



Agenda

Quarterly Community Provider Network (CPN) Meeting

Contra Costa Health Plan – Community Plan

When: Time: 7:30 AM – 9:00 AM
Date: October 28, 2014

Where: 1350 Arnold Drive Conference Room 103
Martinez

The agenda for the meeting is as follows:

I.	CALL TO ORDER and INTRODUCTIONS	James Tysell, MD
II.	REVIEW and APPROVAL of MINUTES from previous meeting	James Tysell, MD
III.	REGULAR REPORTS	
	<ul style="list-style-type: none"> Medical Director's Report 	James Tysell, MD
	<ul style="list-style-type: none"> HEDIS 	James Tysell, MD
IV.	NEW BUSINESS	
	<ul style="list-style-type: none"> Smoking Cessation Flu Updates Adolescent SHA 	Jenny Galindo, RN Mary Berkery, RN
VI.	OTHER	
	<ul style="list-style-type: none"> Provider Concerns 	James Tysell, MD
VII.	ADJOURNMENT	

Unless otherwise indicated below, Contra Costa Health Plan – Community Plan hereby adopts all issues, findings, or resolutions discussed in the Agenda for Contra Costa Health Plan, dated October 28, 2014 and attached herein.

Our next scheduled meeting is:

Tuesday, January 27, 2015
7:30 AM – 9:00 AM

CPN Quarterly Meeting

CONFIDENTIAL – Protected by California Evidence Code 1157

CONTRA COSTA HEALTH PLAN
 East/Central County
 Quarterly Community Provider Network (CPN)
Meeting Minutes – October 28, 2014

Attending:

CCHP Staff: J. Tysell, MD, Chair; R. Cohen, MD, Medical Consultant; M. Berkery, RN; J. Galindo, RN, PHN; L.M. Perez, CPCS

CPN Providers: S.M. Chang, MD; N. Essa, MD; G. Graves, MD; S. Huerta, CPNP; A. Mahdavi, MD; C. Mayor, NP; T. Mostaghani, MD; S. Sachdeva, MD; S. Shtivelman, MD; R. Tracy, MD; L. Yang, MD; J.G. Zimmerman, MD

Discussion	Action	Accountable
Meeting called to order @ 7:40 a.m.		J. Tysell, MD
I. Agenda was approved with no revisions.		J. Tysell, MD
II. Review and Approval of Minutes from July 22, 2014: Minutes were approved as presented. Rose Cohen, MD cardiologist at CCRMC and now working as a medical consultant for CCHP was welcomed.		J. Tysell, MD
III. Regular Reports: <ul style="list-style-type: none"> • Medical Director's Report <ul style="list-style-type: none"> ▪ Health Plan continues to grow with Medi-Cal <ul style="list-style-type: none"> - Impacted services at CCRMC and clinics - May increase CPN and FQHC assignments ▪ 2014 year of added benefits (changes) for Medi-Cal recipients <ul style="list-style-type: none"> - Mental Health <ul style="list-style-type: none"> o Working with referring providers for coordination of care o Future substance use experience capability to the Access Line - Autism <ul style="list-style-type: none"> o Starting to get referrals from providers o Dr. Blaisch is active in this area and working with County pediatricians with assessments o Have criteria for patients who may be eligible for ABA (Applied Behavior Analysis) o Working with existing system to try not to interrupt appropriate care o Expecting better and faster capability than in the past o Health Plan will give updates - Alcohol and Other Drugs substance use disorders for adolescent and adults <ul style="list-style-type: none"> o May become a Health Plan benefit o State is looking at coordinating services ▪ State Quarterly Meeting Update <ul style="list-style-type: none"> - Topics discussed include: <ul style="list-style-type: none"> o Homelessness – State looking at issues that impact health care costs and trying to partner with health plans in matching up services o Tobacco Cessation Program for adolescent – important to screen for tobacco use ▪ Governing Board – Board of Supervisors <ul style="list-style-type: none"> - Staff meets with the Board four times a year - Issues to be advanced to the Board, contact Provider Relations for Board Representative's contact information ▪ Public Health - Ebola <ul style="list-style-type: none"> - There is no Ebola in Contra Costa County and the risk here remains very low - Providers are to screen patients' travel history and be vigilant - Concerns: http://cchealth.org/public-health/ ▪ Prenatal Care <ul style="list-style-type: none"> - Continue to work on prenatal care and trying to improve postpartum and timeliness of prenatal care 		J. Tysell, MD

	<ul style="list-style-type: none"> - <u>Important:</u> Pediatricians to ensure at first child visit that mother is getting postpartum check up between 3 and 8 weeks postpartum ▪ Pediatric Obesity <ul style="list-style-type: none"> - Continuing to work on pediatric obesity - Receiving a considerable amount of requests for Healthy Hearts authorizations - Developed an algorithm with more clear steps necessary to obtain a referral to Healthy Hearts – involves a physical and dietary counseling - Primary care system needs to be engaged - For resources contact Elisa Hernandez, Health Educator (Bilingual). ▪ HEDIS <ul style="list-style-type: none"> - Measure being looked at by the State is patients with persistent asthma using controllers - Ensure patients with persistent asthma are on controllers and patients who do not have persistent asthma are not on controllers - Education and compliance is important - Look forward for improved numbers this coming year 		
IV.	<p>New Business:</p> <ul style="list-style-type: none"> • Smoking Cessation <ul style="list-style-type: none"> ▪ Discussed the Tobacco Cessation Policy dated September 3, 2014 requirements: <ul style="list-style-type: none"> - Initial/annual assessment of tobacco use for patients 18 years and older - Smoking status can be assessed through the use of SHA (Staying Healthy Assessment) - No prior authorization needed for: nicotine gum, nicotine lozenge, nicotine patch and bupropion (90 days x 2 times) - Needs authorization: nicotine inhaler and nicotine spray - Important to keep a list of members who smoke - CCHP will cover four 10 minutes counseling sessions per year - Refer to California Smokers' Helpline: 1-800-NO-BUTTS - Medi-Cal members could call and receive free nicotine patches, \$20.00 gift card and counseling through the phone ▪ Training <ul style="list-style-type: none"> - USPHS "Clinical Practice Guideline, Treating Tobacco Use and Dependence" : http://bphc.hrsa.gov/buckets/treatingtobacco.pdf • Flu Updates <ul style="list-style-type: none"> ▪ Available in the packet • Adolescent SHA <ul style="list-style-type: none"> ▪ Informed providers there is an adolescent SHA 		J. Galindo, RN, PHN M. Berkery, RN
V.	<p>Other:</p> <ul style="list-style-type: none"> • Provider Bulletin was reviewed. 		J. Tysell, MD
VI.	<p>Adjournment: Meeting adjourned @ 8:49 a.m.</p>		

Next meeting – January 27, 2015

CONTRA COSTA HEALTH PLAN
 East/Central County
 Quarterly Community Provider Network (CPN)
Meeting Minutes – July 22, 2014

Attending:

CCHP Staff: M. Berkery, RN, Co-Chair; P. Tanquary, MPH, Ph.D., CEO; K. Drury, Director of Quality Management; B. Jacobs, FNP; J. Galindo, RN, PHN; L.M. Perez, CPCS

CPN Providers: S.M. Chang, MD; N. Essa, MD; P. Gharagozlou, MD; S. Huerta, CPNP; A. Mahdavi, MD; C. Mayor, NP; T. Mostaghassi, MD; J. O'Meany, PA; J. Sequeira, MD; S. Shtivelman, MD; W. Taft, MD; R. Tracy, MD; L. Yang, MD; J.G. Zimmerman, MD

Guests: Paul Leung, MPH, Immunization Coordinator, Communicable Disease Programs, Contra Costa Public Health; J. Yasul, MD (CCRMC)

Discussion	Action	Accountable
Meeting called to order @ 7:45 a.m.		
I.	Agenda was approved with one correction in attendees. Dr. Tysell was absent.	M. Berkery, RN
II.	Review and Approval of Minutes from April 22, 2014: Minutes were approved as presented.	M. Berkery, RN
III.	Regular Reports: <ul style="list-style-type: none"> • HEDIS, CAHPS satisfaction reports, Quality Activities <ul style="list-style-type: none"> - CAHPS Medi-Cal Survey 2013 Summary Adult <ul style="list-style-type: none"> o Scores are mostly improved from 2012 to 2013 o Access scores improved significantly o Customer Service score is high o Filling out forms question declined - CAHPS Medi-Cal Survey 2013 Summary Child <ul style="list-style-type: none"> o Scores similar to adult survey, scores generally up o Access questions improved o Customer Service score not as high as in the adult survey o Filling out forms question declined - Reviewed Medi-Cal HEDIS Measures <ul style="list-style-type: none"> o Low score in postpartum visit o Encourage patients to return between 3-8 weeks for postpartum visit 	K. Drury, Director of Quality Management
IV.	New Business: <ul style="list-style-type: none"> • Public Health Updates, Immunizations <ul style="list-style-type: none"> - Reviewed Health Alert (Public Health) dated April 25, 2014, Pertussis Cases – Corrected Version <ul style="list-style-type: none"> o Recent increase in cases of pertussis reported in Contra Costa County (CCC), almost ½ of the cases were in the 11 to 19 year old age group o Early recognition and aggressive treatment of pertussis in infants less than 6 months is important to prevent poor outcomes including death o Most important strategy to prevent infection in vulnerable infants is Tdap vaccination of the mother o Pregnant women should receive Tdap vaccine during each pregnancy, any trimester but preferably between 27-36 weeks gestation, regardless of their vaccination history o Vaccination of household members and other close family and friends helps protect infants o Discussed recommendations for testing and actions requested of Healthcare Professionals o California has had more than 5,000 cases and 3 infant deaths o <u>Questions and Resources:</u> http://cchealth.org/pertussis/ or http://www.cdc.gov/pertussis/clinical/index.html - Reviewed Health Alert (Public Health) dated February 13, 2014, Measles – Cases <ul style="list-style-type: none"> o CCC had 3 cases of measles earlier this year, 2 of those 	Paul Leung, MPH

	<p>cases imported from the Philippines and 1 case was an indigenous contact to an imported case</p> <ul style="list-style-type: none"> o Clinicians to be vigilant and report suspected measles cases <u>immediately</u> o Discussed recommendations for testing and actions requested of Healthcare Professionals o If suspect measles, provide patient with surgical mask; if child, put blanket over their head and isolate patient in room and close the door o Do not use regular exam room for at least 2 hours after suspected measles patient has left o Make note of all rooms and common areas the suspect patient traveled, if diagnosis confirmed, then exposed people can be identified to assess measles immunity o <u>Questions and Resources:</u> www.cchealth.org/measles or http://www.cdph.ca.gov/HealthInfo/discond/Pages/Measles.aspx <p>- Personal Beliefs Exemption to Required Immunizations CDPH 8262 (10/13) Form (effective January 1, 2014):</p> <ul style="list-style-type: none"> o Encourages education about vaccinations while protecting an individual's constitutional rights o Acknowledges that a health care professional has provided information to the parent or guardian regarding the benefits and risks of immunization, including the health risks to the student and the community resulting from declining the recommended immunizations o Health care provider and the parent must each sign the form before the form is turned in to the school o <u>Questions:</u> www.shotsforschool.org - challenges explaining risks and benefits of vaccines 		
V.	<p>Other:</p> <ul style="list-style-type: none"> • Update on Covered California <ul style="list-style-type: none"> - Due to new requirements, CCHP will no longer be able to participate in the Covered CA state insurance exchange starting in January 2015 - New requirements pose administrative and financial burdens that could impact CCHP's ability to fulfill mission to serve the most vulnerable people in CCC - Will affect approximately 1,100 of 138,000 CCHP members - Finalizing transition letter with DMHC and Covered CA on Exchange member notice to transition these members to other Health Plans in CCC for January 1, 2015, expected to go out by the end of the week - Calling and assisting CCHP Exchange members to understand what their other options are for next year - Remain open to future consideration of participating in a state Bridge or Basic Health Plan focused on the lowest income populations • Where is CCHP going this Year?: <ul style="list-style-type: none"> - Rapidly growing in Medi-Cal. As of January 2014 there has been 35,500 new enrollees in Medi-Cal to CCHP and expect (estimate) to have another 25,000 to 30,000 Medi-Cal enrollees join CCHP before the end of the year - Medi-Cal backlog in every county - CCHP working with the county on the recertification 		P. Tanquary, MPH, PhD, CEO
VI.	<p>Adjournment: Meeting adjourned @ 8:55 a.m.</p>		

Next meeting – October 28, 2014



TOBY DOUGLAS
Director

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



EDMUND G. BROWN JR.
Governor

DATE: SEPTEMBER 3, 2014

POLICY LETTER 14-006

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: COMPREHENSIVE TOBACCO CESSATION SERVICES FOR MEDI-CAL MEMBERS; PREVENTING TOBACCO USE IN CHILDREN AND ADOLESCENTS

PURPOSE:

The purpose of this Policy Letter (PL) is to provide Medi-Cal managed care health plans (MCPs) with minimum requirements for comprehensive tobacco cessation services.

BACKGROUND:

Tobacco use is the leading preventable cause of death in the United States and Medi-Cal members have a higher prevalence of tobacco use than the general California population.¹

Tobacco cessation services have been demonstrated to be both clinically effective and cost effective.² Research shows a return on investment of 3:1 for dollars spent on smoking cessation services in Medicaid populations.³

The Department of Health Care Services' (DHCS) Medi-Cal managed care contracts require MCPs to provide all preventive services identified as United States Preventive Services Task Force (USPSTF) grade "A" and "B" recommendations. The USPSTF recommends (grade A) that health care providers ask all individuals ages 18 and older about tobacco use and that providers offer cessation interventions to those who use tobacco products.

¹ UCLA Center for Health Policy Research, "California Health Interview Survey, 2011 to 2012," <http://healthpolicy.ucla.edu/chis/design/Pages/questionnairesEnglish.aspx>.

² 2008 US Public Health Service Clinical Practice Guideline, "Treating Tobacco Use and Dependence," <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html>.

³ Patrick, R. West K, Ku L, "The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts," PLOS One, January 6, 2012, <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0029665>.

Augmented pregnancy tailored counseling should be offered to pregnant women who smoke.⁴ Successful implementation strategies for primary care practice include instituting a tobacco user identification system, promoting clinician intervention, and dedicating staff to provide treatment. The USPSTF also recommends (grade B) that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.⁵

Additional federal guidance is contained in "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update"⁶ which was sponsored by the U.S. Department of Health and Human Services, Public Health Service (USPHS). A summary is included in Attachment A.

REQUIREMENTS:

Tobacco Cessation Services

Effective November 1, 2014, MCPs shall implement and cover payment of the following tobacco cessation services:

1. Initial and annual assessment of tobacco use for each adolescent and adult member.

MCPs must ensure that providers identify (initially and annually) all members (of any age) who use tobacco products and note this use in the member's medical record.

MCPs must ensure that providers document the following:

- A completed Individual Comprehensive Health Assessment, which includes the Individual Health Education Behavioral Assessment (IHEBA), for all new members within 120 days of enrollment per PL 08-003.⁷ The Staying Healthy Assessment (SHA) is DHCS's IHEBA per PL 13-001 (Revised). Each age-appropriate SHA questionnaire asks about smoking status and/or exposure to tobacco smoke;⁸

⁴ United States Preventive Services Task Force, "Counseling and Interventions to Prevent Tobacco Use and Tobacco-Caused Disease in Adults and Pregnant Women,"

<http://www.uspreventiveservicestaskforce.org/uspstf09/tobacco/tobaccors2.htm>.

⁵ United States Preventive Services Task Force, "Primary Care Interventions to Prevent Tobacco Use in Children and Adolescents," <http://www.uspreventiveservicestaskforce.org/uspstf/uspstbac.htm>.

⁶ Fiore MC, Jaén CR, Baker TB, et al. "Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline." Rockville, MD. U.S. Department of Health and Human Services. Public Health Service. May 2008.

⁷ Previous MMCD PLs are available at: <http://www.dhcs.ca.gov/formsandpubs/Pages/PolicyLetters.aspx>.

⁸ California Department of Health Care Services, "Staying Healthy Assessment,"

<http://www.dhcs.ca.gov/formsandpubs/forms/pages/stayinghealthy.aspx#>.

- Tobacco use status for every member at least once per year. Since the IHEBA must be reviewed or re-administered on an annual basis, smoking status can be re-assessed through the use of the SHA; and
 - That they have asked tobacco users about tobacco use at every visit.
2. FDA-approved tobacco cessation medications (non-pregnant adults of any age).
- MCPs must cover all seven FDA-approved tobacco cessation medications: bupropion SR, Varenicline, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and the nicotine patch for adults who smoke or use other tobacco products. At least one must be available without prior authorization;
 - MCPs must provide a 90-day treatment regimen of medications without other requirements, restrictions, or barriers;
 - MCPs must cover any additional medications once approved by the FDA to treat tobacco use;
 - While counseling is encouraged, MCPs may not require members to attend classes or counseling sessions prior to receiving a prescription for an FDA-approved tobacco cessation medication. Studies have shown that quit attempts are more likely to be successful when policies remove barriers to tobacco cessation treatment, including prior authorizations or limitations on treatments;⁹ and
 - MCPs must cover a minimum of two separate quit attempts per year, with no mandatory break required between quit attempts.
3. Individual, group, and telephone counseling for members of any age who use tobacco products.
- MCPs must ensure that individual, group, and telephone counseling is offered to members who wish to quit smoking, whether or not those members opt to use tobacco cessation medications;
 - MCPs must ensure that four counseling sessions of at least 10 minutes in duration are covered for at least two separate quit attempts per year without

⁹ Centers for Disease Control and Prevention. State Medicaid Coverage for Tobacco Cessation Treatments and Barriers to Coverage — United States, 2008–2014, MMWR, March 28, Volume 63, Number 12.

prior authorization. MCPs must offer individual, group, and telephone counseling without cost to the members; and

- MCPs must ensure that providers refer members to the California Smokers' Helpline (1-800-NO-BUTTS), a free statewide quit smoking service operated by the University of California San Diego (see below) or other comparable quit line services. MCPs should encourage providers to use the "5 A's" model or other validated behavior change model when counseling patients.¹⁰

4. Services for pregnant tobacco users.

At a minimum, MCPs must ensure that providers:

- Ask all pregnant women if they use tobacco or are exposed to tobacco smoke; and
- Offer all pregnant smokers at least one face-to-face counseling session per quit attempt. Face-to-face tobacco-cessation counseling services may be provided by or under supervision of a physician, legally authorized to furnish such services under state law. MCPs must also ensure that pregnant women are referred to a tobacco cessation quit line. These counseling services must be covered for 60 days after delivery plus any additional days up to the end of the month.

Since smoking cessation medication is not recommended during pregnancy, MCPs should alert clinicians to refer to the tobacco cessation guidelines by the American College of Obstetrics and Gynecology before considering offering tobacco cessation medication during pregnancy. MCPs are encouraged to post these guidelines on their websites.

5. Prevention of tobacco use in children and adolescents.

MCPs must ensure primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and

¹⁰ Improving Chronic Illness Care, "5 A's Behavior Change Model, Adapted for Self-Management Support Improvement," http://www.improvingchroniccare.org/downloads/3.5_5_as_behavior_change_model.pdf; and Agency for Healthcare Research and Quality, "Five Major Steps to Intervention (The "5A's")," <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/5steps.html>.

adolescents. Anticipatory guidance as outlined in the American Academy of Pediatrics Bright Futures is recommended.¹¹

6. Provider training.

MCPs shall use the USPHS "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update," which is one of the supporting documents to the USPSTF recommendations. MCPs are also encouraged to use any updates to inform and educate clinicians regarding effective strategies and approaches for providing tobacco cessation treatment for all populations, including specific recommendations for pregnant women. MCPs should encourage providers to implement these comprehensive tobacco use treatment recommendations.

MCPs should include tobacco cessation training with other provider trainings as required in DHCS contracts. These trainings must include:

- New requirements for comprehensive tobacco cessation member services included in this PL;
- Overview of the "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008;"
- How to use and adopt the "5 A's" or other validated model for treating tobacco use and dependence in the provider's clinic practice; and
- Special requirements for providing services for pregnant tobacco users.

MCPs should also inform providers about available online courses in tobacco cessation. Resources are listed in Attachment B.

Monitoring and Evaluation

MCPs must institute a tobacco user identification system in primary care practices, per USPSTF recommendations. In addition, MCPs should develop a system to monitor provider performance in implementing tobacco cessation interventions. Results should guide MCP and provider efforts to strengthen tobacco use screening and cessation interventions, and to determine if the prevalence of smoking decreases over time. At a minimum, measures for adults should include results from tobacco questions in the CAHPS survey.

¹¹ American Academy of Pediatrics Bright Futures, "Performing Preventive Services: A Bright Futures Handbook." <https://brightfutures.aap.org/pdfs/Preventive%20Services%20PDFs/Anticipatory%20Guidance.PDF>.

California Smokers' Helpline

The Public Health Service Guideline recommends the use of tobacco quit lines in addition to services offered by clinicians and health systems. The California Smokers' Helpline (1-800-NO-BUTTS) is a free statewide quit smoking service operated by the University of California San Diego's Moore's Cancer Center.¹² The Helpline offers self-help materials, referral to local programs, and one-on-one telephone counseling to quit smoking. Helpline services have been proven in clinical trials to double a smoker's chances of successfully quitting. Services are available in six languages (English, Spanish, Cantonese, Mandarin, Korean, and Vietnamese), and specialized services are available for teens, pregnant women, and tobacco chewers. The Helpline also provides information for friends and family members of tobacco users.

For more information about the Helpline, contact the Communications and Partner Relations Department at:

California Smokers' Helpline
9500 Gilman Drive, Mail Code #0905
La Jolla, CA 92093-0905
(858) 300-1010
cshoutreach@ucsd.edu

For questions about this PL, contact your Medi-Cal Managed Care Division Contract Manager.

Sincerely,

Original Signed by Margaret Tatar

Margaret Tatar
Acting Deputy Director
Health Care Delivery Systems

Attachments

¹² Additional information is available at: UC San Diego's Moore's Cancer Center, <http://cancer.ucsd.edu/>.

Attachment A: Summary of "2008 US Public Health Services Guidelines: Treating Tobacco Use and Dependence" and Additional Background

For the general population (nonpregnant adults):

1. Because tobacco dependence is a chronic condition that often requires repeated intervention, multiple attempts to quit may be required. At least two quit attempts per year should be covered;
2. While counseling and medication are both effective in treating tobacco use when used alone, they are more effective when used together; and
3. While individual, group, and telephone counseling are effective in treating tobacco use, effectiveness increases with treatment intensity.

Note that federal guidance for implementation of the Patient Protection and Affordable Care Act (ACA) recommends the following coverage for each cessation attempt:

- i. Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling, and individual counseling) without prior authorization; and
- ii. All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.

For pregnant women:

1. Because of the serious risk of smoking to the pregnant smoker and fetus, whenever possible, pregnant smokers should be offered tailored one-on-one counseling that exceeds minimal advice to quit; and
2. Pharmacotherapy is not recommended for pregnant women because there is insufficient evidence on the safety and effectiveness of pharmacotherapy in pregnant women.

Note that the ACA (Section 4107) authorizes coverage of counseling and pharmacotherapy for tobacco cessation for pregnant women. American Academy of Obstetricians and Gynecologists recommends clinical interventions and strategies for pregnant women who smoke. (American Congress of Obstetricians and Gynecologists, "Smoking Cessation During Pregnancy: Committee Opinion," available at:

[http://www.acog.org/Resources And Publications/Committee Opinions/Committee on Health Care for Underserved Women/Smoking Cessation During Pregnancy](http://www.acog.org/Resources%20And%20Publications/Committee%20Opinions/Committee%20on%20Health%20Care%20for%20Underserved%20Women/Smoking%20Cessation%20During%20Pregnancy)

For children and adolescents:

1. Counseling is recommended for adolescents who smoke, because it has been shown to be effective in treating adolescent smokers; and
2. Counseling in a pediatric setting of parents who smoke has also shown to be effective and is recommended. Secondhand smoke can be harmful to children.

Note that coverage of medically necessary tobacco cessation services, including both counseling and pharmacotherapy, is mandatory for children up to age 21 under Medicaid's Early and Periodic Screening, Diagnostic and Treatment benefit. This benefit includes the provision of anticipatory guidance and risk-reduction counseling regarding tobacco use.

Attachment B: Provider Trainings and Resources

Overview of the "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update" (SDL # 11-007): <http://bphc.hrsa.gov/buckets/treatingtobacco.pdf>.

Continuing Medical Education (CME)-accredited training on tobacco cessation and behavioral health: <https://cmecalifornia.com/Activity/1023974/Detail.aspx>.

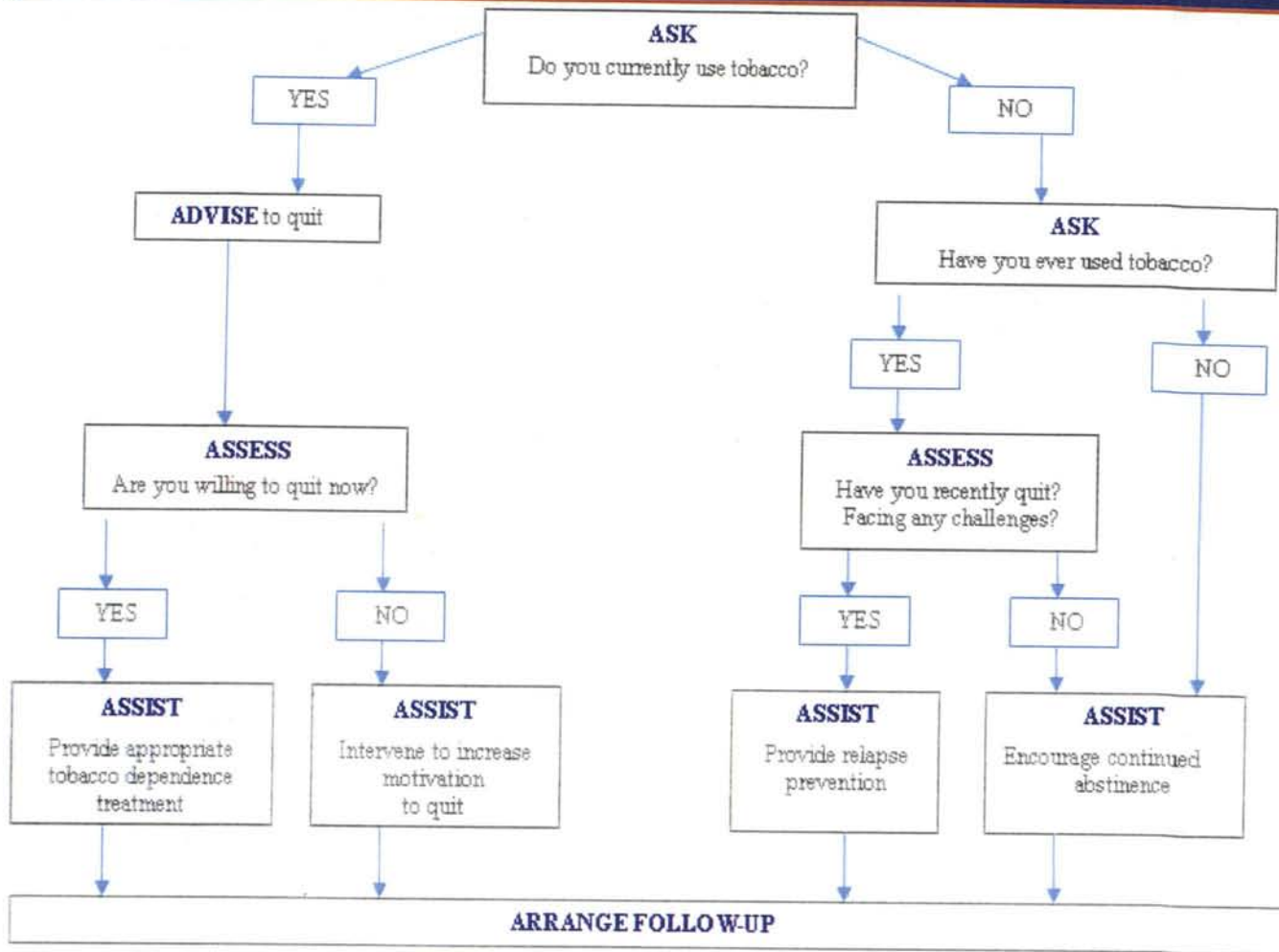
Other cessation trainings: <http://www.centerforcessation.org/training.html>.

University of California San Francisco's (UCSF) Smoking Cessation Leader Center's tools and resources: <http://smokingcessationleadership.ucsf.edu/Resources.htm>

UCSF's Smoking Cessation Leadership Center Webinars for CME/Continuing Education Unit credit: <http://smokingcessationleadership.ucsf.edu/Webinarscme.htm>.

California Smokers' Helpline/Center for Tobacco Cessation:
<http://centerforcessation.org/training.html>.

Medical Incentive to Quit Smoking Project: <http://www.nobutts.org/miqs/>.





Medi-Cal Incentives to Quit Smoking (MIQS)

Ask about **FREE** patches and \$20 gift card bonus! Call 1-800-NO-BUTTS.

General Fact Sheet

BACKGROUND

Smoking is a risk factor for the development of heart disease, lung disease, cancer, and type 2 diabetes. Medi-Cal members are at risk of these diseases because they smoke at higher rates than non-members. The Medi-Cal Incentives to Quit Smoking (MIQS) Project aims to reverse these trends and motivate smoking cessation by incentivizing attempts to quit smoking. The California Smokers' Helpline is a free telephone-based counseling service operated by the University of California, San Diego.

HOW THE INCENTIVE WORKS FOR MEMBERS

For a limited time through 2015 or while supplies last, the MIQS Project is offering free nicotine patches and a \$20 gift card bonus to members who call the Helpline and enroll in counseling. Medi-Cal members age 18 and over who smoke are eligible. To receive the nicotine patches and \$20 gift card bonus, the member must have a valid Medi-Cal Beneficiary Identification Card number and complete the first counseling session.

HERE'S WHAT YOU CAN DO TO HELP MEMBERS QUIT SMOKING

1) **ASK** all Medi-Cal members if they smoke; 2) **ADVISE** them to quit smoking; 3) **REFER** members who smoke to the Helpline at 1-800-NO-BUTTS or www.nobutts.org/referral. Cessation counseling is available in English, Spanish, Vietnamese, Korean, and Chinese; and 4) **MOTIVATE** members to call by telling them about the free nicotine patches and \$20 gift card bonus.

Helpline Launches Web-Based Referrals

The California Smokers' Helpline just made it easier for health professionals to refer their patients who smoke to the Helpline for free, evidence-based, tobacco cessation services in multiple languages. Health professionals can now register online at www.nobutts.org/referral/ for the Helpline's new free, web-based referral service. Once approved, it's easy and convenient to refer patients who want to quit smoking with the Helpline's online referral service: 1) select the provider name from the drop-down menu; 2) enter the patient's name, date of birth, phone number and preferred language; 3) obtain patient consent; and 4) click save!



Free, Effective Help for Smokers

Our new web-based referral service makes it easy to refer clients to free, evidence-based cessation counseling

Funded by the California Department of Public Health and First 5 California



For more information, visit www.nobutts.org/miqs or contact:

Cynthia Vela, Outreach Specialist
Email: Cynthia.Vela@dhcs.ca.gov

Susan Kratochvil, Outreach Specialist
Email: Susan.Kratochvil@dhcs.ca.gov

*Made possible by a grant from the Centers for Medicare and Medicaid Services under the Medicaid Incentives for Prevention of Chronic Diseases program. Some conditions apply. One gift card per person, per year, while supplies last. Medi-Cal Managed Care plans may offer additional tobacco cessation services.

Medi-Cal Incentives to Quit Smoking (MIQS)

A project of the Office of the Medical Director, California Department of Health Care Services

Action Ideas for Medi-Cal Providers

Medi-Cal members who smoke have a great new reason to quit!

Free nicotine replacement patches and \$20 gift card now available for calling the California Smokers' Helpline at 1-800-NO-BUTTS and developing a "quit smoking" plan.

Here's what you can say to a Medi-Cal member:



1. **Ask** about tobacco at every visit. "Do you smoke?"
2. **Advise** those who smoke to quit. "It is important for your health to quit smoking."
3. **Refer** smokers to the California Smokers' Helpline online at <http://nobutts.org/referral/>. "The Helpline help you with a plan to quit smoking. It's free and will double your chances of quitting."
4. **Motivate** Medi-Cal members to call. "For a limited time, members who smoke can receive free nicotine replacement patches and a \$20 gift card bonus that will be mailed to their homes after the first counseling session."

To receive the \$20 gift card: Must be a current Medi-Cal member who smokes, have a valid Beneficiary ID Card number, and complete the first Helpline counseling session.

Tools for Action:

Visit www.nobutts.org/miqs:

- Outreach posters for Medi-Cal members in multiple languages
- Order form for free Helpline materials.
- To order free member posters and postcards, contact Cynthia.Vela@dhcs.ca.gov.

Medi-Cal Incentives to
Quit Smoking (MIQS)



Ask about **FREE** patches
and \$20 gift card bonus!
Call 1-800-NO-BUTTS.

Made possible by a grant from the Center for Medicare and Medicaid Services under the Medicaid Incentives for Prevention of Chronic Disease Program. Some conditions apply. One gift card per person per year while supplies last. Medi-Cal Managed Care Plans may offer additional tobacco cessation services.

Helping
patients quit
smoking is
easier than
ever!



"At Children's Hospital Oakland, we are big fans of the Helpline's new web-based referral system. The web portal is very quick and easy to use, and I get immediate confirmation so I know my referral has been received."

Jyothi Marbin, M.D.



Helpline Offers New Web-Based Referral Service

The California Smokers' Helpline just made it easier for health professionals to refer their patients who smoke to free, evidence-based tobacco cessation services in multiple languages.

The Helpline's new web-based referral service offers busy health professionals the following benefits:

- Quick
- Convenient
- Easy to use
- Immediate email confirmation
- Aggregate referral disposition report upon request

The California Smokers' Helpline

Established in 1992 by researchers at the University of California San Diego, Moores Cancer Center and proven in clinical trials to double a smoker's chance of success, the California Smokers' Helpline offers the following free services over the phone

- 30-minute session with a trained specialist to develop a quit plan, self-help materials, referral to local cessation programs, and up to five follow-up sessions
- All services and materials in English, Spanish, Korean, Vietnamese, Mandarin and Cantonese
- Specialized services for pregnant smokers, tobacco chewers and teens
- Open Monday to Friday, 7 a.m. to 9 p.m., and Saturdays and Sundays, 9 a.m. to 5 p.m.

Register Today

Get started today by registering for the web-based referral service at www.nobutts.org/referral/register. For more information, please contact the Helpline Communications Department at (858) 300-1010.

This material was made possible by funds received from the California Department of Public Health and from First 5 California.

Thousands of Medi-Cal members are

QUITTING SMOKING

You can too! We can help.



FREE Nicotine Patches
and \$20 Gift Card Bonus*



Call the California Smokers' Helpline today!

1-800-NO-BUTTS

When you call, have your Medi-Cal ID card ready.
Nicotine patches are mailed directly to your home.
Remember to ask about the gift card bonus.



*Some conditions apply. One gift card per person, per year. While supplies last.
Medi-Cal managed care plans may offer additional tobacco cessation services.
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MIQS1-02/14

For more information visit:
www.NoButts.org/Medi-Cal

Miles de miembros de Medi-Cal están

DEJANDO DE FUMAR

¡Usted también puede hacerlo! Nosotros le podemos ayudar.



Parches de Nicotina y
Tarjeta de Regalo de \$20*

GRATIS



¡Llame a la Línea de Ayuda para Fumadores hoy!

1-800-45-NO-FUME

Cuando llame, tenga su tarjeta de identificación de Medi-Cal disponible.
Los parches de nicotina son enviados directamente a su domicilio.
Recuerde preguntar sobre la tarjeta de regalo gratuita.

LINEA DE AYUDA
PARA FUMADORES DE CALIFORNIA
1-800-45-NO-FUME
























*Algunas condiciones aplican. Una tarjeta por persona por año. Hasta agotar existencias.
Los planes de Medi-Cal pueden ofrecer servicios adicionales para dejar de fumar.
© 2014 UCSD. Hecho posible por una subvención de los Centros para Servicios de Medicare y Medicaid.
MIQS1-02/14

Para más información visite:
www.NoButts.org/Spanish/Medi-Cal

Pediatric/Adult Influenza Vaccine


2014-2015

For influenza vaccines licensed only for adults, see page 2.

Age	Manufacturer	Brand Name	Presentation	
6–35 months old	sanofi pasteur, Inc.	Fluzone® Quadrivalent 	0.25 mL single-dose syringe	
Healthy Persons 2–49 years old	MedImmune Vaccines, Inc.	FluMist® Quadrivalent² 	0.2 mL single-dose nasal sprayer	
36 months & Older	GlaxoSmithKline Biologicals	Fluarix® Quadrivalent 	0.5 mL single-dose syringe	          
	ID Biomedical (GlaxoSmithKline)	FluLaval® Quadrivalent	5.0 mL ¹ multi-dose vial	
	ID Biomedical (GlaxoSmithKline)	FluLaval® Quadrivalent	0.5 mL single-dose syringe	
	ID Biomedical (GlaxoSmithKline)	FluLaval®	5.0 mL ¹ multi-dose vial	
	sanofi pasteur, Inc.	Fluzone® Quadrivalent	0.5 mL single-dose vial	
	sanofi pasteur, Inc.	Fluzone®	0.5 mL single-dose vial	
	sanofi pasteur, Inc.	Fluzone® Quadrivalent	0.5 mL single-dose syringe	
	sanofi pasteur, Inc.	Fluzone®	0.5 mL single-dose syringe	
	sanofi pasteur, Inc.	Fluzone® Quadrivalent 	5.0 mL ¹ multi-dose vial	
sanofi pasteur, Inc.	Fluzone®	5.0 mL ¹ multi-dose vial		
4 years & Older	Novartis Vaccines and Diagnostics Ltd.	Fluvirin®	5.0 mL ¹ multi-dose vial	 
	Novartis Vaccines and Diagnostics Ltd.	Fluvirin®	0.5 mL single-dose syringe	
5 years & Older <i>(ACIP recommends use for children 9 years and older)</i>	CSL Limited	Afluria®	0.5 mL single-dose syringe	 
	CSL Limited	Afluria®	5.0 mL ¹ multi-dose vial	

All influenza vaccines are stored in the refrigerator. Questions: Toll-free: 877-2Get-VFC (877-243-8832)

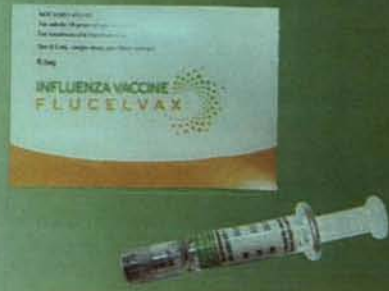



1. Contains preservative and cannot be given to children younger than 3 years of age and pregnant women per California law (Health and Safety Code 124172).
2. ACIP recommends nasal spray influenza vaccine for children 2–8 years of age when it is immediately available.

 These vaccines are available through the Vaccines for Children Program in 2014-2015 and can only be used for VFC eligible children through 18 years of age.

Adult Influenza Vaccine

2014-2015

For influenza vaccines licensed for both adults and children, see page 1.

Age	Brand Name	Presentation	
18 years & Older	Novartis Vaccines & Diagnostics Ltd.	Flucelvax®	0.5 mL, prefilled syringe 
18-64 years	sanofi pasteur, Inc.	Fluzone® Intradermal	0.1 mL, prefilled syringe 
18-49 years	Protein Sciences	FluBlok®	0.5 mL, single-dose vial 
65 years & Older	sanofi pasteur, Inc.	Fluzone® High-Dose	0.5 mL, prefilled syringe 

All influenza vaccines are stored in the refrigerator. Questions: Toll-free: 877-2Get-VFC (877-243-8832)

1. Contains preservative and cannot be given to children younger than 3 years of age and **pregnant women** per California law (Health and Safety Code 124172).

Influenza Vaccine

What You Need to Know

(Flu Vaccine, Live,
Intranasal)

2014-2015

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza (“flu”) is a contagious disease that spreads around the United States every winter, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu, but the risk of getting flu is highest among children. Symptoms come on suddenly and may last several days. They can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can make some people much sicker than others. These people include young children, people 65 and older, pregnant women, and people with certain health conditions – such as heart, lung or kidney disease, nervous system disorders, or a weakened immune system. Flu vaccination is especially important for these people, and anyone in close contact with them.

Flu can also lead to pneumonia, and make existing medical conditions worse. It can cause diarrhea and seizures in children.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine is the best protection against flu and its complications. Flu vaccine also helps prevent spreading flu from person to person.

2 Live, attenuated flu vaccine—LAIV, Nasal Spray

You are getting a **live, attenuated influenza vaccine** (called LAIV), which is sprayed into the nose. “Attenuated” means weakened. The viruses in the vaccine have been weakened so they won’t give you the flu.

There are other “inactivated” and “recombinant” flu vaccines that do not contain live virus. These “flu shots” are given by injection with a needle.

Injectable flu vaccines are described in a separate Vaccine Information Statement.

Flu vaccination is recommended every year. Some children 6 months through 8 years of age might need two doses during one year.

Flu viruses are always changing. Each year’s flu vaccine is made to protect against viruses that are likely to cause disease that year. LAIV protects against 4 different influenza viruses. Flu vaccine cannot prevent all cases of flu, but it is the best defense against the disease.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts several months to a year.

Some illnesses that are **not** caused by influenza virus are often mistaken for flu. Flu vaccine will not prevent these illnesses. It can only prevent influenza.

LAIV may be given to people **2 through 49 years of age**. It may safely be given at the same time as other vaccines.

LAIV does not contain thimerosal or other preservatives.

3 Some people should not get this vaccine

Tell the person who gives you the vaccine:

- **If you have any severe, life-threatening allergies**, including (for example) an allergy to gelatin or antibiotics. If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you should not get vaccinated.
- **If you ever had Guillain-Barré Syndrome** (a severe paralyzing illness, also called GBS). Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you have long-term health problems**, such as certain heart, breathing, kidney, liver, or nervous system problems, your doctor can help you decide if you should get LAIV.



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- If you have gotten any other vaccines in the past 4 weeks, or if you are not feeling well. It is usually okay to get flu vaccine when you have a mild illness, but you might be advised to wait until you feel better. You should come back when you are better.
- You should get the flu shot instead of the nasal spray if you:
 - are pregnant
 - have a weakened immune system
 - are allergic to eggs
 - are a young child with asthma or wheezing problems
 - are a child or adolescent on long-term aspirin therapy
 - will provide care for, or visit someone, within the next 7 days who needs special care for an extremely weakened immune system (ask your health care provider)
 - have taken influenza antiviral medications in the past 48 hours

The person giving you the vaccine can give you more information.

4 Risks of a vaccine reaction

With a vaccine, like any medicine, there is a chance of side effects. These are usually mild and go away on their own.

Problems that could happen after any vaccine:

- Severe allergic reactions from a vaccine are very rare, estimated at less than 1 in a million doses. If one were to occur, it would usually be within a few minutes to a few hours after the vaccination.

Mild problems that have been reported following LAIV

Children and adolescents 2-17 years of age:

- runny nose, nasal congestion or cough
- fever
- headache and muscle aches
- wheezing
- abdominal pain or occasional vomiting or diarrhea

Adults 18-49 years of age:

- runny nose or nasal congestion
- sore throat
- cough, chills, tiredness/weakness
- headache

LAIV is made from weakened virus and **does not cause flu.**

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

5

What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS does not give medical advice.

6

The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

7

How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call 1-800-232-4636 (1-800-CDC-INFO) or
 - Visit CDC's website at www.cdc.gov/flu

Vaccine Information Statement (Interim)
Live Attenuated Influenza Vaccine

08/19/2014

42 U.S.C. § 300aa-26

Office Use Only



Influenza Vaccine

What You Need to Know

(Flu Vaccine,
Inactivated or
Recombinant)
2014-2015

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

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Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu, but the risk of getting flu is highest among children. Symptoms come on suddenly and may last several days. They can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can make some people much sicker than others. These people include young children, people 65 and older, pregnant women, and people with certain health conditions—such as heart, lung or kidney disease, nervous system disorders, or a weakened immune system. Flu vaccination is especially important for these people, and anyone in close contact with them.

Flu can also lead to pneumonia, and make existing medical conditions worse. It can cause diarrhea and seizures in children.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine is the best protection against flu and its complications. Flu vaccine also helps prevent spreading flu from person to person.

2 Inactivated and recombinant flu vaccines

You are getting an injectable flu vaccine, which is either an “**inactivated**” or “**recombinant**” vaccine. These vaccines do not contain any live influenza virus. They are given by injection with a needle, and often called the “flu shot.”

A different, **live, attenuated** (weakened) influenza vaccine is sprayed into the nostrils. *This vaccine is described in a separate Vaccine Information Statement.*

Flu vaccination is recommended every year. Some children 6 months through 8 years of age might need two doses during one year.

Flu viruses are always changing. Each year’s flu vaccine is made to protect against 3 or 4 viruses that are likely to cause disease that year. Flu vaccine cannot prevent all cases of flu, but it is the best defense against the disease.

It takes about 2 weeks for protection to develop after the vaccination, and protection lasts several months to a year.

Some illnesses that are not caused by influenza virus are often mistaken for flu. Flu vaccine will not prevent these illnesses. It can only prevent influenza.

Some inactivated flu vaccine contains a very small amount of a mercury-based preservative called thimerosal. Studies have shown that thimerosal in vaccines is not harmful, but flu vaccines that do not contain a preservative are available.

3 Some people should not get this vaccine

Tell the person who gives you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, including (for example) an allergy to gelatin, antibiotics, or eggs, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome** (a severe paralyzing illness, also called GBS). Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.** It is usually okay to get flu vaccine when you have a mild illness, but you might be advised to wait until you feel better. You should come back when you are better.



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4 Risks of a vaccine reaction

With a vaccine, like any medicine, there is a chance of side effects. These are usually mild and go away on their own.

Problems that could happen after any vaccine:

- Brief fainting spells can happen after any medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Severe shoulder pain and reduced range of motion in the arm where a shot was given can happen, very rarely, after a vaccination.
- Severe allergic reactions from a vaccine are very rare, estimated at less than 1 in a million doses. If one were to occur, it would usually be within a few minutes to a few hours after the vaccination.

Mild problems following inactivated flu vaccine:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

Moderate problems following inactivated flu vaccine:

- Young children who get inactivated flu vaccine and pneumococcal vaccine (PCV13) at the same time may be at increased risk for seizures caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Inactivated flu vaccine does not contain live flu virus, so you cannot **get the flu from this vaccine**.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS does not give medical advice.

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Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call 1-800-232-4636 (1-800-CDC-INFO) or
 - Visit CDC's website at www.cdc.gov/flu

Vaccine Information Statement (Interim) Inactivated Influenza Vaccine

08/19/2014

42 U.S.C. § 300aa-26

Office Use Only



Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP) — United States, 2014–15 Influenza Season

Lisa A. Grohskopf, MD¹, Sonja J. Olsen, PhD¹, Leslie Z. Sokolow, MSc, MPH¹, Joseph S. Bresee, MD¹, Nancy J. Cox, PhD¹, Karen R. Broder, MD², Ruth A. Karron, MD³, Emmanuel B. Walter, MD⁴ (Author affiliations at end of text)

This report updates the 2013 recommendations by the Advisory Committee on Immunization Practices (ACIP) regarding use of seasonal influenza vaccines (1). Updated information for the 2014–15 influenza season includes 1) antigenic composition of U.S. seasonal influenza vaccines; 2) vaccine dose considerations for children aged 6 months through 8 years; and 3) a preference for the use, when immediately available, of live attenuated influenza vaccine (LAIV) for healthy children aged 2 through 8 years, to be implemented as feasible for the 2014–15 season but not later than the 2015–16 season. Information regarding issues related to influenza vaccination not addressed in this report is available in the 2013 ACIP seasonal influenza recommendations (1).

For recommendations pertaining to use of influenza vaccines in children, ACIP reviewed data on the relative efficacy and safety of LAIV and inactivated influenza vaccines (IIVs). An adapted version of the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach was used to rate the quality of the evidence (2). Evidence summary tables

and assessment of risk and benefits are available at <http://www.cdc.gov/vaccines/acip/recs/grade/table-refs.html>. Information in this report reflects discussion during public meetings of ACIP on February 26, 2014, and June 25, 2014. Meeting minutes, information on ACIP membership, and information on conflicts of interest are available at <http://www.cdc.gov/vaccines/acip/meetings/meetings-info.html>. Modifications were made during review at CDC to update and clarify wording. Any updates will be posted at <http://www.cdc.gov/flu>.

Groups Recommended for Vaccination and Timing of Vaccination

Routine annual influenza vaccination is recommended for all persons aged ≥6 months who do not have contraindications. Vaccination optimally should occur before onset of influenza activity in the community. Health care providers should offer vaccination soon after vaccine becomes available (by October, if possible). Vaccination should be offered as long as influenza viruses are circulating. Children aged 6 months through 8 years who require 2 doses (see “Vaccine Dose Considerations for Children Aged 6 Months through 8 Years”) should receive their first dose as soon as possible after vaccine becomes available, and the second dose ≥4 weeks later. To avoid missed opportunities for vaccination, providers should offer vaccination during routine health care visits and hospitalizations when vaccine is available.

Antibody levels induced by vaccine decline postvaccination (3–6). Although a 2008 literature review found no clear evidence of more rapid decline among the elderly (7), a 2010 study noted a statistically significant decline in titers 6 months postvaccination among persons aged ≥65 years (although titers still met European Medicines Agency levels considered adequate for protection) (6). A case-control study conducted in Navarre, Spain, during the 2011–12 season revealed a decline in vaccine effectiveness primarily affecting persons aged ≥65 years (8). Although delaying vaccination might permit greater immunity later in the season, deferral might result in missed opportunities to vaccinate and difficulties in vaccinating a population within a limited time. Vaccination programs should balance maximizing likelihood of persistence of vaccine-induced protection through the season with avoiding missed opportunities to vaccinate or vaccinating after influenza virus circulation begins.

Recommendations for routine use of vaccines in children, adolescents, and adults are developed by the Advisory Committee on Immunization Practices (ACIP). ACIP is chartered as a federal advisory committee to provide expert external advice and guidance to the Director of the Centers for Disease Control and Prevention (CDC) on use of vaccines and related agents for the control of vaccine-preventable diseases in the civilian population of the United States. Recommendations for routine use of vaccines in children and adolescents are harmonized to the greatest extent possible with recommendations made by the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), and the American College of Obstetrics and Gynecology (ACOG). Recommendations for routine use of vaccines in adults are harmonized with recommendations of AAFP, ACOG, and the American College of Physicians (ACP). ACIP recommendations adopted by the CDC Director become agency guidelines on the date published in the Morbidity and Mortality Weekly Report (MMWR). Additional information regarding ACIP is available at <http://www.cdc.gov/vaccines/acip>.

Influenza Vaccine Composition for the 2014–15 Season

For 2014–15, U.S.-licensed influenza vaccines will contain the same vaccine virus strains as those in the 2013–14 vaccine. Trivalent influenza vaccines will contain hemagglutinin (HA) derived from an A/California/7/2009 (H1N1)-like virus, an A/Texas/50/2012 (H3N2)-like virus, and a B/Massachusetts/2/2012-like (Yamagata lineage) virus. Quadrivalent influenza vaccines will contain these antigens, and also a B/Brisbane/60/2008-like (Victoria lineage) virus (9).

Available Vaccine Products and Indications

Various influenza vaccine products are anticipated to be available during the 2014–15 season (Table). These recommendations apply to all licensed influenza vaccines used within Food and Drug Administration–licensed indications. Differences between ACIP recommendations and labeled indications have been noted (Table).

Vaccine Dose Considerations for Children Aged 6 Months through 8 Years

Children aged 6 months through 8 years require 2 doses of influenza vaccine (administered ≥ 4 weeks apart) during their first season of vaccination to optimize immune response (10,11). In one study conducted over two seasons during which the influenza A(H1N1) vaccine virus strain did not change but the B antigen did change, unprimed children aged 10 through 24 months who received 1 dose of IIV during the fall of each season had similar responses to the unchanged A(H1N1) virus antigen and to the drifted A(H3N2) virus antigen, compared with children aged 6 through 24 months who received 2 doses of the same IIV during the latter season; however, the first group had significantly lower responses to the B antigen (12). In determining the appropriate number of doses, previous receipt of vaccine containing 2009 influenza A(H1N1) pandemic antigen (included in monovalent pandemic vaccine during 2009–10 and in seasonal influenza vaccines since the 2010–11 season) also should be considered. In addition, because the strains contained in the 2014–15 seasonal influenza vaccines are identical to those contained in the 2013–14 vaccines, only 1 dose is required for any child aged 6 months through 8 years who previously received ≥ 1 dose of 2013–14 seasonal influenza vaccine.

Two approaches are recommended for determination of the necessary doses for the 2014–15 season; both are acceptable. The first approach (Figure 1) considers only doses of seasonal influenza vaccine received since July 1, 2010. Where adequate vaccination history from before the 2010–11 season is available, the second approach (Figure 1 [footnote]) may be used.

Considerations for the Use of Live Attenuated Influenza Vaccine and Inactivated Influenza Vaccine when Either is Available and Appropriate

Both LAIV and IIV have been demonstrated to be effective in children and adults. In adults, most comparative studies have demonstrated either that LAIV and IIV were of similar efficacy or that IIV was more efficacious (13–18). However, several studies have demonstrated superior efficacy of LAIV in children. A randomized controlled trial conducted among 7,852 children aged 6–59 months demonstrated a 55% reduction in culture-confirmed influenza among children who received LAIV compared with those who received IIV. LAIV efficacy was higher than that of IIV against both antigenically drifted and well-matched influenza viruses (19). Compared with IIV, LAIV provided 32% increased protection in preventing culture-confirmed influenza in children and adolescents aged 6–17 years with asthma (20) and 52% increased protection in children aged 6–71 months who had previously experienced recurrent respiratory tract infections (21).

ACIP reviewed the evidence pertaining to the relative efficacy of LAIV and IIV for healthy children, and concluded that LAIV is more efficacious than IIV against laboratory-confirmed influenza among younger children (based on studies including children aged 6 through 71 months), with overall moderate quality of evidence. Risks for harms assessed (including fever, wheezing, and serious adverse events) appear to be similar for LAIV and IIV. Data pertaining to relative efficacy are more limited in older children and teens. There are insufficient data to determine at what age or with how many successive seasons of vaccination the relatively greater efficacy of LAIV diminishes in children aged 6 through 18 years.

For children and adults with chronic medical conditions conferring a higher risk for influenza complications, data on the relative safety and efficacy of LAIV and IIV are limited. A study of LAIV and IIV among children aged 6 through 17 years with asthma noted no significant difference in wheezing events after LAIV (20). Available data are insufficient to determine the level of severity of asthma for which administration of LAIV would be inadvisable.

For 2014–15, ACIP recommends the following:

1. All persons aged ≥ 6 months should receive influenza vaccine annually. Influenza vaccination should not be delayed to procure a specific vaccine preparation if an appropriate one is already available.
2. When immediately available, LAIV should be used for healthy children aged 2 through 8 years who have no contraindications or precautions (Category A). If LAIV is not immediately available, IIV should be used. Vaccination should not be delayed to procure LAIV. The age of 8 years

TABLE. Influenza vaccines — United States, 2014–15 influenza season*

Trade name	Manufacturer	Presentation	Mercury content from thimerosal ($\mu\text{g Hg}/0.5\text{ mL}$)	Ovalbumin content ($\mu\text{g}/0.5\text{ mL}$)	Age indications	Route
Inactivated influenza vaccine, quadrivalent (IIV4), standard dose						
<i>Contraindications*:</i> Severe allergic reaction to any component of the vaccine, including egg protein, or after previous dose of any influenza vaccine.						
<i>Precautions*:</i> Moderate to severe illness with or without fever; history of Guillain-Barré syndrome within 6 weeks of receipt of influenza vaccine.						
Fluarix Quadrivalent	GlaxoSmithKline	0.5 mL single-dose prefilled syringe	—	≤ 0.05	≥ 3 yrs	IM†
FluLaval Quadrivalent	ID Biomedical Corporation of Quebec (distributed by GlaxoSmithKline)	0.5 mL single-dose prefilled syringe 5.0 mL multidose vial	— <25	≤ 0.3 ≤ 0.3	≥ 3 yrs ≥ 3 yrs	IM† IM†
Fluzone Quadrivalent	Sanofi Pasteur	0.25 mL single-dose prefilled syringe 0.5 mL single-dose prefilled syringe 0.5 mL single-dose vial 5.0 mL multidose vial	— — — 25	§§§ §§§ §§§ §§§	6–35 mos ≥ 36 mos ≥ 36 mos ≥ 6 mos	IM† IM† IM† IM†
Inactivated influenza vaccine, trivalent (IIV3), standard dose						
<i>Contraindications*:</i> Severe allergic reaction to any component of the vaccine, including egg protein, or after previous dose of any influenza vaccine.						
<i>Precautions*:</i> Moderate to severe illness with or without fever; history of Guillain-Barré syndrome within 6 weeks of receipt of influenza vaccine.						
Afluria	bioCSL	0.5 mL single-dose prefilled syringe 5.0 mL multidose vial	— 24.5	<1 <1	≥ 9 yrs*** ≥ 9 yrs***	IM† IM†
Fluarix	GlaxoSmithKline	0.5 mL single-dose prefilled syringe	—	≤ 0.05	≥ 3 yrs	IM†
FluLaval	ID Biomedical Corporation of Quebec (distributed by GlaxoSmithKline)	0.5 mL single-dose prefilled syringe 5.0 mL multidose vial	— <25	≤ 0.3 ≤ 0.3	≥ 3 yrs ≥ 3 yrs	IM† IM†
Fluvirin	Novartis Vaccines and Diagnostics	0.5 mL single-dose prefilled syringe 5.0 mL multidose vial	≤ 1 25	≤ 1 ≤ 1	≥ 4 yrs ≥ 4 yrs	IM† IM†
Fluzone	Sanofi Pasteur	0.5 mL single-dose prefilled syringe 5.0 mL multidose vial	— 25	§§§ §§§	≥ 36 mos ≥ 6 mos	IM† IM†
Fluzone Intradermal [§]	Sanofi Pasteur	0.1 mL prefilled microinjection system	—	§§§	18–64 yrs	ID**
Inactivated influenza vaccine, trivalent, standard dose, cell culture-based (ccIIV3)						
<i>Contraindications*:</i> Severe allergic reaction to any component of the vaccine, including egg protein, or after previous dose of any influenza vaccine.						
<i>Precautions*:</i> Moderate to severe illness with or without fever; history of Guillain-Barré syndrome within 6 weeks of receipt of influenza vaccine.						
Flucelvax	Novartis Vaccines and Diagnostics	0.5 mL single-dose prefilled syringe	—	†††	≥ 18 yrs	IM†
Inactivated influenza vaccine, trivalent (IIV3), high dose						
<i>Contraindications*:</i> Severe allergic reaction to any component of the vaccine, including egg protein, or after previous dose of any influenza vaccine.						
<i>Precautions*:</i> Moderate to severe illness with or without fever; history of Guillain-Barré syndrome within 6 weeks of receipt of influenza vaccine.						
Fluzone High-Dose ^{††}	Sanofi Pasteur	0.5 mL single-dose prefilled syringe	—	§§§	≥ 65 yrs	IM†
Recombinant influenza vaccine, trivalent (RIV3)						
<i>Contraindications*:</i> Severe allergic reaction to any component of the vaccine.						
<i>Precautions*:</i> Moderate to severe illness with or without fever; history of Guillain-Barré syndrome within 6 weeks of receipt of influenza vaccine.						
FluBlok	Protein Sciences	0.5 mL single-dose vial	—	0	18–49 yrs	IM†
Live attenuated influenza vaccine, quadrivalent (LAIV4)						
<i>Contraindications*:</i> Severe allergic reaction to any component of the vaccine, including egg protein, or after previous dose of any influenza vaccine.						
<i>Concomitant use of aspirin or aspirin-containing medications in children and adolescents.</i>						
<i>In addition, ACIP recommends LAIV4 not be used for pregnant women, immunosuppressed persons, persons with egg allergy, and children aged 2–4 years who have asthma or who have had a wheezing episode noted in the medical record within the past 12 months, or for whom parents report that a health care provider stated that they had wheezing or asthma within the last 12 months.</i>						
<i>LAIV should not be administered to persons who have taken influenza antiviral medications within the previous 48 hours. Persons who care for severely immunosuppressed persons who require a protective environment should not receive LAIV, or should avoid contact with such persons for 7 days after receipt.</i>						
<i>Precautions*:</i> Moderate to severe illness with or without fever.						
<i>History of Guillain-Barré syndrome within 6 weeks of receipt of influenza vaccine.</i>						
<i>Asthma in persons aged 5 years and older.</i>						
<i>Medical conditions which might predispose to higher risk for complications attributable to influenza.</i>						
FluMist Quadrivalent ^{§§}	MedImmune	0.2 mL single-dose prefilled intranasal sprayer	—	<0.24 (per 0.2 mL)	2–49 yrs	IN

See table footnotes on page 694.

TABLE. (Continued) Influenza vaccines — United States, 2014–15 influenza season*

Abbreviations: IM = intramuscular; ID = intradermal; IN = intranasal; ACIP = Advisory Committee on Immunization Practices.

* Immunization providers should check Food and Drug Administration–approved prescribing information for 2014–15 influenza vaccines for the most complete and updated information, including (but not limited to) indications, contraindications, warnings, and precautions. Package inserts for U.S.-licensed vaccines are available at <http://www.fda.gov/biologicsbloodvaccines/vaccines/approvedproducts/ucm093833.htm>.

† For adults and older children, the recommended site of vaccination is the deltoid muscle. The preferred site for infants and young children is the anterolateral aspect of the thigh. Specific guidance regarding site and needle length for intramuscular administration can be found in ACIP's *General Recommendations on Immunization* (available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6002a1.htm>).

‡ Trivalent inactivated vaccine, intradermal: A 0.1-mL dose contains 9 µg of each vaccine antigen (27 µg total).

§ The preferred site is over the deltoid muscle. Fluzone Intradermal is administered using the delivery system included with the vaccine.

¶ Trivalent inactivated vaccine, high-dose: A 0.5-mL dose contains 60 µg of each vaccine antigen (180 µg total).

§§ FluMist is shipped refrigerated and stored in the refrigerator at 35°F–46°F (2°C–8°C) after arrival in the vaccination clinic. The dose is 0.2 mL divided equally between each nostril. Health care providers should consult the medical record, when available, to identify children aged 2 through 4 years with asthma or recurrent wheezing that might indicate asthma. In addition, to identify children who might be at greater risk for asthma and possibly at increased risk for wheezing after receiving LAIV, parents or caregivers of children aged 2 through 4 years should be asked, "In the past 12 months, has a health care provider ever told you that your child had wheezing or asthma?" Children whose parents or caregivers answer "yes" to this question and children who have asthma or who had a wheezing episode noted in the medical record within the past 12 months should not receive FluMist.

§§§ Age indication per package insert is ≥5 years; however, ACIP recommends Afluria not be used in children aged 6 months through 8 years because of increased risk for febrile reactions noted in this age group with bioCSL's 2010 Southern Hemisphere IIV3. If no other age-appropriate, licensed inactivated seasonal influenza vaccine is available for a child aged 5 through 8 years who has a medical condition that increases the child's risk for influenza complications, Afluria can be used; however, providers should discuss with the parents or caregivers the benefits and risks of influenza vaccination with Afluria before administering this vaccine. Afluria may be used in persons aged ≥9 years.

§§§§ Information not included in package insert. Estimated to contain <50 femtograms (5x10⁻⁸ µg) of total egg protein (of which ovalbumin is a fraction) per 0.5 mL dose of Flucelvax.

§§§§ Available upon request from Sanofi Pasteur (telephone: 1-800-822-2463; e-mail: mis.emails@sanofipasteur.com).

is selected as the upper age limit for this recommendation based on demonstration of superior efficacy of LAIV (ages 2 to 6 years), and for programmatic consistency (8 years is the upper age limit for receipt of 2 doses of influenza vaccine in a previously unvaccinated child). This recommendation should be implemented for the 2014–15 season as feasible, but not later than the 2015–16 season.

3. LAIV should not be used in the following populations:
 - Persons aged <2 years or >49 years;
 - Those with contraindications listed in the package insert:
 - Children aged 2 through 17 years who are receiving aspirin or aspirin-containing products;
 - Persons who have experienced severe allergic reactions to the vaccine or any of its components, or to a previous dose of any influenza vaccine;
 - Pregnant women;
 - Immunosuppressed persons;
 - Persons with a history of egg allergy;
 - Children aged 2 through 4 years who have asthma or who have had a wheezing episode noted in the medical record within the past 12 months, or for whom parents report that a health care provider stated that they had wheezing or asthma within the last 12 months (Table [footnote]). [For those aged ≥5 years with asthma, recommendations are described in item 4 of this list];
 - Persons who have taken influenza antiviral medications within the previous 48 hours.
4. In addition to the groups for whom LAIV is not recommended above, the "Warnings and Precautions" section of the LAIV package insert indicates that persons of any age with asthma might be at increased risk for wheezing after administration of

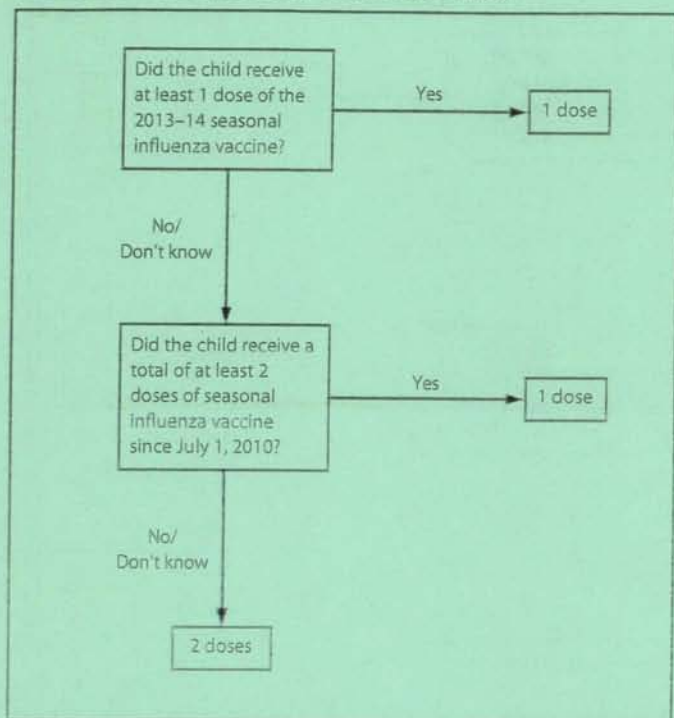
LAIV (22), and notes that the safety of LAIV in persons with other underlying medical conditions that might predispose them to complications after wild-type influenza infection (e.g., chronic pulmonary, cardiovascular [except isolated hypertension], renal, hepatic, neurologic, hematologic, or metabolic disorders [including diabetes mellitus] (1)) has not been established. These conditions, in addition to asthma in persons aged ≥5 years, should be considered precautions for the use of LAIV.

5. Persons who care for severely immunosuppressed persons who require a protective environment should not receive LAIV, or should avoid contact with such persons for 7 days after receipt, given the theoretical risk for transmission of the live attenuated vaccine virus.

Influenza Vaccination of Persons with a History of Egg Allergy

With the exceptions of trivalent recombinant influenza vaccine (RIV3 [FluBlok], Protein Sciences) and cell culture-based inactivated influenza vaccine (ccIIV3 [Flucelvax], Novartis), currently available influenza vaccines are prepared by propagation of virus in embryonated chicken eggs. A review of published data (including data on 4,172 patients, 513 of whom were reported to have a history of severe allergic reaction to egg) noted that no occurrences of anaphylaxis were reported, although some milder reactions did occur (23), suggesting that severe allergic reactions to egg-based influenza vaccines are unlikely. On this basis, some guidance recommends that no additional measures are needed when administering influenza vaccine to egg-allergic persons (24). However, occasional cases of anaphylaxis in egg-allergic persons have been reported to the Vaccine Adverse Event Reporting System (VAERS) after administration of influenza vaccine (25,26). In

FIGURE 1. Influenza vaccine dosing algorithm for children aged 6 months through 8 years — Advisory Committee on Immunization Practices, United States, 2014–15 influenza season*



* For simplicity, this algorithm takes into consideration only doses of seasonal influenza vaccine received since July 1, 2010, to determine the number of doses needed for the 2014–15 season. As an alternative approach in settings where vaccination history from before July 1, 2010, is available, if a child aged 6 months through 8 years is known to have received either 1) at least 1 dose of 2013–14 seasonal influenza vaccine, or 2) at least two seasonal influenza vaccines during any previous season, and at least 1 dose of a 2009(H1N1)-containing vaccine (i.e., seasonal vaccine since 2010–11 or the monovalent 2009[H1N1] vaccine), then the child needs only 1 dose for 2014–15. Using this approach, children aged 6 months through 8 years need only 1 dose of vaccine for 2014–15 if they have received any of the following: 1) at least 1 dose of 2013–14 seasonal influenza vaccine; or 2) 2 or more doses of seasonal influenza vaccine since July 1, 2010; or 3) 2 or more doses of seasonal influenza vaccine before July 1, 2010, and 1 or more doses of monovalent 2009(H1N1) vaccine; or 4) 1 or more doses of seasonal influenza vaccine before July 1, 2010, and 1 or more doses of seasonal influenza vaccine since July 1, 2010. Children in this age group for whom one of these conditions is not met require 2 doses for 2014–15.

† Doses should be administered at least 4 weeks apart.

published studies, vaccines containing as much as 0.7 μg /0.5 mL of ovalbumin have been tolerated (27,28); however, a threshold below which no reactions would be expected is not known (27). Among IIVs for which ovalbumin content was disclosed during the 2011–12 through 2013–14 seasons, the reported maximum amounts were $\leq 1 \mu\text{g}$ /0.5 mL dose. Ovalbumin is not directly measured for Flucelvax; it is estimated by calculation from the initial content in the reference virus strains to contain less than $5 \times 10^{-8} \mu\text{g}$ of total egg protein per 0.5 mL dose, of which ovalbumin is a fraction (Novartis, personal communication, 2013). FluBlok is considered egg-free. However, neither Flucelvax nor FluBlok are licensed for use in children aged <18 years.

ACIP recommends the following:

- Persons with a history of egg allergy who have experienced only hives after exposure to egg should receive influenza vaccine. Because relatively few data are available for use of LAIV in this setting, IIV or trivalent recombinant influenza vaccine (RIV3) should be used. RIV3 may be used for persons aged 18 through 49 years who have no other contraindications. However, IIV (egg- or cell-culture based) may also be used, with the following additional safety measures (Figure 2):
 - Vaccine should be administered by a health care provider who is familiar with the potential manifestations of egg allergy; and
 - Vaccine recipients should be observed for ≥ 30 minutes for signs of a reaction after administration of each vaccine dose.
- Persons who report having had reactions to egg involving such symptoms as angioedema, respiratory distress, lightheadedness, or recurrent emesis; or who required epinephrine or another emergency medical intervention, may receive RIV3 if they are aged 18 through 49 years and there are no other contraindications. If RIV3 is not available or the recipient is not within the indicated age range, IIV should be administered by a physician with experience in the recognition and management of severe allergic conditions (Figure 2).
- Regardless of allergy history, all vaccines should be administered in settings in which personnel and equipment for rapid recognition and treatment of anaphylaxis are available (29).
- Persons who are able to eat lightly cooked egg (e.g., scrambled egg) without reaction are unlikely to be allergic. Egg-allergic persons might tolerate egg in baked products (e.g., bread or cake). Tolerance to egg-containing foods does not exclude the possibility of egg allergy. Egg allergy can be confirmed by a consistent medical history of adverse reactions to eggs and egg-containing foods, plus skin and/or blood testing for immunoglobulin E directed against egg proteins (30).
- For persons with no known history of exposure to egg, but who are suspected of being egg-allergic on the basis of previously performed allergy testing, consultation with a physician with expertise in the management of allergic conditions should be obtained before vaccination (Figure 2). Alternatively, RIV3 may be administered if the recipient is aged 18 through 49 years.
- A previous severe allergic reaction to influenza vaccine, regardless of the component suspected of being responsible for the reaction, is a contraindication to future receipt of the vaccine.

What is currently recommended?

The Advisory Committee on Immunization Practices (ACIP) recommends that all persons aged ≥6 months without contraindications receive annual vaccinations for protection against seasonal influenza. A number of different seasonal influenza vaccine formulations are available, some of which are licensed for specific age groups or are more appropriate than others for persons with certain medical conditions.

Why are the recommendations being modified now?

CDC and ACIP issue guidance on seasonal influenza vaccination annually. The current document contains updated recommendations made by ACIP in February and June 2014, to be effective for the 2014–15 season.

What are the new recommendations?

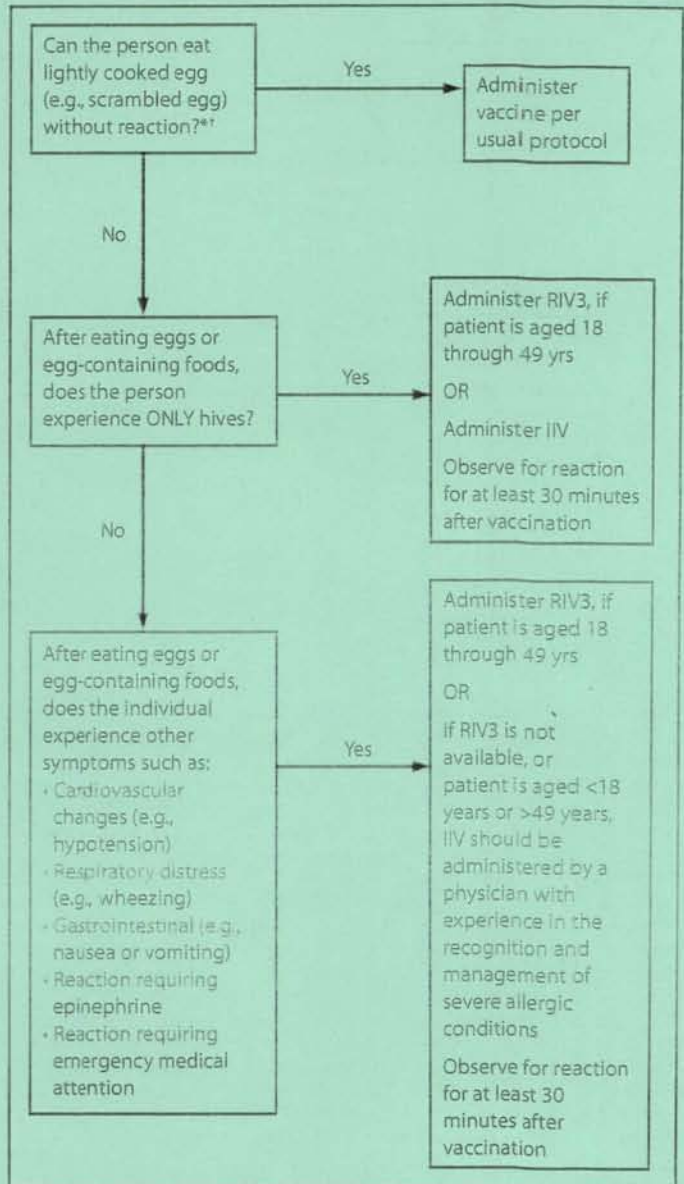
Annual influenza vaccination is recommended for all persons aged 6 months and older, as has been recommended since the 2010–11 influenza season. This guidance contains some new information. Because the virus composition of the 2014–15 seasonal influenza vaccine is the same as it was for the 2013–14 season, children aged 6 months through 8 years need only **1 dose of vaccine in 2014–15 if they received ≥1 dose of 2013–14 seasonal influenza vaccine**, regardless of previous vaccination history. Other information regarding determining whether 1 or 2 doses are needed is discussed in this report. There are also new recommendations regarding the use of live-attenuated influenza vaccine (LAIV) for healthy children aged 2 through 8 years. When immediately available, LAIV should be used for healthy children aged 2 years through 8 years who have no contraindications or precautions. However, inactivated influenza vaccine (IIV) should be used if LAIV is not immediately available. Vaccination should not be delayed to get LAIV.

Acknowledgments

ACIP members (membership roster for July 2013–June 2014 available at <http://www.cdc.gov/vaccines/acip/committee/members-archive/members-2013-2014.html>). Alicia Fry, MD, Jessie Clippard, MPH, Influenza Division, National Center for Immunization and Respiratory Diseases; Oidda Museru, MSN, MPH, Immunization Safety Office, National Center for Emerging and Zoonotic Infectious Diseases, CDC. Laurie DeMarcus, MPH, Katie Tastad, MPH, Shauna Zorich, MD, US Air Force School of Aerospace Medicine. Clarence Creech MD, Kathryn Edwards, MD, Vanderbilt University School of Medicine. The Clinical Immunization Safety Assessment (CISA) Project. ACIP Influenza Work Group.

¹Influenza Division, National Center for Immunization and Respiratory Diseases, CDC; ²Immunization Safety Office, National Center for Emerging and Zoonotic Infectious Diseases, CDC; ³Johns Hopkins University; ⁴Duke University School of Medicine (Corresponding contributor: Lisa Grohskopf, lkg6@cdc.gov)

FIGURE 2. Recommendations regarding influenza vaccination of persons who report allergy to eggs — Advisory Committee on Immunization Practices, United States, 2014–15 influenza season



Abbreviations: IIV = inactivated influenza vaccine; RIV3 = recombinant influenza vaccine, trivalent.

* Persons with egg allergy might tolerate egg in baked products (e.g., bread or cake). Tolerance to egg-containing foods does not exclude the possibility of egg allergy (Erlewyn-Lajeunesse M, Brathwaite N, Lucas JS, Warner JO. Recommendations for the administration of influenza vaccine in children allergic to egg. *BMJ* 2009;339:b3680).

† For persons who have no known history of exposure to egg, but who are suspected of being egg-allergic on the basis of previously performed allergy testing, consultation with a physician with expertise in the management of allergic conditions should be obtained before vaccination. Alternatively, RIV3 may be administered if the recipient is aged 18 through 49 years.



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Clinical Guidelines

- [2013 Prevention Guidelines For Adults](#)
- [2013 Prevention Guidelines For Adults Chart](#)
- [2013 Chronic Pain Management Policy](#)
 - [Coordinating Chronic Pain Management](#)
- [2013 Heart Failure OP Clinical Pathway](#)
- [2013 Asthma Guidelines](#)
- [Prevention Guidelines For Children and Adolescents](#)
- [Diabetes Clinical Guidelines](#)
- [Normal Pregnancy Clinical Guidelines](#)
- [Pediatric Obesity Clinical Guidelines](#)

Key Changes to Preventive Guidelines

- Aspirin — Now limited to those individuals whose benefits exceed harms. Explanation in text of how to calculate risk and harm values each patient.
- Breast Cancer Mammography Screening — adopted USPSTF and American College of Physicians recommendations to screen ages 50 - 74 with mammography every 2 years. The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms.
- HIV, Hep B, TB — references updated, risk groups spelled out in detail.
- Osteoporosis — Screen all women age ≥ 65 and younger women whose FRAX score is 9.3% or higher (fracture risk of average 65 year old woman).
- Cervical Cancer Screening — every 2 years ages 21 — 29, every 3 years ages 30 - 64.
- Tdap Vaccine — Offer ONCE to all ages 7 and older in place of a routine tetanus booster. May give a month after receiving Td. No older age limit. Important especially to immunize caregivers of young children to reduce Pertussis epidemic.

CCHP Medi-Cal HEDIS Measures

	2014 CCHP	2014 RMC	2012 CPN	2013 CPN	2014 CPN	2014 KSR	2013 Cross MPL	2014 MPL	2014 HPL	2013 Medi-Cal Mean
BMI %ile calculated for children	62.29%	74.43%	57.63%	43.79%	40.37%	90.32%	57.66%	37.96%	80.24%	71.55%
Nutrition counseling given for children	59.37%	69.41%	49.15%	52.94%	40.99%	83.87%	52.31%	47.45%	75.18%	72.53%
Physical activity counseling for children	50.85%	63.01%	28.81%	33.33%	27.95%	83.87%	36.74%	34.55%	64.72%	58.28%
*Yearly well child visit 3-6 yr.	74.75%	71.20%	72.22%	73.42%	73.78%	87.50%	63.93%	67.40%	82.08%	74.50%
*Combo 3 immunizations	74.70%	81.12%	73.57%	78.18%	64.00%	80.00%	76.16%	66.08%	83.32%	77.25%
*First trimester prenatal	83.45%	81.93%	77.65%	88.80%	84.73%	90.32%	79.46%	79.85%	92.82%	83.17%
Postpartum visit 26-51 days	60.34%	61.85%	62.35%	60.00%	57.25%	61.29%	44.64%	57.91%	73.83%	58.61%
Avoiding Use of Imaging for Low Back Pain	87.45%	85.60%	85.71%	92.26%	98.16%	93.94%	81.48%	71.52%	82.34%	80.84%
*Cervical cancer screening	54.99%	46.40%	51.22%	58.70%	49.48%	96.88%	57.11%	58.99%	76.64%	65.11%
Diabetes Eye Exam 2 yrs.	51.34%	53.74%	42.57%	45.37%	43.00%	56.67%	38.61%	44.37%	67.64%	51.32%
Diabetes screening LDL-C	75.67%	75.44%	73.27%	86.11%	74.00%	84.86%	64.36%	71.03%	83.52%	78.54%
Diabetes LDL <100	42.34%	44.13%	34.65%	44.44%	36.00%	46.67%	29.21%	27.90%	43.80%	38.27%
*Diabetes HbA1c testing	84.43%	85.41%	86.14%	84.26%	80.00%	90.00%	69.31%	79.23%	90.97%	83.19%
Diabetes HbA1c (>9%) (lower is better)	41.61%	37.72%	37.62%	36.11%	53.00%	40.00%	52.97%	52.58%	31.14%	40.35%
Diabetes HbA1c (<8%)	48.18%	51.25%	54.46%	60.19%	41.00%	43.33%	39.60%	39.80%	58.64%	49.35%
Diabetes Nephropathy screen or treatment	83.94%	83.99%	76.24%	75.93%	80.00%	96.67%	67.33%	75.00%	85.85%	81.80%
Diabetes BP <140/90	61.31%	65.48%	49.50%	54.63%	50.00%	86.67%	50.99%	53.74%	74.55%	63.20%
Avoidance of Antibiotics in Adults With Acute Bronchitis	44.09%	45.36%	30.68%	46.45%	37.86%	77.27%	54.29%	17.92%	35.45%	29.96%
Immunizations for Adolescents	73.24%	73.12%	58.87%	67.30%	69.94%	84.81%	68.35%	58.06%	85.64%	72.66%
Controlling High Blood Pressure	53.28%	56.03%	24.73%	45.26%	35.05%	94.38%	46.15%	50.00%	69.55%	58.30%
Medication Management for People with Asthma 50%	43.46%	54.98%		41.06%	52.50%	41.44%	40.34%	44.83%	61.66%	58.85%
Medication Management for People with Asthma 75%	22.79%	31.90%		16.91%	25.36%	41.01%	18.18%	22.17%	38.71%	36.52%
All-Cause Readmissions (lower is better)	12.29%	12.13%	11.90%	16.56%	12.45%	13.20%	18.62%			14.43%
All-Cause Readmission, SPDs	13.05%	12.82%	15.09%	21.03%	13.02%	15.08%				
All-Cause Readmission, Non SPDs	9.50%	9.32%	8.94%	8.59%	10.66%	8.45%				
Ambulatory Care - Outpatient Visits per 1000 Member Months	246.81	119.88	248.04	185.03	85.54	41.38	202.66	N/A	N/A	283.14
Ambulatory Care - Emergency Department Visits per 1000 Member Months	53.25	32.18	58.97	50.81	17.51	3.56	61.62	N/A	N/A	43.15
Monitoring for Patients on persistent Medications - ACE or ARB	86.52%	87.73%	87.34%	80.22%	82.73%	100.00%	77.90%	84.58%	91.21%	80.77%
Monitoring for Patients on persistent Medications - Digoxin	95.45%	97.66%	100.00%	81.25%	85.71%	0/0	N/A	87.50%	94.95%	86.91%
Monitoring for Patients on persistent Medications - Diuretics	85.11%	85.83%	79.90%	82.75%	82.51%	100.00%	71.53%	83.76%	91.30%	80.54%
Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months	94.62%	95.77%	88.54%	85.81%	91.77%	98.21%	96.93%	95.51%	98.49%	94.42%
Children and Adolescents' Access to Primary Care Practitioners - 25 Months-6 Years	86.07%	85.70%	77.03%	73.49%	83.40%	94.36%	85.01%	86.37%	93.60%	84.89%
Children and Adolescents' Access to Primary Care Practitioners - 7-11 Years	86.71%	83.56%	80.49%	78.69%	87.37%	94.94%	85.18%	87.77%	95.25%	85.89%
Children and Adolescents' Access to Primary Care Practitioners - 12-19 Years	83.44%	80.13%	77.95%	75.44%	82.42%	93.59%	82.76%	86.09%	93.77%	85.62%

*included in default algorithm

below Minimum Performance Level (MPL), national Medicaid 25th percentile
 above High Performance Level (HPL), national Medicaid 90th percentile

last data

* Specifications changed

5 CAP measures are below MPL but do not require Improvement Plan

CCHP Medi-Cal HEDIS Measures		2013 CCHP	2014 CCHP	2014 KSR	2014 RMC	2014 CPN	CPN (w/o La Clinica or Lifelong)	La Clinica De La Raza	Lifelong Medical Care	2014 MPL	2014 HPL	2013 Medi- Cal Mean
BMI %ile calculated for children		56.20%	62.29%	90.32%	74.43%	40.37%	27.62%	14.29% ³	80.95%	37.96%	80.24%	71.55%
Nutrition counseling given for children		55.96%	59.37%	83.87%	69.41%	40.99%	30.48%	21.43% ³	73.81%	47.45%	75.18%	72.53%
Physical activity counseling for children		46.23%	50.85%	83.87%	63.01%	27.95%	16.19%	7.14% ³	64.29%	34.55%	64.72%	58.28%
*Yearly well child visit 3-6-yr.		73.31%	74.75%	87.50%	71.20%	73.78%	66.29%	52.94% ³	91.38%	67.40%	82.08%	74.50%
*Combo 3 immunizations		84.47%	74.70%	90.60%	81.12%	64.00%	62.77%	71.43% ³	64.29%	66.08%	83.32%	77.25%
*First trimester prenatal		86.86%	83.45%	90.82%	81.93%	84.73%	80.00%	90.91%	86.05%	79.85%	92.82%	83.17%
PPC Postpartum visit 21-56 days		62.53%	60.34%	61.29%	61.85%	57.25%	45.45%	69.70%	62.79%	57.91%	73.83%	58.61%
LBP Avoiding Use of Imaging for Low Back Pain		92.06%	97.85%	93.94%	85.60%	88.10%	84.09%	97.37%	88.10%	71.52%	82.34%	80.84%
CCS *Cervical cancer screening ¹		66.04%	54.99%	96.88%	46.40%	49.48%	47.37%	52.00%	50.00%	58.99%	76.64%	65.11%
Diabetes Eye Exam 2 yrs.		51.09%	51.34%	56.67%	53.74%	43.00%	40.00%	63.16% ³	35.48%	44.37%	67.64%	51.32%
Diabetes screening LDL-C		82.00%	75.67%	83.33%	75.44%	74.00%	72.00%	73.68% ³	77.42%	71.03%	83.52%	78.54%
Diabetes LDL <100		41.61%	42.34%	46.67%	44.13%	36.00%	46.00%	10.53% ³	35.48%	27.90%	43.80%	38.27%
*Diabetes HbA1c testing		85.40%	84.43%	90.00%	85.41%	80.00%	80.00%	89.47% ³	74.19%	79.23%	90.97%	83.19%
CDC Diabetes HbA1c (>9%) (lower is better)		40.39%	41.61%	40.00%	37.72%	53.00%	54.00%	63.16% ³	45.16%	52.58%	31.14%	40.35%
Diabetes HbA1c (<8%)		49.88%	48.18%	43.33%	51.25%	41.00%	30.00%	26.32% ³	45.16%	39.80%	58.64%	49.35%
Diabetes Nephropathy screen or treatment		82.00%	83.94%	96.67%	83.99%	80.00%	80.00%	68.42% ³	87.10%	75.00%	85.85%	81.80%
Diabetes BP <140/90		59.37%	61.31%	60.00%	65.48%	50.00%	42.00%	52.63% ³	61.29%	53.74%	74.55%	63.20%
AAB Avoidance of Antibiotics in Adults With Acute Bronchitis		43.27%	44.69%	77.27%	45.30%	37.86%	34.26%	36.36% ³	57.14% ³	17.92%	35.45%	29.96%
IMA Immunizations for Adolescents		71.61%	73.24%	82.86%	73.12%	69.94%	66.98%	69.23% ³	80.65%	58.06%	85.64%	72.66%
CBP Controlling High Blood Pressure		51.34%	53.28%	84.39%	56.03%	35.05%	21.67%	46.15% ³	62.5% ³	50.00%	69.55%	58.30%
MMA Medication Management for People with Asthma 50%		56.90%	43.46% ²	48.1%	54.98%	52.50%	54.78%	36.84% ³	51.92%	44.83%	61.66%	58.85%
MMA Medication Management for People with Asthma 75%		33.95%	22.79% ²	38.1%	31.90%	25.36%	28.66%	31.58% ³	19.23%	22.17%	38.71%	36.52%
PCR All-Cause Readmissions (lower is better)		16.99%	12.29%	13.20%	12.13%	12.45%	11.90%	11.83%	13.66%			14.43%
All-Cause Readmissions, SPDs		19.48%	13.05%	15.08%	12.82%	13.02%	12.44%	10.34%	15.04%			
All-Cause Readmission, SPDs		12.72%	9.50%	8.45%	9.32%	10.66%	10.17%	14.29%	7.14% ³			
MPM All-Cause Readmission, Non SPDs		83.77%	86.52%	100.00%	87.73%	82.73%	85.37%	85.71%	80.66%			
MPM Monitoring for Patients on persistent Medications - ACE or ARB		85.71%	95.45%	0/0	97.30%	85.71%	100% ³	0% ³	100% ³			
MPM Monitoring for Patients on persistent Medications - Diuretics		83.68%	85.11%	100.00%	85.83%	82.51%	83.40%	84.71%	79.37%	83.76%	91.30%	80.54%

¹Included in default algorithm
²Specifications changed

below Minimum Performance Level (MPL), national Medicaid 25th percentile
 above High Performance Level (HPL), national Medicaid 90th percentile
³ Bad Data
⁴ n<30

Staying Healthy Assessment

12 - 17 Years

Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	Grade in School:
Person Completing Form	<input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Other (Specify)			School Attendance Regular? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter?
 Yes No

<i>Clinic Use Only:</i>					
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables at least 2 times per day?	Yes	No	Skip	
3	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes	Skip	
5	Do you exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
6	Are you concerned about your weight?	No	Yes	Skip	
7	Do you watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
8	Does your home have a working smoke detector?	Yes	No	Skip	Safety
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always wear a seatbelt when riding in a car?	Yes	No	Skip	
11	Do you spend time in a home where a gun is kept?	No	Yes	Skip	
12	Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
13	Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
14	Have you ever witnessed abuse or violence?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes	Skip	
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, down, or hopeless?	No	Yes	Skip	Mental Health
19	Do you spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
20	Do you smoke cigarettes or chew tobacco?	No	Yes	Skip	
21	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	No	Yes	Skip	

22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	
Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.					
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? <i>If no, skip to question 35.</i>	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have concerns about liking someone of the same sex?	No	Yes	Skip	
36	Do you have any other questions or concerns about your health?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Alcohol, Tobacco, Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/> Patient Declined the SHA
PCP's Signature:		Print Name:		Date:	
SHA ANNUAL REVIEW					
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	
PCP's Signature:		Print Name:		Date:	