CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

Agenda

Quarterly Community Provider Network (CPN) Meeting

Date: **April 23, 2019**
Time: **7:30 AM – 9:00 AM**
Location: **Muir Parkway Office Center**
1340 Arnold Drive, Conference Room 112
Martinez, CA. 94553

I.	**CALL TO ORDER and INTRODUCTIONS**	Christine Gordon, RN, BSN, PHN, DHCS-MT
II.	**REVIEW and APPROVAL of Previous Meeting Minutes**	Christine Gordon, RN, BSN, PHN, DHCS-MT
III.	**GUEST SPEAKERS**	
	• **Opioid Pilot** • **Autism**	Dr. M. Jasmine Silva, Creator and Medical Director of the FOOT Steps Program IPM Medical Group Dr. Brian Blaisch, MD Autism, Behavior, & Child Development Center
IV.	**REGULAR REPORTS**	
	• **Legislative / CCHP Update:** Governors Letter regarding Pediatric care/Pediatric Measures • **Quality:** HEDIS • **Pharmacy:** Review Care Matters • **Utilization Management:** Current & Upcoming UM enhancements • **Q & A**	Sharron Mackey, CEO Contra Costa Health Plan Jose Yasul, MD Medical Director, CCHP
V.	**OTHER**	
	• **IHA, SHA, USPSTF Updates** • **A.** Ocular Prophylaxis for Gonococcal Opthalmia Neonatorum • **B.** Counseling Interventions to Prevent Perinatal Depression	Christine Gordon, RN, BSN, PHN, DHCS-MT
VI.	**CLAIMS Q&A**	Claims Unit Staff

Our next scheduled meeting is July 23, 2019

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

CONTRA COSTA HEALTH PLAN

Central County

Quarterly Community Provider Network (CPN)

Meeting Minutes – January 22, 2019

Attending:

CCHP Staff: Jose Yasul, MD, Medical Director; Christopher Farnitano, MD, Public Health Officer; Christine Gordon, RN, BSN, DHCS-MT; Minawar Tuman, RN; Sylvia Rodriguez, Claims Dept.; Delaina Gillaspy, Secretary

CPN Providers: Sloane Blair, NP; Ming S. Chang, MD; Stanley Ng, MD; Edward H. Risgalla, MD; Suresh Sachdeva, MD; Charles Som, MD; Stephanie Swenson, CPNP; Ryan Tracy, MD; Kaitlin Warren, MD;

Discussion	Action	Accountable
Meeting called to order at 7:33 A.M.		Christine Gordon, RN, BSN, DHCS-MT
I. Agenda was approved with no revisions.		Jose Yasul, MD Medical Director, CCHP
II. Reminders • DHCS o Annual DHCS audit is coming up soon. o DHCS may select a small percentage of contracted CCHP providers to interview and/or review facility. ▪ CCHP Community Liaisons in Provider Relations can go to the selected facilities to prepare the selected Provider for the audit. ▪ Provider must contact Provider Relations Community Liaisons to inform them that have been chosen for the audit and would like assistance with preparing. • Initial Health Assessment (IHA) o Must be completed within 120 days of enrollment into the health plan or documented within the 12 months prior to Plan enrollment. o If member assigned to new PCP, IHA must be completed within 120 days of that assignment if no IHA documented within the past 12 months. o IHA includes H&P, IHEBA (SHA), USPSTF screenings, ensure up-to-date immunizations per ACIP. • USPSTF Update: Intimate Violence o Handouts provided ▪ Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening ▪ Screening of Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults- US Preventative Services Task Force Final Recommendation Statement o Objective: To update the US Preventative Services Task Force (USPSTF) 2013 recommendation on screening for IPV, elder abuse, and abuse of vulnerable adults. • Prior Authorization Changes o Change to Urgent and Routine authorization request process.		Christine Gordon, RN, BSN, DHCS-MT

○ eFax system- operation to improve authorization transmission. ○ Review CPN Care Matter Bulletin, page 10 for more details.		
III. Guest Speaker **Public Health Officer Update for Community Provider Network** • Objective ○ Review recommendations regarding wildfire smoke events and air quality response. ○ Review Getting to Zero Campaign to eliminate the HIV epidemic. • <u>Emergency Preparedness (Wildfires)</u> ○ Wildfire smoke contains high level of PM2.5. ▪ Triggers lung inflammation (i.e. Asthma attacks, COPD flares, and Congestive Heart Failure exacerbations) ▪ These effects can start days/weeks after a wildfire. ○ If you smell or see smoke: ▪ Minimize outside activities ▪ Children, elderly and others with respiratory problems or heart conditions should especially avoid outdoors with bad air quality. ▪ Close windows ▪ If you are coughing, short of breath, or have other symptoms you think are caused by smoke, contact your healthcare provider. ○ Wildfire smoke tips ▪ For air quality in your area visit sparetheair.org or airnow.gov ▪ One of the best resources regarding wildfire smoke is Wildfire Smoke- A Guide for Public Health Officials which is located at https://www3.epa.gov/airnow/wildifre_may2016.pdf ○ <u>"Getting to Zero" (HIV)</u> ○ Eliminating the HIV epidemic in Contra Costa County ○ Goal: 90-90-90 by 2021 ○ 90% of people with HIV know their diagnosis ○ 90% of diagnosed HIV+ prescribes antivirals ○ 90% of HIV+ on meds virally suppressed ○ **= 72% virally suppressed compared to 80-80-80=52.2%** ○ HIV care continuum for US, Alameda County and Contra Costa County (2014-2015 Data) ▪ National- 87% diagnosed, 75% linked to care, 57% retained in care and 55% VL<200 ▪ Alameda County- 87% diagnosed, 74% linked to care, 44% retained in care and 56% VL<200 ▪ Contra Costa County-87% diagnosed, 80% linked to care, 62% retained in care and 56% VL<200 ○ V3 Key Initiatives ▪ PrEP (Pre-Exposure Prophylaxis) expansion ▪ RAPID (Rapid ART Program for HIV Diagnoses) ▪ Retention in Care ○ New HIV diagnoses per year in Contra Costa County ▪ 2014: 107 ▪ 2015: 92 ▪ 2016: 121 ▪ 2018: 87* (preliminary data) ▪ Goal <50 by 2021		Dr. Christopher Farnitano, MD Public Health Officer

▪ (50% of 2014-15 average) o PrEP ▪ 1 pill a day to prevent HIV ▪ Safe medication ▪ Any provider can prescribe PrEP ▪ Health Centers can take referrals from PCPs for PrEP. ▪ Does not require parent consent. o Rapid-CC: Contra Costa Health Services Goal: Reduce the time from positive HIV Antibody test to first dose of antivirals from months to under 7 days. o Phone referrals call the Contra Costa Public Health HIV/AIDS Program at 925-313-6771 from 8:00 a.m.-5:00 p.m. Monday-Friday. When calling ask to speak to "Social Worker of the Day" who is process the referral.		
IV. Regular Reports -CCHP Updates **Legislative/CCHP Update** • Maternal Mental Health o AB 2193: Maternal Mental Health FAQ Handout Provided o Providers have patients answer short questionnaire like the PHQ-9 or EPDS 9 (developed specifically for pregnancy/postpartum). o CCHP covers and pays for treatment. • Dashboard o Enrollment Trend Report for October 2018 (CPN) ▪ CCHP decreasing in size • Economy is better • Lack of redeterminations ▪ Senior Medicare has been dropped **CCHP Benefits Update** • Diabetes Prevention Program o All health plans provide Diabetes Prevention Program as of January 1st, 2019. o Authorization is required. o Eligibility criteria includes: ▪ 18 years of age or older and not pregnant at time of enrollment and ▪ Body mass index (BMI) of ≥25 kg/m2 (≥23kg/m2, if Asian American) and ▪ Participants cannot have a previous diagnosis of type 1 or type 2 diabetes prior to enrollment and ▪ Have a blood test result in the prediabetes range within the past year: • A recent blood test meeting one of these specifications: o Fasting glucose of 100 to 125 mg/dl o Plasma glucose measured 2 hours after 75 gm glucose load of 140 to 199 mg/dl o A1c of 5.7% to 6.4% o Clinically diagnosed gestational diabetes mellitus (GDM) during a previous pregnancy o More information can be found on the CPN Care Matters Bulletin, page 3.		Jose Yasul, MD Medical Director, CCHP

	Quality
	• Mammography
	  ○ CCHP will be checking all data to see which members are due for Mammogram.
	  ○ CCHP will be sending out a list for Mammography to all PCPs according to DHCS guidelines.
	
	Pharmacy
	• Review Care Matters
	  ○ CCHP is covering CGM
	  ▪ New Criteria:
	  • Diagnosis of type 1 or type 2 diabetes
	  • Current insulin therapy requiring multiple injections per day and/or
	  • Documented medical need to check glucose more frequent than 4 times per day (such as frequent hospitalizations, hypoglycemia, GD, DKA, etc.)
	• Opiate Program
	  ○ Program has been doing well.
	  ○ 20% decrease of opiate and benzo
	  ○ Cancer/Hospice members should not be a part of Opiate Program.
	
	Utilization Management
	• Current & Upcoming UM Enhancements
	  ○ eFax system (no more fax machines)
	  ○ Hired New Utilization Director
	  ○ Telephone team to limit wait times for HPARS
	  ▪ The telephone team will be able to separate members and provider calls.
	  ▪ Average of 500 calls received per day.
	
	Language Line/Interpreter Services
	• Face to face interpreters are optional
	• There will be video interpreter services available
	
	Care Matters Provider Bulletin
	• Patricia Tanquary has retired after 13 years with CCHP.
	• New Interim CEO, Sharron Mackey
	• Sharron Mackey has over 25 years of experience in the health care field and 2 years with CCHP as the Chief Operations Officer.		

IV.	**Claims Questions & Answers:** • No Claims questions asked		
	Adjournment: Meeting adjourned at 9:00 A.M.		

CCHP CPN AUTISM AWARENES, SCREENING, AND REFERRAL – April 2019

Brian Blaisch, MD
Autism, Behavior and Child Development Center
Contra Costa Regional Medical Center
Referral: Office: 925-370-5635
MD Consultation: Direct: 925-542-7705; Brian.Blaisch@cchealth.org

ABCD Clinic

- 2 part-time Developmental Behavioral Pediatricians – CDE assessments; ABA auth & review
- 1 full-time Pediatrician – mid-level ASD assessments, ADHD assessments, learning and behavior evaluations, medication management, coordination of care
- 2 full-time LCSW social workers – intakes, case management and limited therapy
- 1 part-time Community Health Worker / Clerk – appointments, paperwork, messages
- 1 part-time Speech Therapist (part-time) – speech and language evaluations only
- 2 part-time Occupational Therapists – assessments for fine motor and sensory concerns

What Is Autism

Social communication challenges

Children and adults with autism have **difficulty with verbal and non-verbal communication**. For example, they may not understand or appropriately use:

- Spoken language (around a third of people with autism are nonverbal)
- Gestures
- Eye contact
- Facial expressions
- Tone of voice
- Expressions not meant to be taken literally

Additional social challenges can include difficulty with:

- Recognizing emotions and intentions in others
- Recognizing one's own emotions
- Expressing emotions
- Seeking emotional comfort from others
- Feeling overwhelmed in social situations
- Taking turns in conversation
- Gauging personal space (appropriate distance between people)

Restricted and repetitive behaviors

Restricted and repetitive behaviors vary greatly across the autism spectrum. They can include:

- Repetitive body movements (e.g. rocking, flapping, spinning, running back and forth)
- Repetitive motions with objects (e.g. spinning wheels, shaking sticks, flipping levers)
- Staring at lights or spinning objects
- Ritualistic behaviors (e.g. lining up objects, repeatedly touching objects in a set order)
- Narrow or extreme interests in specific topics
- Need for unvarying routine/resistance to change (e.g. same daily schedule, meal menu, clothes, route to school)

Many people with autism have **sensory issues.** These typically involve over- or under-sensitivities to sounds, lights, touch, tastes, smells, pain and other stimuli.

Autism Screening

- Routine periodic / WCC developmental screening

9 Month **18 Month** **2½ Year**	Child Development	AAP "Developmental Screening Tools" table
		Ages & Stages Questionnaires, Third Edition (ASQ-3)
		Parents' Evaluation of Developmental Status (PEDS)
		Survey of Well-being of Young Children (SWYC) (milestones)
18 Month **2 Year**	Autism Spectrum Disorder	Modified Checklist for Autism in Toddlers, Revised, with Follow-Up (M-CHAT-R/F) • Translations
		Survey of Well-being of Young Children (SWYC) (Parent's Observations of Social Interactions)

- Ages and Stages Questionnaire (ASQ-3)
    - 9 months, 18 months, 30 months
- Modified Checklist for Autism in Toddlers, Revised, with Follow-Up™ (M-CHAT-R/F)
    - Normed for 16 months – 30 months
    - 18 months; 24 months
    - Link: https://mchatscreen.com/
- The Survey of Well-being of Young Children (SWYC)
    - Age-specific SWYC forms are available for each age on the pediatric periodicity schedule from 2 to 60 months
- Timely follow-up vs. referral

Referrals

- Audiology – CCRMC Audiology vs. UCSF CHO Audiology
- Regional Center of The East Bay
- CCRMC ABCD Center

Assessments

- Speech and Language Evaluation
    - RCEB vs. ABCD
- Occupational Therapy Evaluation (fine motor and sensory)
    - RCEB vs. ABCD
- Comprehensive Diagnostic Evaluation (CDE)
    - RCEB vs. ABCD vs. vendorized outside developmental psychologist or DB pediatrician
    - Autism Diagnostic Observation Schedule (ADOS-2)
    - Childhood Autism Rating Scale (CARS-2)
    - Vineland-3 Adaptive Behavior Scales
    - Bailey Scales of Infant and Toddler Development Screening Test – 3rd Edition

Therapies

- Speech therapy – RCEB vs. school district
- Occupation therapy – RCEB vs. school district
    - Fine motor and/or sensory
- Applied Behavioral Analysis (ABA) Therapy – mandated through health plan; sometimes provided by RCEB
    - Applied Behavior Analysis (ABA) is a therapy based on the science of learning and behavior.
    - Behavior analysis helps us to understand:
        - How behavior works
        - How behavior is affected by the environment

        - How learning takes place
    - ABA therapy applies our understanding of how behavior works to real situations. The goal is to increase behaviors that are helpful and decrease behaviors that are harmful or affect learning.
    - ABA therapy programs can help:
        - Increase language and communication skills
        - Improve attention, focus, social skills, memory, and academics
        - Decrease problem behaviors
    - ABA helps teach social, motor, and verbal behaviors, as well as reasoning skills, and works to manage challenging behavior. It's based on teaching these skills through observation and positive reinforcement.

- Alternatives include:
    - Floortime
        - Floortime is a relationship-based therapy for children with autism. The intervention is called Floortime because the parent gets down on the floor with the child to play and interact with the child at their level.
    - Relationship Development Intervention (RDI)
        - Relationship Development Intervention (RDI) is a family-based, behavioral treatment which addresses the core symptoms of autism. It focuses on building social and emotional skills. Parents are trained as the primary therapist in most RDI programs.
        - RDI helps people with autism form personal relationships by strengthening the building blocks of social connections. This includes the ability to form an emotional bond and share experiences with others.
    - Pivotal Response Treatment (PRT)
        - Pivotal Response Treatment, or PRT, is a behavioral treatment for autism. This therapy is play-based and initiated by the child. PRT is based on the principles of Applied Behavior Analysis (ABA).

Medication

- ABCD vs. ACCESS / Psychiatry
- Comorbid ADHD
    - Alpha agonists (clonidine; guanfacine)
    - Stimulants (methylphenidate, adderall)
- Aggression
    - Alpha agonists
    - Atypical antipsychotics (risperidone, abilify)
- Anxiety
    - SSRI antidepressants (Prozac, Celexa)

Follow-up

- Monitor for med efficacy and side effects
- Review ABA and IEP
- ABA reauthorized every 6 months
- IEP renewed every year with triennial review

Participants Say....

"You'll get your life back." GL

"The treatment team could not have been more compassionate and made my transition seamless." JD

"Try this program with an open mind. This program does help. It helped me." MG

"Best program ever taken!" RS

"No need to face this alone - the support and knowledge gained from the group is a comfort." CT

To schedule a consultation or speak with a FOOT Steps team member:

Phone: 925-482-8151
Fax: 925-884-0322
footstepswc@ipmdoctors.com

The FOOT Steps Program

Focus On Opiate Transition

Current locations

- Walnut Creek
- Capitola

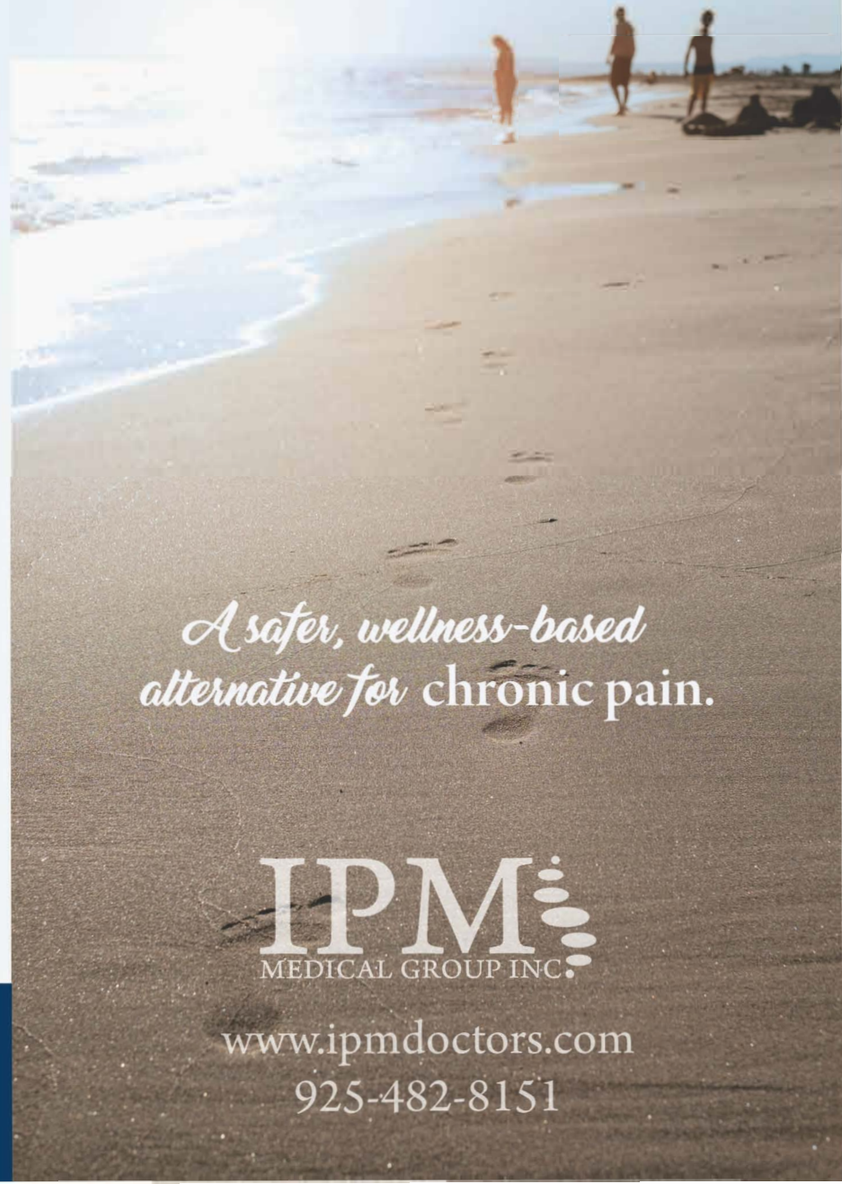
Additional locations coming in 2019:

- Orange County
- Sacramento

WWW.IPMDOCTORS.COM

FOOT Steps

Focus on Opiate Transition



A safer, wellness-based alternative for chronic pain.

IPM MEDICAL GROUP INC.

www.ipmdoctors.com
925-482-8151

Do you use opiate pain medications & experience these symptoms?

- Adverse side effects, & medication-related health problems
- Brain fog and poor concentration
- Increased need for higher or more frequent doses of medication over time
- Dulled emotions
- Declining function in physical or personal life
- Poorly controlled pain
- Inability to work
- Inability to complete everyday tasks
- New aches & pains in your body in areas that have not suffered injury

There is an alternative: The FOOT *Steps* Program

The Focus on Opiate Transition Program or **FOOT *Steps***, is a pain management treatment alternative that helps people with chronic pain transition away from classic opiate use while fostering resilience, health, and wellness.

FOOT Steps uses integrative, evidence-based activities during the medication transition, *such as:*

- Personalized, private medication management sessions
- Educational discussions
- Acupressure & Acupuncture
- Gentle, adaptive movement training
- Guided biofeedback & meditation

For many patients, attempts to reduce or stop the use of classic opiates result in failure, due to intolerable side effects, or inadequate pain control.

Transitioning off traditional opiates, or to a safer medication, has helped many patients rebuild function and regain control of their bodies and lives.

To schedule a consultation or speak with a FOOT Steps team member ——— Phone: 925-482-8151 Fax: 925-482-1166

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Focus on Opioid Transition (FOOT STEPS) Program

A valuable care planning resource for you and your patients on chronic high dose opiates.

WHAT IS IT?

The FOOT Steps Program is an interdisciplinary program designed to assist patients with chronic pain to transition *away* from use of classic opiates. Each treatment session is unique and multifaceted. FOOT Steps participants have private opiate transition medication meetings with the FOOT Steps physician, and they also participate in group settings to learn techniques that encourage one's body to recruit and optimize its own healing mechanisms.

After a patient graduates from FOOT Steps, several care-resumption outcomes are possible:

1. The patient can return to the PTP (you) on **no opiates.**
2. The patient can return to the PTP on **buprenorphine for pain.** This option does NOT Require a Data 2000 waiver, or "X license".
3. The patient can return to the PTP **on buprenorphine for MAT** (Medication Assisted Therapy), *if* he or she meets criteria for Opioid Use Disorder, and *if* his or her PTP has a Data 2000 waiver, or "X license".
4. If a patient meets criteria for Opioid Use Disorder, and if his or her PTP does not have a Data 2000 waiver, or "X license", FOOT Steps can refer the patient to the appropriate MAT provider for meds only. In such a case the patient can return to his or her PTP for management of *all treatment* other than MAT.

WHO IS APPROPRIATE?

Candidates for the program are currently taking opioid medications* for their chronic pain but would like an alternative due to:

- intolerance of weaning
- unacceptable opiate side effects or history of accidental overdose
- poor pain control
- lack of functional gain

**Rarely, we will enroll a patient who is no longer on opiates, depending on historical factors.*

We are prepared to engage all private, Medicare and worker's compensation insurances, as well as CCHP & CCAH (Medi-Cal contracted health plans).

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Focus on Opioid Transition (FOOT STEPS) Program

Here are the assessment points that are used during FOOT Steps evaluations:

Inclusion Criteria for FOOT Steps Referral (not all criteria need to be met):

- Chronic pain patients on a daily opioid regimen (typically at least over 30mg morphine equivalent a day)
- Patients who have tried and failed an opiate wean, or have experienced a plateau in their opiate taper
- Patients who frequently request early refills exhibiting opiate escalation, tolerance, and/or low-to-moderate aberrant use
- Patients on opiates who are not meeting realistic functional goals
- Patients on opiates who still have poorly controlled pain, or whom you suspect may have opioid-induced hyperalgesia
- Patients who meet the DSM V criteria for Mild Opiate Use Disorder (Moderate and Severe Opiate Use Disorder and most forms of poly-substance abuse will be referred to a chemical dependency resource or higher level of care during the FOOT Steps evaluation)
- Patients who experience intolerable side effects from opiate use
- Patients interested in trying something different &/or safer in their chronic pain medication regimen

Absolute and relative contraindications to FOOT Steps and/or buprenorphine-based treatments: (*If in doubt, proceed with a FOOT Steps referral and we can determine candidacy during the evaluation*)

- Moderate-severe liver disease
- Concurrent use of a few specific anti-retroviral medications
- Concurrent benzodiazepine or Soma use
- Concurrent regular alcohol use
- Patients who have frankly engaged in diversion
- Patients with Severe Opiate Use Disorder, IV drug abusers, and most poly substance abusers will be referred to a higher level of care.
- Some health co morbidities are better treated with in-patient supervision during the detoxification process.

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Focus on Opioid Transition (FOOT STEPS) Program

HOW CAN PATIENTS ACCESS THE PROGRAM?

Send a referral either directly to The FOOT Steps Program (contact information below) or an authorization request to CCHP's Authorizations Department.

Thank you for your time and please don't hesitate to contact us with questions!

Sincerely,

Dr. M. Jasmine Silva, DO, FOOT Steps Medical Director
Tatiana Hernandez, FOOT Steps Program Coordinator.

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Focus on Opioid Transition (FOOT STEPS) Program Referral Form

Patient Name:	PCP Name:
Patient Phone:	PCP Phone:

Please note that we do not prescribe medications at the initial consultation, and only do so at a later date if the patient enrolls in the FOOT Steps Program.

1. **Has the patient shown any aberrant medication use behaviors (inappropriate CURES or drug tests)?**

   Yes_____ No_____

   - If ***"Yes"***, has this patient's monitoring shown evidence of polysubstance abuse or overt Opiate Use Disorder? **Yes___ No___**

     - If ***"No"***, please explain the nature of the aberrancy in the space provided below
     - *If "**Yes**", please also consider a referral to the appropriate Chemical Dependency resource prior to referring to FOOT Steps.*

2. Does this patient have any unstable psychiatric comorbidities? Yes*_____ No_____

***If "Yes"**, please refer the patient to Case Management Services for a complex case support and/or the appropriate Behavioral Health resource prior to referring to FOOT Steps.*

3. Please list any additional clinical questions or information, complicating factors, or areas of need that you have identified for this patient's chronic pain treatment.

_____

_____

_____

_____

Please kindly fax your referral to FOOT Steps at 925-884-0322 or email at footstepswc@ipmdoctors.com.

CALIFORNIA MINOR CONSENT AND CONFIDENTIALITY LAWS*

MINORS OF ANY AGE MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
PREGNANCY	"A minor may consent to medical care related to the prevention or treatment of pregnancy," except sterilization. (Cal. Family Code § 6925).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
CONTRACEPTION	A minor may receive birth control without parental consent. (Cal. Family Code § 6925).	
ABORTION	A minor may consent to an abortion without parental consent. (Cal. Family Code § 6925; *American Academy of Pediatrics v. Lungren,* 16 Cal.4th 307 (1997)).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (*American Academy of Pediatrics v. Lungren,* 16 Cal.4th 307 (1997); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
SEXUAL ASSAULT[1] SERVICES [1]For the purposes of minor consent alone, sexual assault includes acts of oral copulation, sodomy, and other crimes of a sexual nature.	"A minor who [may] have been sexually assaulted may consent to medical care related to the diagnosis,…treatment and the collection of medical evidence with regard to the …assault." (Cal. Family Code § 6928).	The health care provider must attempt to contact the minor's parent/guardian and note in the minor's record the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the assault. (Cal. Family Code § 6928). Both rape and sexual assault of a minor are considered child abuse under California law and must be reported as such to the appropriate authorities by mandated reporters. The child abuse authorities investigating a child abuse report legally may disclose to parents that a report was made. (See Cal. Penal § 11167 and 11167.5.)
RAPE[2] SERVICES FOR MINORS UNDER 12 YRS[3] [2]Rape is defined in Cal. Penal Code **§ 261**. [3]See also "Rape Services for Minors 12 and Over" on page 3 of this chart	A minor under 12 years of age who may have been raped "may consent to medical care related to the diagnosis,…treatment and the collection of medical evidence with regard" to the rape. (Cal. Family Code § 6928).	

MINORS OF ANY AGE MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
EMERGENCY MEDICAL SERVICES* *An emergency is "*a situation . . . requiring immediate services for alleviation of severe pain or immediate diagnosis of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death*" (Cal. Code Bus. & Prof. § 2397(c)(2)).	A provider shall not be liable for performing a procedure on a minor if the provider "reasonably believed that [the] procedure should be undertaken immediately and that there was insufficient time to obtain [parental] informed consent." (Cal. Bus. & Prof. Code § 2397).	The parent or guardian usually has a right to inspect the minor's records. (Cal. Health & Safety Code §§ 123110(a); Cal. Civ. Code § 56.10. *But see exception at endnote ([EXC.]).*
SKELETAL X-RAY TO DIAGNOSE CHILD ABUSE OR NEGLECT* * The provider does not need the minor's or her parent's consent to perform a procedure under this section.	"A physician and surgeon or dentist or their agents . . . may take skeletal X-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of." (Cal. Penal Code § 11171.2).	Neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information reported pursuant to this law in any court proceeding.
MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	**LAW/DETAILS**	**MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?**
INFECTIOUS, CONTAGIOUS COMMUNICABLE DISEASES (DIAGNOSIS, TREATMENT)	"A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease… is one that is required by law…to be reported…." (Cal. Family Code § 6926).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
SEXUALLY TRANSMITTED DISEASES (PREVENTIVE CARE, DIAGNOSIS, TREATMENT)	A minor 12 years of age or older who may have come into contact with a sexually transmitted disease may consent to medical care related to the diagnosis or treatment of the disease. (Cal. Family Code § 6926). Beginning in January 2012, "A minor who is 12 years of age or older may consent to medical care related to the prevention of a sexually transmitted disease." (AB 499 (2011); Cal. Family Code § 6926).	

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
AIDS/HIV TESTING AND TREATMENT	A minor 12 and older is competent to give written consent for an HIV test. (Cal. Health and Safety Code § 121020). A minor 12 and older may consent to diagnosis and treatment of HIV/AIDS. (Cal. Family Code § 6926).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
RAPE SERVICES FOR MINORS 12 and OVER	"A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape." (Cal. Family Code § 6927).	The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11). RAPE Rape of a minor is considered child abuse under California law and mandated reporters, including health care providers, must report it as such. Providers cannot disclose to parents that they have made this report without the adolescent's authorization. However, adolescent patients should be advised that the child abuse authorities investigating the report may disclose to parents that a report was made.

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
OUTPATIENT MENTAL HEALTH SERVICES[4]/ SHELTER SERVICES [4]This section does not authorize a minor to receive convulsive therapy, psychosurgery or psychotropic drugs without the consent of a parent or guardian.	Two statutes give minors the right to consent to mental health treatment. If a minor meets the criteria under either statute, the minor may consent to his or her own treatment. If the minor meets the criteria under both, the provider may decide which statute to apply. There are differences between them. See endnote ** for more on these differences: Family Code § 6924 "A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis or to residential shelter services, if both of the following requirements are satisfied: (1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services. AND (2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse." (Cal. Family Code § 6924.) Health & Safety Code § 124260 "[A] minor who is 12 years of age or older may consent to [outpatient] mental health treatment or counseling services if, in the opinion of the attending professional person, the minor is mature enough to participate intelligently in the mental health treatment or counseling services." (Cal. Health & Saf. Code § 124260.)	MENTAL HEALTH TREATMENT: The health care provider is required to involve a parent or guardian in the minor's treatment unless the health care provider decides that such involvement is inappropriate. This decision and any attempts to contact parents must be documented in the minor's record. (Cal. Fam. Code § 6924; 45 C.F.R. 164.502(g)(3)(ii).) For services provided under Health and Safety Code § 124260, providers must consult with the minor before deciding whether to involve parents. (Cal. Health & Saf. Code § 124260(a).) While this exception allows providers to inform and involve parents in treatment when appropriate, it does not give providers a right to disclose medical records to parents without the minor's authorization. The provider can only share the minor's medical records with parents with a signed authorization from the minor. (Cal. Health & Saf. Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11, 56.30; Cal. Welf. & Inst. Code § 5328. *See also endnote*(EXC).) SHELTER: Although minor may consent to service, the shelter must use its best efforts based on information provided by the minor to notify parent/guardian of shelter services.

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
DRUG AND ALCOHOL ABUSE TREATMENT • This section does not authorize a minor to receive replacement narcotic abuse treatment without the consent of the minor's parent or guardian. • This section does not grant a minor the right to refuse medical care and counseling for a drug or alcohol related problem when the minor's parent or guardian consents for that treatment. (Cal. Family Code § 6929(f)).	"A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem." (Cal. Family Code §6929(b)).	There are different confidentiality rules under federal and state law. Providers meeting the criteria listed under 'federal' below must follow the federal rule. Providers that don't meet these criteria follow state law. **FEDERAL**: Federal confidentiality law applies to any individual, program, or facility that meets the following two criteria: 1. The individual, program, or facility is federally assisted. (Federally assisted means authorized, certified, licensed or funded in whole or in part by any department of the federal government. Examples include programs that are: tax exempt; receiving tax-deductible donations; receiving any federal operating funds; or registered with Medicare.)(42 C.F.R. §2.12); **AND** 2. The individual or program: 1) Is an individual or program that holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral; **OR** 2) Is a staff member at a general medical facility whose primary function is, and who is identified as, a provider of alcohol or drug abuse diagnosis, treatment or referral; **OR** 3) Is a unit at a general medical facility that holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral. (42 C.F.R. §2.11; 42 C.F.R. §2.12). For individuals or programs meeting these criteria, federal law prohibits disclosing any information to parents without a minor's written consent. One exception, however, is that an individual or program may share with parents if the individual or program director determines the following three conditions are met: (1) that the minor's situation poses a substantial threat to the life or physical well-being of the minor or another; (2) that this threat may be reduced by communicating relevant facts to the minor's parents; and (3) that the minor lacks the capacity because of extreme youth or a mental or physical condition to make a rational decision on whether to disclose to her parents. (42 C.F.R. §2.14). **STATE RULE**: Cal. Family Code §6929(c). Parallels confidentiality rule described under "Mental Health Treatment" at page 4 above. *See also exception at endnote ([EXC]).*

MINOR 15 YEARS OF AGE OR OLDER	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
GENERAL MEDICAL CARE	"A minor may consent to the minor's medical re or dental care if all of the following conditions are satisfied: (1) The minor is 15 years of age or older. (2) The minor is living separate and apart om the minor's parents or guardian, whether with r without the consent of a parent or guardian and gardless of the duration of the separate residence.) The minor is managing the minor's own financial affairs, regardless of the source of the minor's income." (Cal. Family Code § 6922(a).)	"A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian." (Cal. Family Code § 6922(c). *See also exception at endnote (EXC)).*
MINOR MUST BE EMANCIPATED (GENERALLY 14 YEARS OF AGE OR OLDER)	**LAW/DETAILS**	**MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?**
GENERAL MEDICAL CARE for EMANCIPATED YOUTH	An emancipated minor may consent to medical, dental and psychiatric care. (Cal. Family Code § 7050(e)). *See* Cal. Family Code § 7002 for emancipation criteria.	The health care provider is not permitted to inform a parent or legal guardian without minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).

Endnotes:

* There are many confidentiality and consent rules. Different rules apply in different contexts. This chart addresses the rules that apply when minors live with their parents or guardians. It does not address the rules that apply when minors are under court jurisdiction or in other special living situations. Further, the confidentiality section focuses on parent and provider access. It does not address when other people or agencies may have a right to access otherwise confidential information.

** In addition to having slightly different eligibility criteria, there are other small differences between Health and Safety Code §124260 and Family Code § 6924. For example, the two laws both allow "professional persons" to deliver minor consent services but the two laws define "professional person" differently. Also, there is a funding restriction that applies to Health and Safety Code §124260 but not to Family Code § 6924. (See Cal. Family Code 6924, Cal. Health & Saf. Code § 124260 and Cal. Welf. & Inst. Code § 14029.8 and look for more information on www.teenhealthlaw.org.).

EXC: Providers may refuse to provide parents access to a minor's medical records, where a parent normally has a right to them, if "the health care provider determines that access to the patient records requested by the [parent or guardian] would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being." Cal. Health & Safety Code § 123115(a)(2). A provider shall not be liable for any good faith decisions concerning access to a minor's records. Id.

Counseling Interventions to Prevent Perinatal Depression

The US Preventive Services Task Force (USPSTF) has recently published recommendations on providing counseling interventions to prevent perinatal depression.

What Is Perinatal Depression?

Perinatal depression refers to depression in women during pregnancy or after giving birth (known as **postpartum depression**). It is a problem that is both common and treatable and, in some women, preventable. Symptoms of perinatal depression include feeling sad, hopeless, drained of energy, angry, or disconnected from your baby and other loved ones. In more severe cases, it can lead to thinking about harming yourself or your baby. It is normal to sometimes feel sad, worried, or stressed about becoming or being a new parent, but perinatal and postpartum depression refers to symptoms that are more constant and overwhelming, like a darkness that does not lift.

Some women have a higher chance of developing perinatal depression than others. Risk factors include a personal or family history of depression, a history of physical or sexual abuse, having an unplanned or unwanted pregnancy, intimate partner violence, current stressful life events, lack of social or financial support, and younger (adolescent) maternal age.

How Can Perinatal Depression Be Prevented?

Studies have shown that counseling interventions, including cognitive behavioral therapy and interpersonal therapy, can help prevent perinatal depression. **Cognitive behavioral therapy** teaches mothers how to manage negative thoughts and create positive actions. **Interpersonal therapy** focuses on addressing interpersonal issues that contribute to underlying depression or anxiety. Counseling sessions can be done in individual or group settings by psychologists, midwives, nurses, and other mental health care professionals.

What Is the Population Under Consideration for Providing Counseling Interventions to Prevent Perinatal Depression?

This recommendation applies to pregnant women and women who have given birth within the last year who do not have a current diagnosis of depression but who are considered to be at increased risk of developing perinatal depression.

What Are the Potential Benefits and Harms of Providing Counseling Interventions to Prevent Perinatal Depression?

The USPSTF found convincing evidence that counseling interventions are effective in preventing perinatal depression. Although there is no standard risk assessment tool available, based on the population of women included in these studies, women with a history of depression, current depressive symptoms, or certain socioeconomic risk factors could be considered at higher risk and may benefit from counseling interventions. Potential harms of counseling interventions are believed to be small and mainly involve side effects from medications that are sometimes used along with counseling to prevent perinatal depression.

How Strong Is the Recommendation to Provide Counseling Interventions to Prevent Perinatal Depression?

The USPSTF concludes with moderate certainty that counseling interventions to prevent perinatal depression have a moderate net benefit for pregnant or postpartum women at increased risk.

Counseling Interventions to Prevent Perinatal Depression

Perinatal depression is a common, treatable, and preventable problem in pregnant women and new mothers. Some women are at higher risk than others for developing perinatal depression.

Population

Pregnant and postpartum persons who have given birth within the last year who do not have a current diagnosis of depression but who are considered to be at increased risk of developing perinatal depression

USPSTF recommendation

B

Clinicians should provide or refer pregnant and postpartum individuals who are at increased risk of perinatal depression to counseling interventions.

FOR MORE INFORMATION

US Preventive Services Task Force
http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/perinatal-depression-preventive-interventions

To find this and other JAMA Patient Pages, go to the For Patients collection at *jamanetworkpatientpages.com*.

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JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum
US Preventive Services Task Force Reaffirmation Recommendation Statement

US Preventive Services Task Force

IMPORTANCE In the United States, the rate of gonococcal ophthalmia neonatorum was an estimated 0.4 cases per 100 000 live births per year from 2013 to 2017. Gonococcal ophthalmia neonatorum can cause corneal scarring, ocular perforation, and blindness as early as 24 hours after birth. In the absence of ocular prophylaxis, transmission rates of gonococcal infection from mother to newborn are 30% to 50%.

OBJECTIVE To reaffirm the US Preventive Services Task Force (USPSTF) 2011 recommendation on ocular prophylaxis for gonococcal ophthalmia neonatorum.

EVIDENCE REVIEW The USPSTF commissioned a reaffirmation evidence update to identify new and substantial evidence sufficient enough to change its prior recommendation.

FINDINGS Using a reaffirmation process, the USPSTF found no new data that would change its previous conclusion that topical ocular prophylaxis is effective in preventing gonococcal ophthalmia neonatorum and related ocular conditions. The USPSTF found no new data that would change its previous conclusion that there is convincing evidence that topical ocular prophylaxis of all newborns is not associated with serious harms. Therefore, the USPSTF reaffirms its previous conclusion that there is convincing evidence that topical ocular prophylaxis for all newborns provides substantial benefit.

CONCLUSIONS AND RECOMMENDATION The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum. (A recommendation)

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Related article page 404 and JAMA Patient Page page 414

CME Quiz at jamanetwork.com/learning

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

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

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

Summary of Recommendation and Evidence

The USPSTF recommends prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum (A recommendation) (**Figure 1**).

Rationale

Importance

In the United States, the rate of gonococcal ophthalmia neonatorum was an estimated 0.4 cases per 100 000 live births per year from 2013 to 2017.[1-4] Gonococcal ophthalmia neonatorum can cause corneal scarring, ocular perforation, and blindness as early as 24 hours after birth.[5-7] In the absence of ocular prophylaxis, transmission rates of gonococcal infection from mother to newborn are 30% to 50%.[8]

Reaffirmation

In 2011, the USPSTF reviewed the evidence on prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum and issued an A recommendation.[5] The USPSTF has decided to use a reaffirmation deliberation process to update this recommendation. The USPSTF uses the reaffirmation process for well-established, evidence-based standards of practice in current primary care practice for which only a very high level of evidence would justify a change in the grade of the recommendation.[9] In its deliberation of the evidence, the USPSTF considers whether

Figure 1. USPSTF Grades and Levels of Evidence

What the USPSTF Grades Mean and Suggestions for Practice

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

USPSTF Levels of Certainty Regarding Net Benefit

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

USPSTF indicates US Preventive Services Task Force.

the new evidence is of sufficient strength and quality to change its previous conclusions about the evidence.

Benefits of Preventive Medication

The USPSTF found convincing evidence that ocular prophylaxis of newborns with 0.5% erythromycin ophthalmic ointment can prevent gonococcal ophthalmia neonatorum.

Harms of Preventive Medication

The USPSTF found convincing evidence that ocular prophylaxis of newborns with 0.5% erythromycin ophthalmic ointment is not associated with serious harms.

USPSTF Assessment

Using a reaffirmation process,[9] the USPSTF concludes with high certainty that the net benefit of topical ocular prophylaxis of all newborns to prevent gonococcal ophthalmia neonatorum is substantial.

Clinical Considerations

Patient Population Under Consideration

This recommendation applies to all newborns regardless of gestational age (**Figure 2**).

Figure 2. Clinical Summary: Ocular Prophylaxis for Gonococcal Ophthalmia Neonatorum

Population	Newborns
Recommendation	Provide prophylactic ocular topical medication to prevent gonococcal ophthalmia neonatorum. Grade: A

Preventive Medication	Erythromycin ophthalmic ointment is the only drug approved by the US Food and Drug Administration for the prophylaxis of gonococcal ophthalmia neonatorum. Ocular prophylaxis of newborns is mandated in most states and is considered standard neonatal care.
Relevant USPSTF Recommendations	The USPSTF recommends screening for gonorrhea in all sexually active women 24 years and younger and in older women at increased risk for infection, as well as pregnant women.

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

U.S. Preventive Services TASK FORCE

JAMA

USPSTF indicates US Preventive Services Task Force.

Preventive Medication

Erythromycin ophthalmic ointment is considered effective in preventing gonococcal ophthalmia neonatorum.[10] Other medications, such as tetracycline ophthalmic ointment and silver nitrate, have been evaluated for the prevention of gonococcal ophthalmia neonatorum but are no longer available in the United States.[3] Gentamicin was used during a period of erythromycin shortage, although its use was associated with ocular reactions (chemical conjunctivitis).[11] Povidone-iodine has been proposed for prophylaxis, but there are limited data on its benefits and harms.[3] Currently, erythromycin is the only drug approved by the US Food and Drug Administration for the prophylaxis of gonococcal ophthalmia neonatorum.[11] Ocular prophylaxis of newborns is mandated in most states[6] and is considered standard neonatal care.[11]

Additional Approaches to Prevention

The rates of gonococcal ophthalmia neonatorum are related to gonococcal infection rates in women of reproductive age.[3] Accordingly, screening for and treatment of gonococcal infection in pregnant women is an important strategy for reducing the sexual transmission of gonorrhea and subsequent vertical transmission leading to gonococcal ophthalmia neonatorum. While screening and treatment programs have reduced the rates of gonorrhea in pregnant women, there are large disparities in access to prenatal care in the United States.[1,12] Risk-based prophylaxis has also been proposed as an alternative strategy for preventing gonococcal ophthalmia neonatorum. Currently, there are no risk-based tools for screening pregnant women and no studies examining the use of risk-based vs universal prophylaxis. Therefore, ocular prophylaxis remains an important tool in the prevention of gonococcal ophthalmia neonatorum.

Useful Resources

The USPSTF recommends screening for gonorrhea in all sexually active women 24 years and younger and in older women at increased risk for infection, as well as pregnant women.[13] The Centers for Disease Control and Prevention provides clinical guidance for ocular prophylaxis and treatment of gonococcal ophthalmia neonatorum.[10]

Other Considerations

Research Needs and Gaps

The only available drug approved by the US Food and Drug Administration for the prevention of gonococcal ophthalmia neonatorum is 0.5% erythromycin ophthalmic ointment. It is currently unknown whether *Neisseria gonorrhoeae* has developed resistance to erythromycin ointment in the United States. However, given increased antimicrobial resistance noted in other countries, further research is needed to find safe and effective alternatives to erythromycin. Another area for research is whether risk-based prophylaxis of newborns, based on maternal risk factors, is as effective as universal prophylaxis.

Discussion

Burden of Disease

Ophthalmia neonatorum is conjunctivitis occurring in infants during the first month of life. Gonococcal ophthalmia neonatorum occurs when gonococcal infection is transmitted to newborns during delivery by women infected with *N gonorrhoeae*.[10] The rates of gonococcal conjunctivitis in infants are directly related to the rates of gonorrhea among women of reproductive age.[3] In the United States, adolescents and young adult women have the highest rates of gonorrhea, with rates peaking at age 19 years (872.2 cases per 100 000 women); among women aged 20 to 24 years, there were 648.8 cases per 100 000 women in 2017.[1] Estimated rates of gonorrhea among pregnant women in the US primary care

setting are not available. Although gonococcal infection rates have declined since national screening programs were implemented in the 1970s, reported gonorrhea cases have increased recently, from 105.3 cases to 171.9 cases per 100 000 population from 2013 to 2017, respectively.[1] An estimated 6.2% of births in the United States occur among women receiving little to no prenatal care, although rates as high as 20% have been documented in certain populations based on location and race/ethnicity.[12]

Data based on infant age (younger than 1 year) and specimen source (conjunctiva or eye) indicate there were an estimated 42 infections (≤0.4 cases) per 100 000 live births per year from 2013 to 2017.[1] However, limitations in reporting suggest this is an underestimate.[14] Using a broader definition that includes cases with unknown, other, or missing specimen sources, the prevalence of gonococcal ophthalmia neonatorum during that period could possibly be higher.[3]

Untreated gonococcal ophthalmia neonatorum can result in severe and lasting conditions, including corneal scarring, ocular perforation, and blindness.[7] There are no contemporary estimates of blindness related to gonococcal ophthalmia neonatorum in the United States. Historical estimates from 19th-century Europe show that gonococcal ophthalmia neonatorum was a major cause of childhood blindness, resulting in corneal damage in 20% of infected infants and blindness in 3%.[15,16] An observational study from Nairobi, Kenya, in the 1980s reported that 16% of a series of 64 infants with gonococcal ophthalmia neonatorum had corneal involvement.[17]

Scope of Review

To reaffirm its 2011 recommendation on ocular prophylaxis for gonococcal ophthalmia neonatorum,[5] the USPSTF commissioned a targeted evidence review.[3,4] The aim of this review was to identify substantial new evidence that was sufficient to change the prior recommendation.

Benefits of Preventive Medication

Previous USPSTF reviews found convincing evidence that topical ocular prophylaxis can prevent gonococcal ophthalmia neonatorum. The USPSTF found no new data that would change its previous conclusion that topical ocular prophylaxis is effective in preventing gonococcal ophthalmia neonatorum and related ocular conditions.

Potential Harms of Preventive Medication

The USPSTF found no new data that would change its previous conclusion that there is convincing evidence that topical ocular prophylaxis of all newborns is not associated with serious harms. Possible harms include the potential for antimicrobial resistance to treatment medication.

Estimate of Magnitude of Net Benefit

The USPSTF considered the evidence using a reaffirmation process and found that topical ocular prophylaxis is effective in preventing gonococcal ophthalmia neonatorum and related ocular conditions, with small associated harms and substantial benefit. Therefore, the USPSTF reaffirms its previous conclusion that there is convincing evidence that topical ocular prophylaxis for all newborns provides substantial benefit.

Response to Public Comment

A draft version of this recommendation statement was posted for public comment on the USPSTF website from September 11 to October 9, 2018. Several comments questioned the continued need for universal prophylaxis given the relative low rate of disease. The USPSTF reaffirmed its recommendation based on several factors, including the rapid course and serious adverse effects of infection, increasing rates of gonococcal infection, and the large number of persons who do not receive screening for gonococcal infection during pregnancy in the United States. Comments also supported risk-based prophylaxis as an alternative strategy for prevention. However, there are no tools for assessing the risk of infection in newborns and no studies examining the use of risk-based vs universal prophylaxis. The USPSTF revised the recommendation to clarify this point. In addition, a number of comments promoted the use of iodine solutions (povidone-iodine) as an alternative to erythromycin ophthalmic ointment. The evidence review found limited studies on the use of iodine solutions and notes that they are not approved for use in the United States as ocular prophylaxis for gonococcal ophthalmia neonatorum. The USPSTF added language to address this concern.

Reaffirmation of Previous USPSTF Recommendation

This recommendation is a reaffirmation of the USPSTF 2011 recommendation statement.[5] In 1996[18] and 2005,[19] the USPSTF reviewed the evidence on ocular prophylaxis for gonococcal ophthalmia neonatorum and found that the benefits of screening substantially outweigh the harms. For the current recommendation, the USPSTF commissioned a targeted review to look for substantial new evidence on the benefits and harms of ocular prophylaxis and determined that the net benefit of ocular prophylaxis continues to be well established. The USPSTF found no new substantial evidence that could change its recommendation and therefore reaffirms its recommendation to provide prophylactic ocular topical medication for all newborns to prevent gonococcal ophthalmia neonatorum.

Recommendations of Others

The Centers for Disease Control and Prevention, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the World Health Organization all recommend universal topical ocular prophylaxis to prevent gonococcal ophthalmia neonatorum.[1,20,21] The Canadian Pediatric Society recommends against universal prophylaxis. Several European countries, including Denmark, Norway, Sweden, and the United Kingdom, no longer require universal prophylaxis, instead opting for a prevention strategy of increased screening and treatment of pregnant women.[22] In 2017, the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommended screening all pregnant women at risk for gonorrhea or who live in a high-prevalence area at the first prenatal visit; women with gonococcal infection should be retested in 3 to 6 months, preferably in the third trimester. In addition, if the result of the first test is negative but the woman is at high risk for gonorrhea, retesting at the beginning of the third trimester is recommended.[20]

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

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	CCHP Medi-Cal HEDIS Measures	2016 CCHP	2017 CCHP	2018 CCHP	**2019 CCHP**	2019 MPL	2019 HPL
WCC	Nutrition counseling given for children	72.68%	72.93%	80.05%	82.96%	59.85%	83.45%
	Physical activity counseling for children	71.58%	71.71%	80.05%	82.59%	52.31%	78.35%
W34	*Yearly well child visit 3-6 yr.	78.14%	71.57%	74.70%	73.83%	67.15%	83.70%
CIS	*Combo 3 immunizations	73.97%	76.67%	77.62%	76.16%	65.45%	79.56%
PPC	*First trimester prenatal	86.13%	91.24%	86.37%	88.22%	76.89%	90.75%
	Postpartum visit 21-56 days	68.13%	75.43%	70.56%	74.43%	59.61%	73.97%
LBP	Avoiding Use of Imaging for Low Back Pain	82.30%	76.18%	79.57%	79.22%	67.19%	79.88%
BCS	Breast Cancer Screening		58.96%	58.94%	60.10%	51.78%	68.94%
CCS	*Cervical cancer screening	58.15%	58.48%	66.59%	69.00%	54.26%	70.68%
CDC	Diabetes Eye Exam 2 yrs.	51.94%	48.74%	61.88%	59.12%	50.85%	68.61%
	*Diabetes HbA1c testing	86.17%	90.91%	89.41%	91.73%	84.93%	92.70%
	Diabetes HbA1c(>9%) (lower is better)	41.50%	31.82%	40.47%	37.71%	47.20%	29.68%
	Diabetes HbA1c (<8%)	50.24%	55.56%	48.24%	51.82%	44.44%	59.49%
	Diabetes Nephropathy screen or treatment	88.83%	88.13%	88.47%	90.27%	88.56%	93.43%
	Diabetes BP <140/90	60.44%	63.13%	68.47%	77.86%	56.20%	77.50%
AAB	Avoidance of Antibiotics in Adults With Acute Bronchitis	41.08%	46.60%	46.56%	51.73%	27.63%	44.64%
IMA-2	Immunizations for Adolescents: Combo 2		27.93%	38.44%	46.72%	26.28%	46.72%
AMR	Asthma Medication Ratio		46.73%	52.52%	64.45%	56.85%	71.93%
CBP	*Controlling High Blood Pressure	57.11%	58.87%	69.59%	69.10%	49.15%	71.04%
CDF	Screening for Depression and follow up--Screening		18.03%	16.30%	16.54%		
	Screening for Depression and follow up--Follow Up		100.00%	38.42%	3.08%		
ACR	All-Cause Readmissions (lower is better)	15.52%	13.95%	15.09%	15.54%		
	All-Cause Readmission, SPDs	19.70%	17.22%	17.30%	19.15%		
	All-Cause Readmission, Non SPDs	12.22%	13.19%	13.15%	13.11%		
MPM	Monitoring for Patients on persistent Medications - ACE or ARB	86.96%	88.54%	87.74%	88.83%	85.97%	92.87%
	Monitoring for Patients on persistent Medications - Diuretics	86.26%	87.39%	87.70%	88.57%	86.06%	92.90%
AMB	Ambulatory Care - Outpatient Visits per 1000 Member Months	339.74	287.22	295.57	452.10	307.98	467.96
	Ambulatory Care - Emergency Department Visits per 1000 Member Months	55.65	53.05	51.47	50.25	50.63	82.21
CAP	Children and Adolescents' Access to Primary Care Practitioners - 12-24 Months	94.42%	94.00%	93.32%	93.97%	93.64%	97.71%
	Children and Adolescents' Access to Primary Care Practitioners - 25 Months-6 Years	83.56%	81.25%	83.45%	85.04%	84.39%	92.88%
	Children and Adolescents' Access to Primary Care Practitioners - 7-11 Years	86.20%	84.93%	85.55%	86.42%	87.73%	96.18%
	Children and Adolescents' Access to Primary Care Practitioners - 12-19 Years	83.95%	80.84%	82.42%	83.66%	85.81%	94.75%

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

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

*included in default algorithm