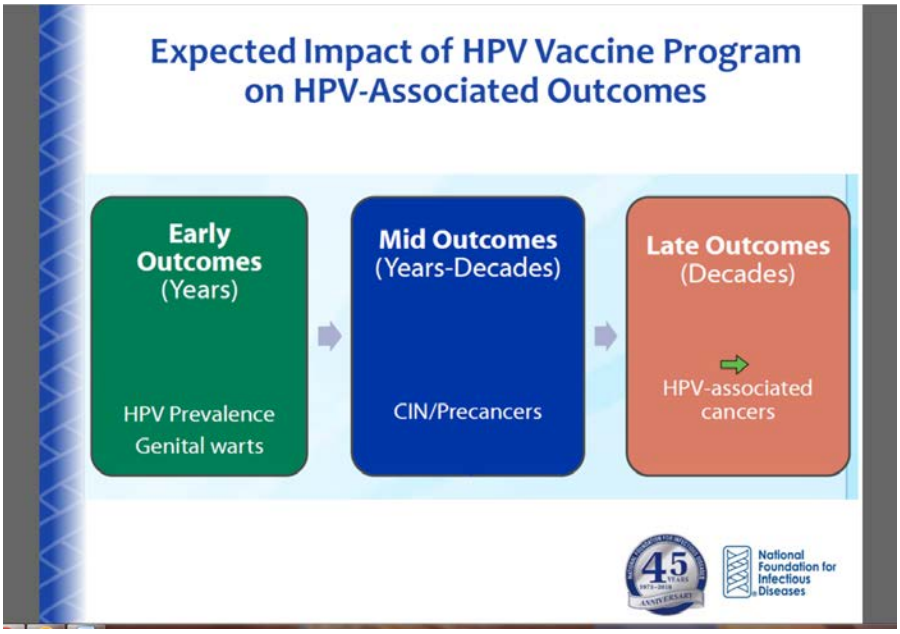
Insufficient information to provide link to vaccine



Global advisory committee (WHO)



ACIP – no concerning signals from real time monitoring



We can't see outcomes yet as it takes decades for cancer to develop

However we can see early outcomes: changes in rates of genital warts, cervical lesions, types of HPV prevalent

Prevalence of HPV Vaccine Types Before and After Introduction of 4vHPV in Females

HPV type	2003-2006	2009-2012[1]	2011-2014[2]	2003 to 2014
HPV 6/11/16/18				
14-19 y/o	11.5%	4.3%	3.3%	↓ 71%
20-24 y/o	18.5%	12.1%	7.2%	↓ 61%
25-29 y/o	11.8%	11.7%	8.8%	↓ 25%
HPV16/18	7.1%	2.8%	-----	↓ 60%
4vHPV types in sexually active, unvaccinated vs vaccinated with ≥1 dose (14-24 y/o)			12.2% vs 2.0%[3]	VE = 83%
Rates of non-4vHPV and non-4vHPV-HR types were unchanged				

National Health and Nutrition Examination Survey (NHANES), US, 2003-2014; Nationally representative cross-sectional survey; self collected cervicovaginal swab, pre- and post-vaccine introduction

[1] *Pediatrics* 2016;137(3):e20151968 [2] *J Infect Dis* 2017;0000:1–10
[3] 89% decrease in immunized, 34% decrease in unimmunized

National Foundation for Infectious Diseases

This slide shows how prevalence of HPV types over time, indicating vaccination is working in reducing types of HPV related to cancers

Juvenile-Onset Recurrent Respiratory Papillomatosis: Australia

- Due to HPV 6 and 11
- HPV vaccination of females begun in 2007
- Surveillance Unit, 5 year findings
- 15 cases
  - No mothers vaccinated
  - 20% with Hx of genital warts
  - 13/15 vaginal delivery
  - HPV-6 (n=4), HPV-11 (n=3)

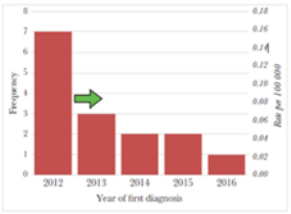


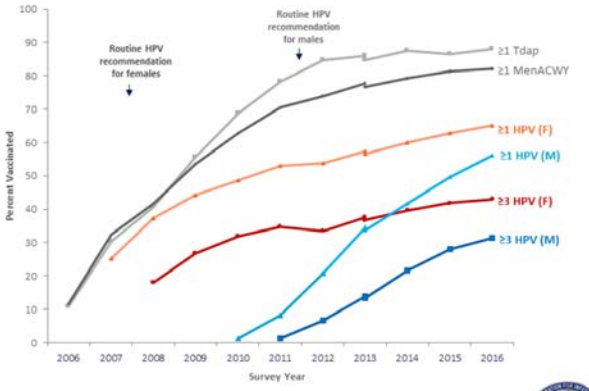
Figure 1. Incident cases of juvenile onset recurrent respiratory papillomatosis notified in Australia per year 2012–2016. *Frequency and rates per 100,000 children aged 0–14 years. Notes: Difference between rate in 2012 and 2016 $P = 0.036$. *Surveillance commenced in October 2011 but no cases were reported in 2011.

J Infect Dis 2018;217:208–12

National Foundation for Infectious Diseases

This is a disorder in young infants born to mothers with HPV. Reduced

Estimated Vaccination Coverage Among Adolescents Aged 13–17 years, NIS-Teen, United States, 2006–2016



Walker et al. MMWR 2017 NIS-Teen, National Immunization Survey-Teen;
Note: revised definition of adequate provider data in 2013

National Foundation for Infectious Diseases

Coverage much lower than we see for other vaccines

Why Is HPV Vaccine Coverage So Low?

Parents

- Not offered vaccination
- Perceive vaccine as optional or unnecessary at that time
- Perceive that their providers discouraged vaccination
- Want information about vaccine safety
- Do not understand the reason to vaccinate at 11 to 12 years of age

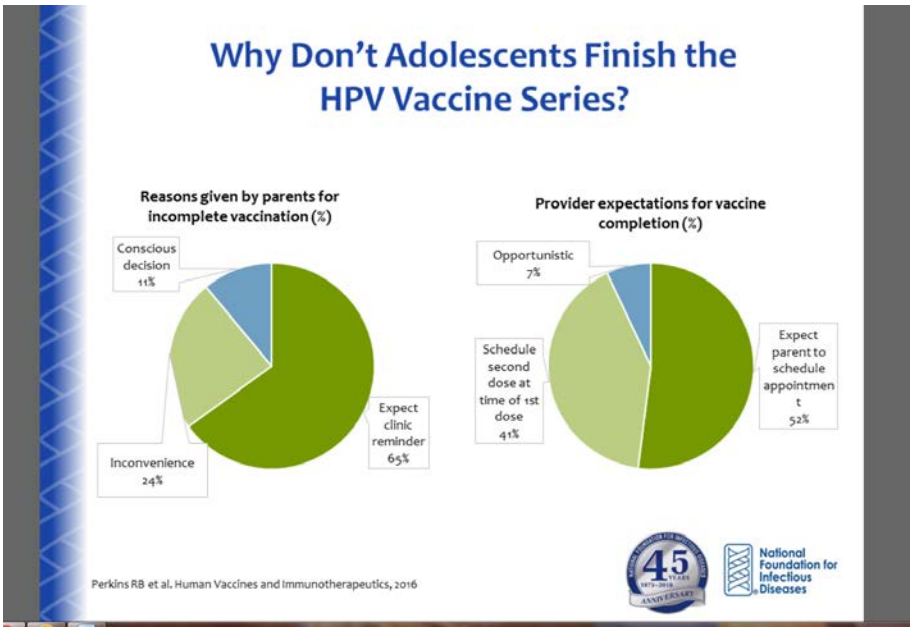
Providers

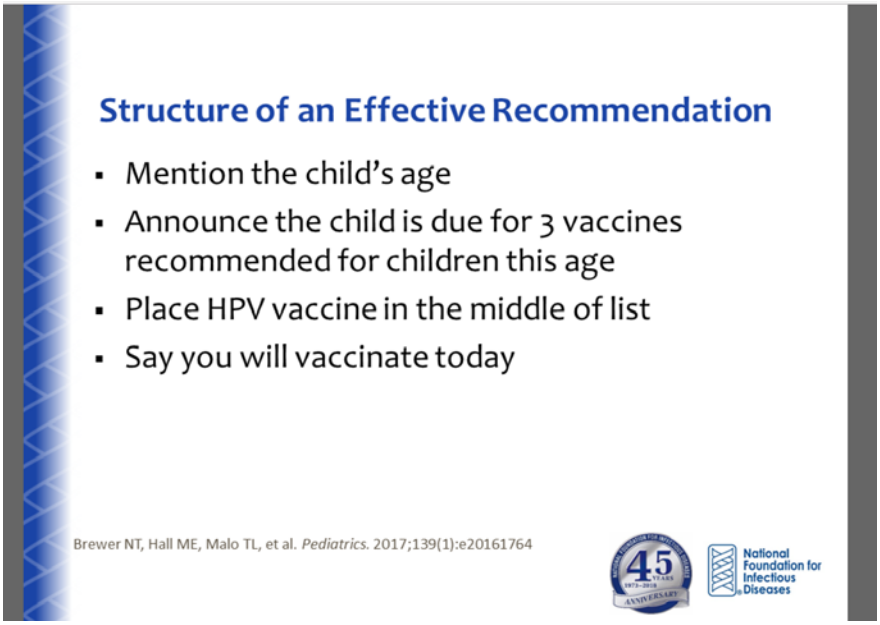
- Reluctant to give multiple shots at one visit
- Introduce HPV vaccination at age 11 years but do not recommend it strongly
- Recommend vaccination based on their estimation of sexual activity
- Have limited experience with HPV and underestimate risk
- Perceive HPV as more emotionally charged than other vaccines
- Delaying vaccination leads to nonvaccination

Both providers and parents know they are often unaware of the timing of sexual debut.

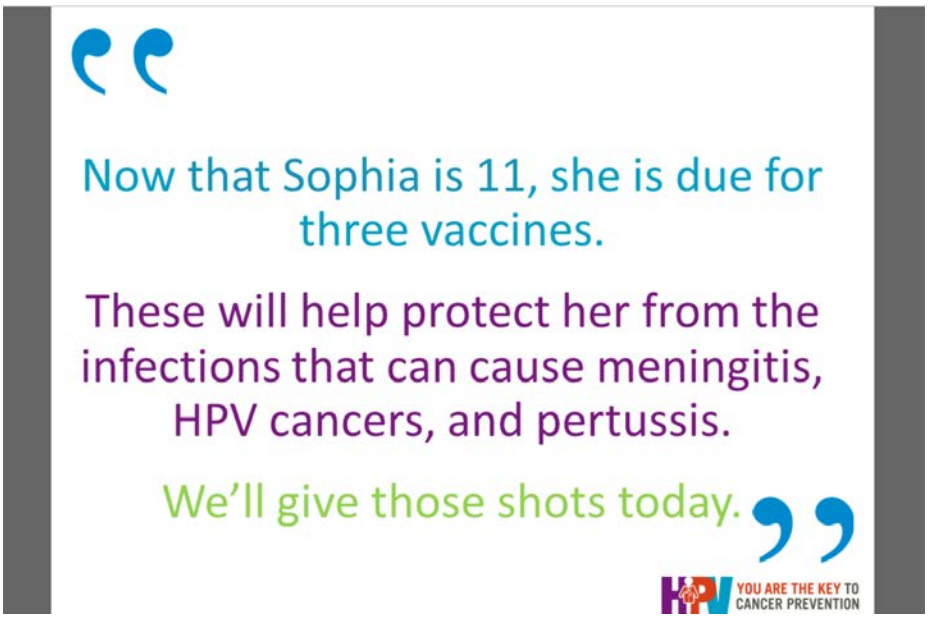
Perkins RB et al. Pediatrics 2014;134:e666-e674

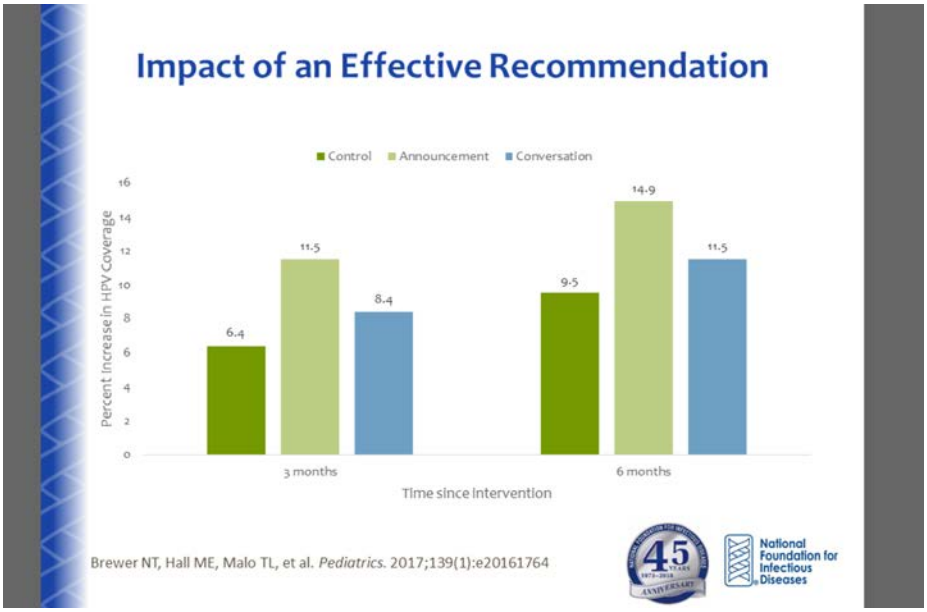
National Foundation for Infectious Diseases



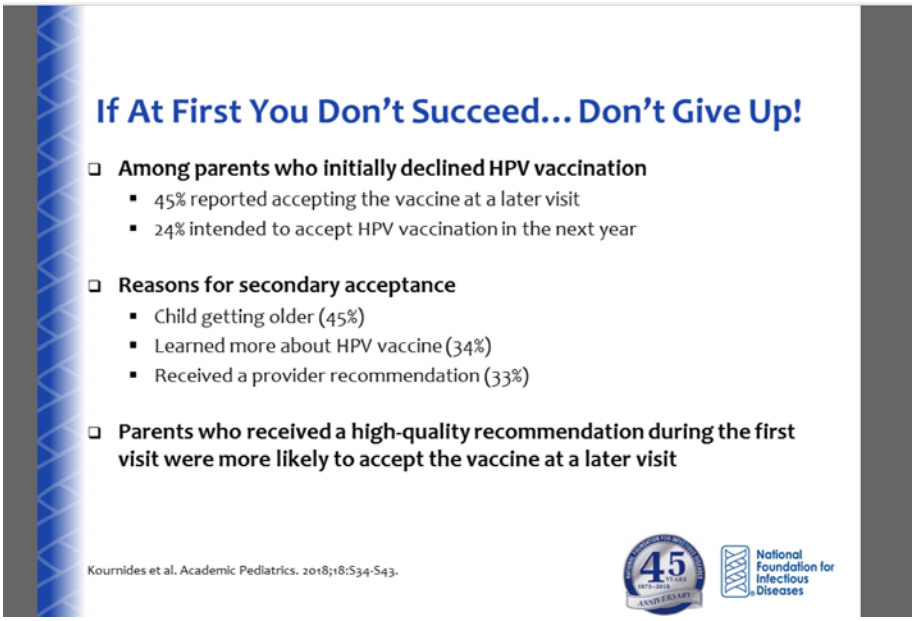


Say Tdap last as this is required for school





Results of testing this approach



Q&A

Q: IF they have received HPV 4, is it advisable to get HPV 9 later?

A: Yes, it provides add'l coverage. Can get full series of 9 valent. Safe and effective to do so. Will need 3 doses as will likely be over 15 yo. Not clear if insurance will cover.

Vast majority of oral/pharyngeal cancer are due to type 16

Q: Is vaccine safe in women who are older?

A: Yes safe in 27-40, effective. Wasn't pursued in licensure. If they want to get it, they can if their provider decides they could benefit. However, may not be covered by insurance.

Subject: HCV Policy Update

Dear Medi-Cal Managed Care Health Plan (MCP) Partners:

DHCS would like to inform you that as of July 1, 2018 treatment for all patients ages 12 and above with Hepatitis C, regardless of liver fibrosis stage or co-morbidity, excepting patients with a shortened life expectancy, will be available as a Medi-Cal benefit.

DHCS is in the process of updating its Hepatitis C policy which will be available in the DHCS Provider Manual, as well as at the DHCS website, shortly after July 1st (current policy here: http://www.dhcs.ca.gov/Pages/HepatitisC.aspx). The updated policy will refer to the American Association for the Study of Liver Diseases (AASLD) for recommended treatment regimens and duration of treatment. Treatment candidates will be all patients ages 12 and above with chronic Hepatitis C infection, excepting those with a limited life expectancy (less than twelve months). Further details will be forthcoming in the updated policy.

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Interventions to Prevent Falls in Community-Dwelling Older Adults

US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

Related article and JAMA Patient Page

CME Quiz at

Related article at

IMPORTANCE Falls are the leading cause of injury-related morbidity and mortality among older adults in the United States. In 2014, 28.7% of community-dwelling adults 65 years or older reported falling, resulting in 29 million falls (37.5% of which needed medical treatment or restricted activity for a day or longer) and an estimated 33 000 deaths in 2015.

OBJECTIVE To update the 2012 US Preventive Services Task Force (USPSTF) recommendation on the prevention of falls in community-dwelling older adults.

EVIDENCE REVIEW The USPSTF reviewed the evidence on the effectiveness and harms of primary care–relevant interventions to prevent falls and fall-related morbidity and mortality in community-dwelling older adults 65 years or older who are not known to have osteoporosis or vitamin D deficiency.

FINDINGS The USPSTF found adequate evidence that exercise interventions have a moderate benefit in preventing falls in older adults at increased risk for falls and that multifactorial interventions have a small benefit. The USPSTF found adequate evidence that vitamin D supplementation has no benefit in preventing falls in older adults. The USPSTF found adequate evidence to bound the harms of exercise and multifactorial interventions as no greater than small. The USPSTF found adequate evidence that the overall harms of vitamin D supplementation are small to moderate.

CONCLUSIONS AND RECOMMENDATION The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls. (B recommendation) The USPSTF recommends that clinicians selectively offer multifactorial interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls. Existing evidence indicates that the overall net benefit of routinely offering multifactorial interventions to prevent falls is small. When determining whether this service is appropriate for an individual, patients and clinicians should consider the balance of benefits and harms based on the circumstances of prior falls, presence of comorbid medical conditions, and the patient's values and preferences. (C recommendation) The USPSTF recommends against vitamin D supplementation to prevent falls in community-dwelling adults 65 years or older. (D recommendation) These recommendations apply to community-dwelling adults who are not known to have osteoporosis or vitamin D deficiency.

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

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( )

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News Release

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH

FOR IMMEDIATE RELEASE
May 14, 2018
PH18-029
CONTACT: Corey Egel | 916.440.7259 | CDPHpress@cdph.ca.gov

Reported Sexually Transmitted Diseases Reach a New High in California

SACRAMENTO – A record number of Californians were diagnosed with a sexually transmitted disease (STD) in 2017, according to a new report released by the California Department of Public Health (CDPH). More than 300,000 cases of chlamydia, gonorrhea, and early syphilis were reported: a 45 percent increase compared to five years ago.

Particularly concerning, in 2017, there were 30 stillbirths due to congenital syphilis in California. This is the highest number reported since 1995.

STDs can cause a number of serious health problems. If left untreated, chlamydia and gonorrhea can cause pelvic inflammatory disease and lead to infertility, ectopic pregnancy, and chronic pelvic pain. Syphilis can cause permanent loss of vision, hearing and other neurologic problems.

Chlamydia and gonorrhea rates are highest among people under age 30. Rates of chlamydia are highest among young women, and males account for the majority of syphilis and gonorrhea cases.

“STDs are preventable by consistently using condoms, and many STDs can be cured with antibiotics,” said CDPH Director and State Public Health Officer Dr. Karen Smith. “Regular testing and treatment are very important for people who are sexually active, even for people who have no symptoms. Most people infected with an STD do not know it.”

CDPH is collaborating with local health departments and organizations throughout the state to raise awareness. CDPH is working with the California Department of Education and community groups to implement the newly enacted California Healthy Youth Act, which mandates comprehensive STD/HIV prevention education in schools.

Other state efforts leverage innovative strategies such as courses for medical providers and teachers, expedited partner treatment to local clinics, and free and low cost online ordering options for home delivery of condoms and STD test kits. For more information, visit the CDPH Sexually Transmitted Diseases Control Branch.

www.cdph.ca.gov

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Screening for Osteoporosis to Prevent Fractures
US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

IMPORTANCE By 2020, approximately 12.3 million individuals in the United States older than 50 years are expected to have osteoporosis. Osteoporotic fractures, particularly hip fractures, are associated with limitations in ambulation, chronic pain and disability, loss of independence, and decreased quality of life, and 21% to 30% of patients who experience a hip fracture die within 1 year. The prevalence of primary osteoporosis (ie, osteoporosis without underlying disease) increases with age and differs by race/ethnicity. With the aging of the US population, the potential preventable burden is likely to increase in future years.

OBJECTIVE To update the 2011 US Preventive Services Task Force (USPSTF) recommendation on screening for osteoporosis.

EVIDENCE REVIEW The USPSTF reviewed the evidence on screening for and treatment of osteoporotic fractures in men and women, as well as risk assessment tools, screening intervals, and efficacy of screening and treatment in subgroups. The screening population was postmenopausal women and older men with no known previous osteoporotic fractures and no known comorbid conditions or medication use associated with secondary osteoporosis.

FINDINGS The USPSTF found convincing evidence that bone measurement tests are accurate for detecting osteoporosis and predicting osteoporotic fractures in women and men. The USPSTF found adequate evidence that clinical risk assessment tools are moderately accurate in identifying risk of osteoporosis and osteoporotic fractures. The USPSTF found convincing evidence that drug therapies reduce subsequent fracture rates in postmenopausal women. The USPSTF found that the evidence is inadequate to assess the effectiveness of drug therapies in reducing subsequent fracture rates in men without previous fractures.

CONCLUSIONS AND RECOMMENDATION The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older. (B recommendation) The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool. (B recommendation) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis to prevent osteoporotic fractures in men. (I statement)

Editorial

Related article and JAMA Patient Page

CME Quiz at and page 2554

Related article at

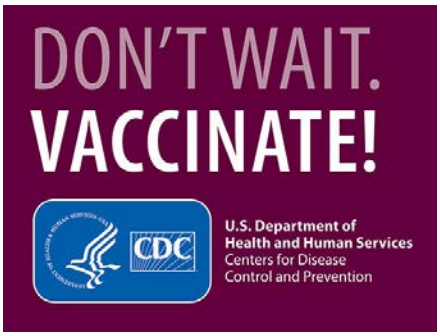
Author/Group Information: The US Preventive Services Task Force (USPSTF) members are listed at the end of this article.

Corresponding Author: Susan J. Curry, PhD, University of Iowa, 111 Jessup Hall, Iowa City, IA 52242 ( ).

JAMA. 2018;319(24):2521-2531. doi:

CCHP Adds New Shingles Vaccine to the Formulary

Andrew Haydon, PharmD – CCHP Pharmacy Director



Almost all adults over the age of 40 carry the chickenpox virus. In most people the virus is dormant and doesn't cause any problems as we get older, but unfortunately in others the virus may reawaken and cause shingles. Shingles usually develops on one side of the body (often the face or torso), and causes a red blistery rash that can be extremely painful. Typically shingles rashes clear up within 4 weeks, but may last longer in some people. In fact, about one in five people with shingles will go on to develop long-lasting nerve pain (known as post-herpetic neuralgia), which is nerve pain that can linger for months or even years after the rash goes away. According to the Centers for Disease Control and Prevention (CDC), shingles affects about 1 million people in the U.S. every year, and nearly one in three adults will experience a bout of shingles in their lifetime.

Zostavax was approved in 2006 as the first shingles vaccine, and was recommended by the Advisory Committee on Immunization Practices (ACIP) to be used in patients 60 years and older. Zostavax is given as a single shot, and has been shown to decrease the chances of getting shingles by approximately 51 percent (aggregate risk reduction over all age groups). Zostavax effectiveness in preventing shingles diminishes quickly in the aged population, with manufacturer data showing effectiveness in individuals 60-69 years of age, 70-79 years of age, and 80 years of age and older at the time of vaccination of 34%, 29%, and 36%, respectively in the fifth year post-vaccination (some recent data has actually hinted that Zostavax efficacy may wane substantially in as little as the 3rd year post-injection). This has led to the development of a second shingles vaccine.

In late 2017, a new shingles vaccine called Shingrix was licensed by the U.S. Food and Drug Administration (FDA). The CDC/ACIP finalized their recommendations in early 2018, and stated that Shingrix should be used as the preferred shingles vaccine over Zostavax. Shingrix is given as two doses, two to six months apart, and has been shown to be much more effective in preventing shingles and post-herpetic neuralgia than Zostavax. Shingrix effectiveness in preventing shingles doesn't diminish as dramatically in the aged population, with manufacturer data showing effectiveness in individuals 50-69 years of age, and 70 years and older at the time of vaccination of 97% and 91% respectively. Most importantly, Shingrix protection remains high (more than 85%) in people 70 years and older at least four years post-vaccination. The CDC recommends that all healthy adults 50 years and older should get Shingrix even if:

SHINGRIX
HERPES ZOSTER VACCINE (NON-LIVE RECOMBINANT, AS01$_B$ ADJUVANTED)

- they had shingles in the past
- they received Zostavax in the past
- they are not sure if they had chickenpox in the past

It is also important to note that there is no maximum age for getting Shingrix, and there is no specific length of time that you need to wait after having shingles before you can receive Shingrix (but

generally you should make sure the shingles rash has gone away before getting vaccinated). Also, if you received Zostavax in the past, you should wait at least eight weeks before getting Shingrix.

Because Shingrix has been shown to be much more effective than the older vaccine, and because the CDC recommends that Shingrix be given instead of Zostavax, CCHP has added Shingrix to the formulary for all of our members effective January 1, 2018. Please contact the CCHP pharmacy unit with any questions.

Zoster Vaccine Quick Reference:

	SHINGRIX HERPES ZOSTER VACCINE (NON-LIVE RECOMBINANT, AS01B ADJUVANTED)	ZOSTAVAX Zoster Vaccine Live
CDC/ACIP Preferred Zoster Vaccine	YES	NO
Eligible Patients	50 years and above	60 years and above
Series	2 shots (2-6 months apart)	1 shot
Administration	Intra-muscular	Sub-Q
Live vaccine?	NO	YES
Contains an adjuvant booster?	YES	NO
Efficacy	Superior (short/long-term)	Inferior
On the CCHP formulary?	YES	YES

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.”

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