CONTRA COSTA HEALTH PLAN
A Division of Contra Costa Health Services

Agenda

Quarterly Community Provider Network (CPN) Meeting (East)

Date: January, 28, 2020
Time: 12:30 PM – 2:00 PM

Location: Pittsburg Health Center
2311 Loveridge Rd.,
Cypress Room - 1st Floor
Pittsburg, CA 94565

I.	**CALL TO ORDER and INTRODUCTIONS**	Elisa Hernandez, MPH, CHES
II.	**REVIEW and APPROVAL of Previous Meeting Minutes**	Elisa Hernandez, MPH, CHES
III.	**IHA, SHA, USPSTF**	Elisa Hernandez, MPH, CHES
	• **IHA, SHA** • **USPSTF** • **Grievance Policy**	
IV.	**GUEST SPEAKERS**	
	• **California Children's Services (CCS)** • **Children and Family Services (CFS)**	Sharmila Wright, M.A., Medical Social Worker II Hannah Slade, Social Service Program Analyst Ariana Martinez, MSW Staff Development Specialist
V.	**REGULAR REPORTS**	
	1. Legislative / CCHP Update **2. Trauma Screenings and Trauma-Informed Care Training** **3. CCHP Benefits update** **4. Quality** **5. Pharmacy** **6. Utilization Management**	Jose Yasul, MD Medical Director, CCHP
VI.	**CLAIMS Q&A**	Claims Unit Staff

Our next scheduled meeting is April 28, 2020
CPN meeting reimbursement will be prorated based on length of time attendee is present in the meeting.

CONTRA COSTA HEALTH PLAN

East County
Quarterly Community Provider Network (CPN)
Meeting Minutes – January 28, 2020

Attending:

CCHP Staff: Jose Yasul, MD, Medical Director; Kristina Stortz, Clerical Support; Elisa Hernandez, MPH, CHES; Sylvia Rodriguez, Claims Supervisor

CPN Providers: C. Cave, NP; N. Dave; G. Del Rio, MD; J. Gallo, DO; B. Gharagozlou, MD; J. Leon, NP; A. Mahdavi, MD;

M. Mamillon, PA; J. Sequeira, MD; C. Som, DO;

Guest Ariana Martinez, MSW; Hannah Slade; Sharmjila Wright, MA

Discussion		Action	Accountable
	Meeting called to order at 12:45 P.M.		Elisa Hernandez, MPH, CHES, CCHP
I.	Minutes were approved with no revisions.		Jose Yasul, MD Medical Director, CCHP
II.	**Reminders/Updates** • 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: o As of Dec. 2019: Abdominal Aortic Aneurysm (AAA) screening ▪ Screening men between the ages 65-75 who have ever smoked • Grievance Policy o Any expression of dissatisfaction from member should trigger the Provider to submit a complaint form should go directly to the Health Plan. o Member Grievance or Appeals Form included in the packet (English and Spanish)		Elisa Hernandez, MPH, CHES, CCHP
III.	**Guest Speaker** **California Children's Services (CCS)** • What is CCS? o A state program for children with certain disease or health problems established in 1927 by State Legislature o Children up to 21 years old can receive health care and other services needed ▪ After the age of 21 they can be referred to the Genetically Handicapped Persons Program (GHHP)		Sharmila Write, MA, Medical Social Worker, CCS

	- CCS assist with connecting doctors and other trained health care professionals who know how to assist the children with their special healthcare needs. - CCS provides services to 200,000 children in California and 4,100 cases in Contra Costa County - Benefits of CCS - Diagnosis of and/or treatment for CCS Medically Eligible conditions - Rehabilitation Services with Pediatric Physical/Occupational Therapist - Care Coordination - Nurse Case Management - CCS Eligibility (Must meet 4) - Under 21 years of age - Medically eligible: determined by CCS Medical Consultant - Residential Eligibility: CA resident - Financial Eligibility: - prepaid plans or no insurance adjusted gross income (AGI) must be less than $40k or - income greater than $40k, out of pocket family medical expenses are over 20% of AGI - Must meet financial screening requirements for children with share-of-cost or restricted Medi-Cal; Full scope Medi-Cal; and optional Targeted Low-Income Children Program coverage - Senate Bill 75 - Full scope Medi-Cal for individuals under 19 years of age Who do not meet satisfactory immigration status, but meet all other eligibility requirements for the Medi-Cal program - Referral to CCS From - Providers, parents, and schools - All referrals must document medical reports stating the medical diagnosis with supporting lab documents/image results, and a completed CCS application - Medical Case Management Diagnostic Services - Tests, specialty evaluation, imaging for a condition likely to be CCS Medical Eligible - Rule out abnormal newborn screen tests - High risk infant follow-up - Developmental tests; Neurology Test; Ophthalmology, Audiology; Hospital based program - Medical Case Management Services - Treatment Services: Treatment request, Transplant request, authorize DME, medications, supplies, medical foods and enteral nutrition products - Medically eligible conditions - Nurse Case Management: 9 Public Health Nurses, medical determination, annual case reviews, authorize requested medical services, care coordination and identification of needs and referral to appropriate resources - Medical Therapy Program (MTP) - Physical Therapy and Occupational Services, school based MTP, Vendored Therapy - There is no financial eligibility requirements for children whose cases are open for MTP services only		Sharmila Write, MA, Medical Social Worker, CCS

	Children and Family Services (CFS)
	• What is child abuse?
	  o Physical abuse, neglect (general/severe), sexual abuse (assault/exploitation), and emotional abuse
	• Mandated Reporting
	  o Two Types:
	  ▪ Mandated Reporting: required by law, liable if they fail to report, and immune from liability
	  ▪ Discretionary Reporting: not required by law and not liable if they fail to report
	• When to report?
	  o Immediately or as soon as practically possible, and within 36 hours
	  o Submit form SS8572 or SCAR
	• Screening Social Workers
	  o Screening social workers must asses if the situation meets the criteria for intervention, assess correction Contra Costa jurisdiction, is an in-person response needed, and what is the correct timeframe response.
	• Emergency Response Social Workers
	  o Assess the immediate safety of the child, assess the needs of the family, diffuse conflict, discover family strengths, gather information and provide referrals.
	• Working with CFS
	  o Courtesy call the Social Worker after a child has been seen regarding helpful and important medical concerns/updates.
	• Health Education Passport (HEP)
	  o This is a record of all obtainable health and education information for children in foster care from birth to present
	  o Hep information can be submitted to hep@ehsd.cccounty.us
	• Authorization for treatment and to release information
	  o Signed at detention:
	  ▪ Authorization of medical treatment and the authorization to release information disclosure of medical and mental health information to EHSD
	• Resources for Foster Youth and Families
	  o Caregiver Liaison
	  o Youth Partner
	  o Respite
	  o Kinship support
	  o Mental Health Referrals
	  o Substance Abuse Programs
	  o Connoting Foster and Kinship Care Education classes/training
	  o Caregiver support groups
			Hannah Slade, Social Service Program Analyst, CFS

IV	**Regular Reports - CCHP Updates** • **Legislative/CCHP Update**		Jose Yasul, MD

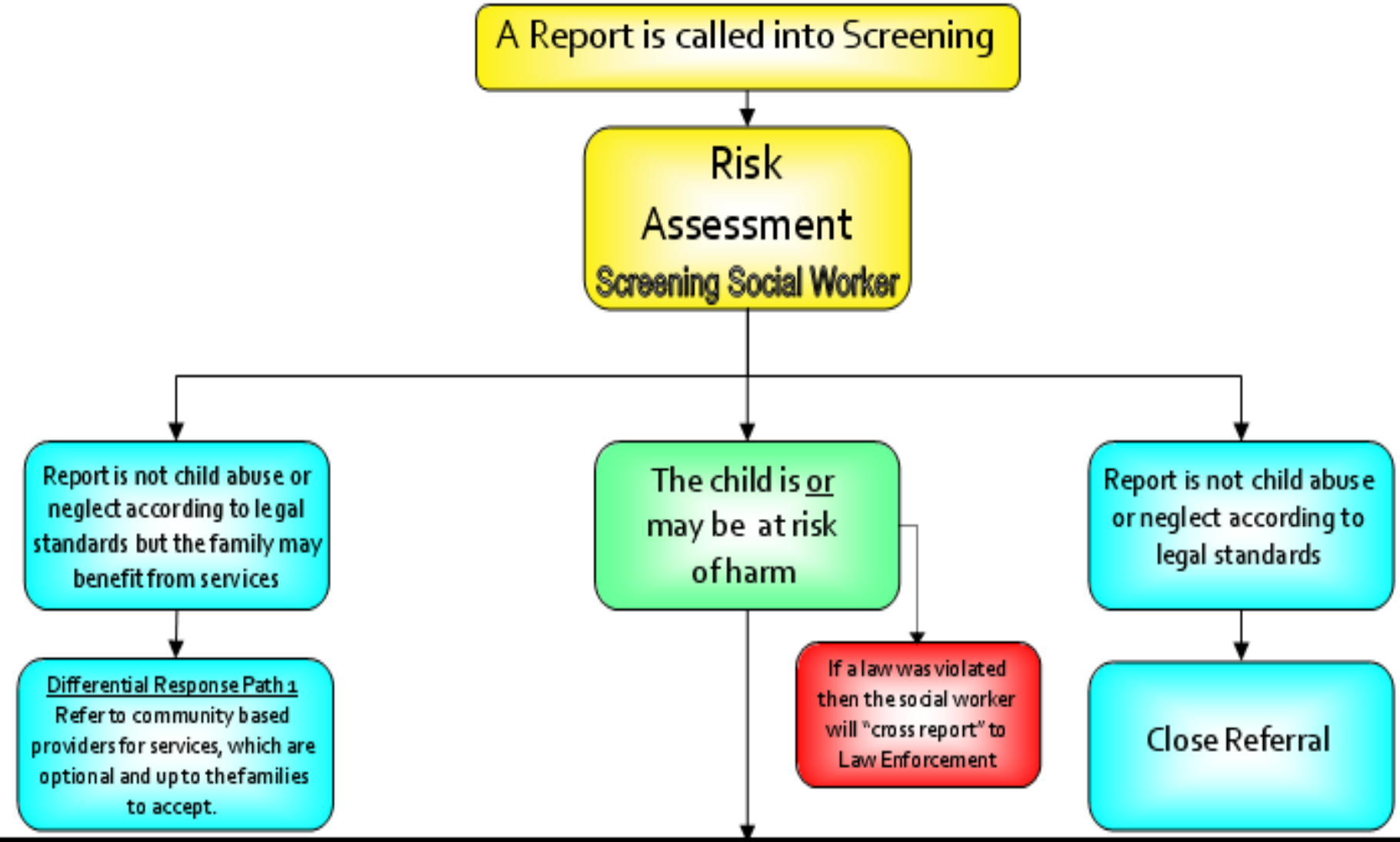
	o (CAL-AIM), Medi-Cal Healthier California for All ▪ Identify and manage member risk and needs through Whole Person Care Approaches and addressing Social Determinants of Health ▪ Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility. o Suzanne Tsang ▪ New Director of Marketing, Member Outreach and Public Affairs ▪ Previous work experience: Alameda Alliance, Kaiser, Blue Shield of CA and San Mateo Medical Center. • **CCHP Benefits Update** o Restored Optional Benefits ▪ 2 visits per month o Opioid Pilot Program ▪ Should CCHP reduce to 90 MEU • **Quality** o Additional proposed measures ▪ Managed Care Accountability Sets (MCAS)/External Accountability Sets (EAS) ▪ Assess for the appropriate utilization of preventative services in accordance with contractual requirements • **Pharmacy** o Review of Care Matter Bulletin: Asthma and Osteoporosis • **Other** o Adverse Childhood Experiences (ACES)- ▪ Beginning 1/1/2020 DHCS will pay Medi-Cal providers $29.00 per trauma screening for children and adults with Medi-Cal coverage.		Medical Director, CCHP
V	• **Q & A/Problems and Concerns** o **(Q)** Why do medical records take a long time when aging out? (Dr. Del Rio) ▪ **(A)** CCS unable to get medical records o **(Q)** What is the process for transition to Adult MD? ▪ **(A)** Tell patients to contact HP/specialist before transitioning. o **(Q)** Member Services issue: Wait time is too long. Can you make a provider line to change doctors? ▪ **(A)** Dr. Yasul will speak to Member Service regarding wait times.		Attending Providers
Adjournment: Meeting adjourned at 2:00 P.M.			
Next meeting April 28, 2020			

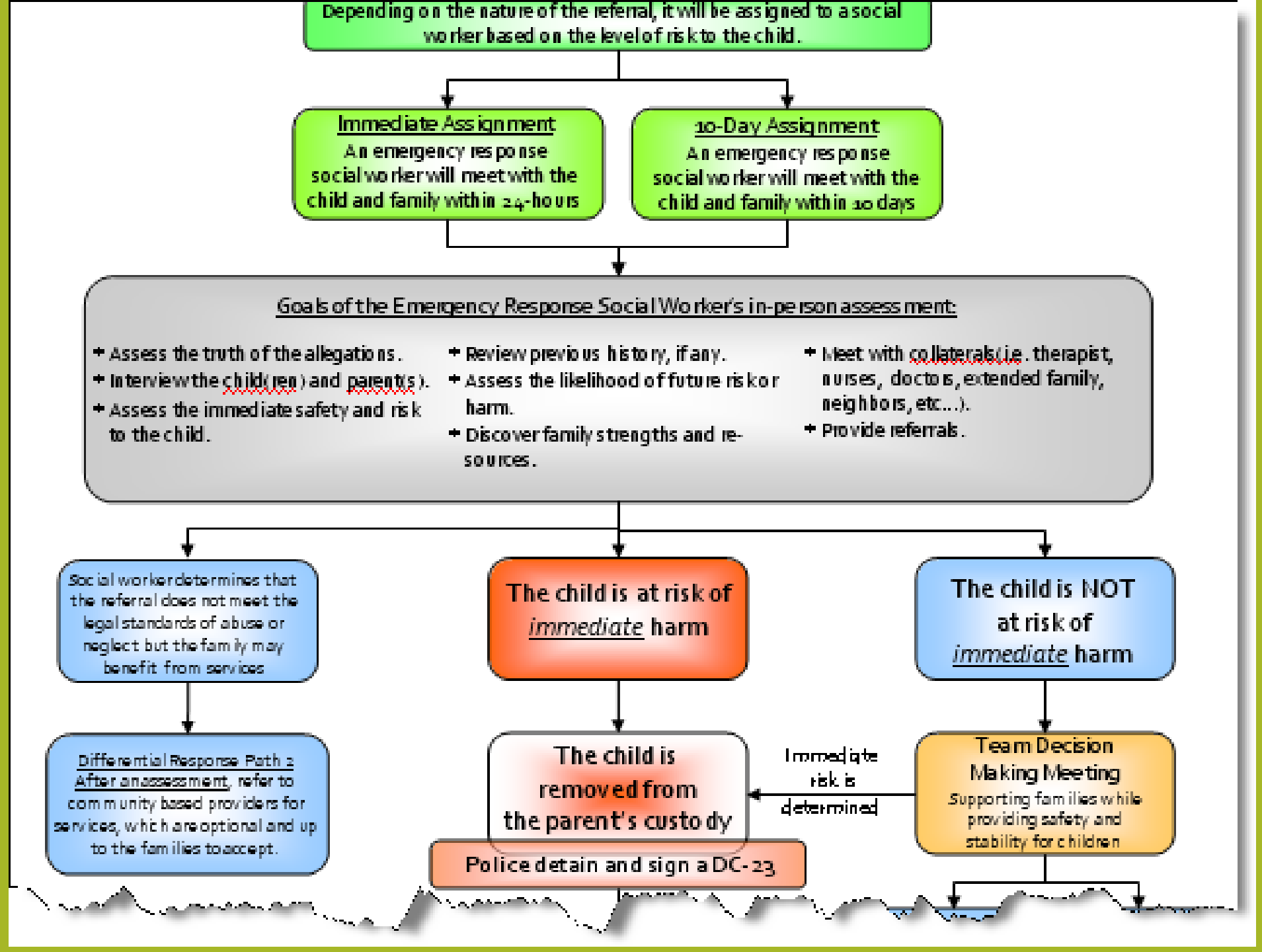
CONTRA COSTA COUNTY CHILDREN & FAMILY SERVICES

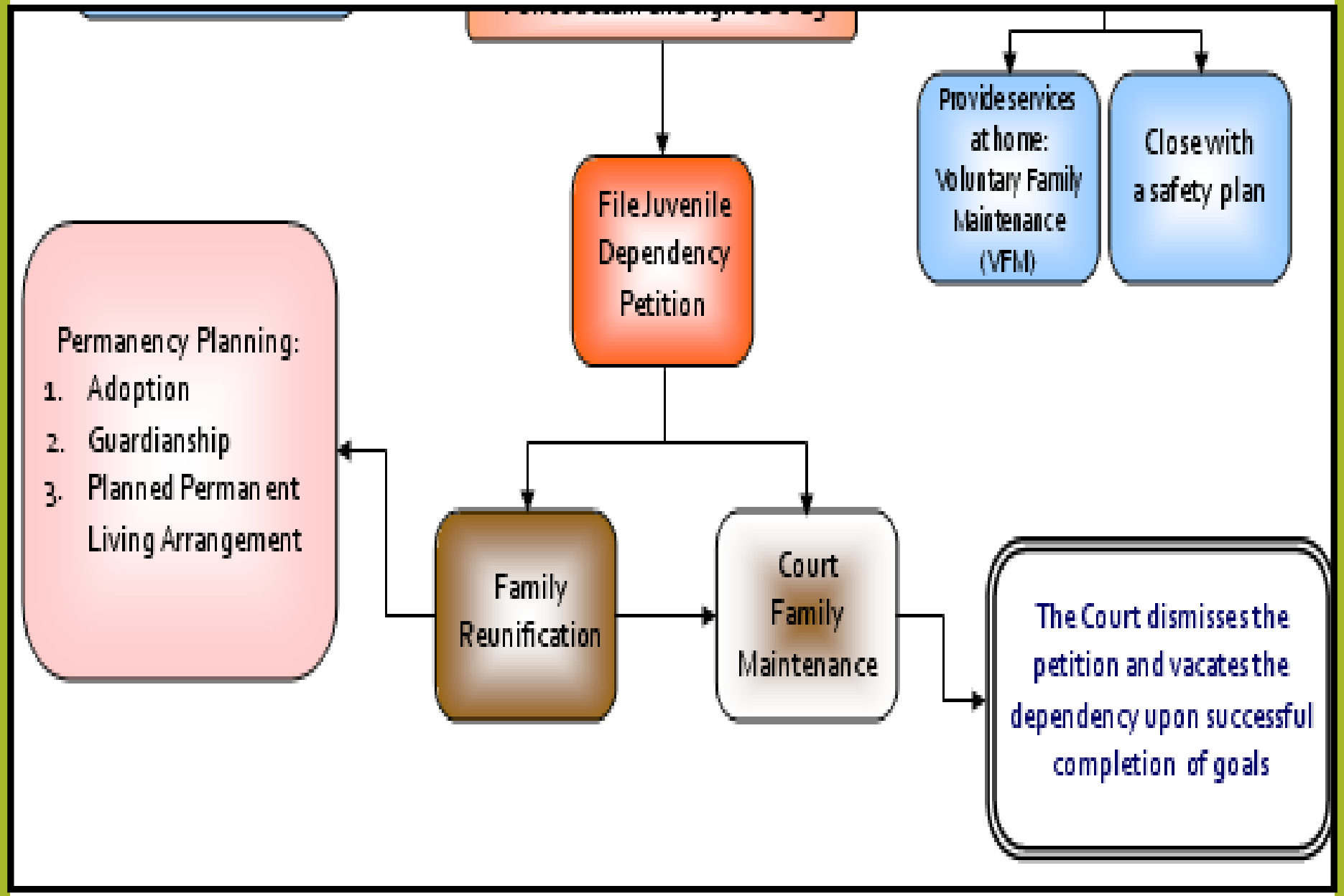
Ariana Martinez, MSW

Staff Development Specialist

Children & Family Services Flow Chart




Depending on the nature of the referral, it will be assigned to a social worker based on the level of risk to the child.
Immediate Assignment
An emergency response social worker will meet with the child and family within 24-hours
10-Day Assignment
An emergency response social worker will meet with the child and family within 10 days
Goals of the Emergency Response Social Worker's in-person assessment:
Assess the truth of the allegations.
Interview the child(ren) and parent(s).
Assess the immediate safety and risk to the child.
Review previous history, if any.
Assess the likelihood of future risk or harm.
Discover family strengths and resources.
Meet with collaterals (i.e. therapist, nurses, doctors, extended family, neighbors, etc...).
Provide referrals.
Social worker determines that the referral does not meet the legal standards of abuse or neglect but the family may benefit from services
The child is at risk of immediate harm
The child is NOT at risk of immediate harm
Differential Response Path 2
After an assessment, refer to community based providers for services, which are optional and up to the families to accept.
The child is removed from the parent's custody
Police detain and sign a DC-23
Immediate risk is determined
Team Decision Making Meeting
Supporting families while providing safety and stability for children


Provide services at home: Voluntary Family Maintenance (VFM)
Close with a safety plan
File Juvenile Dependency Petition
Permanency Planning:
1. Adoption
2. Guardianship
3. Planned Permanent Living Arrangement
Family Reunification
Court Family Maintenance
The Court dismisses the petition and vacates the dependency upon successful completion of goals

Screening Social Workers

- Does the situation meet the criteria for intervention?
- Is Contra Costa the correct jurisdiction?
- Is an in-person response needed?
- What should be the response timeframe? (Is there imminent danger?)

Emergency Response Social Workers

- Assess the immediate safety and risk of the child(ren)
- Assess the needs of the family and begin to build rapport
- Diffuse conflict
- Discover family strengths
- Gather information
- Provide referrals

ER Social Worker's primary decision…

- Can the child safely remain home?
- If the child can remain at home, what does the family need to ensure the child continues to be safe?

- If the child cannot safely remain home, child may enter out of home placement.

Working with CFS

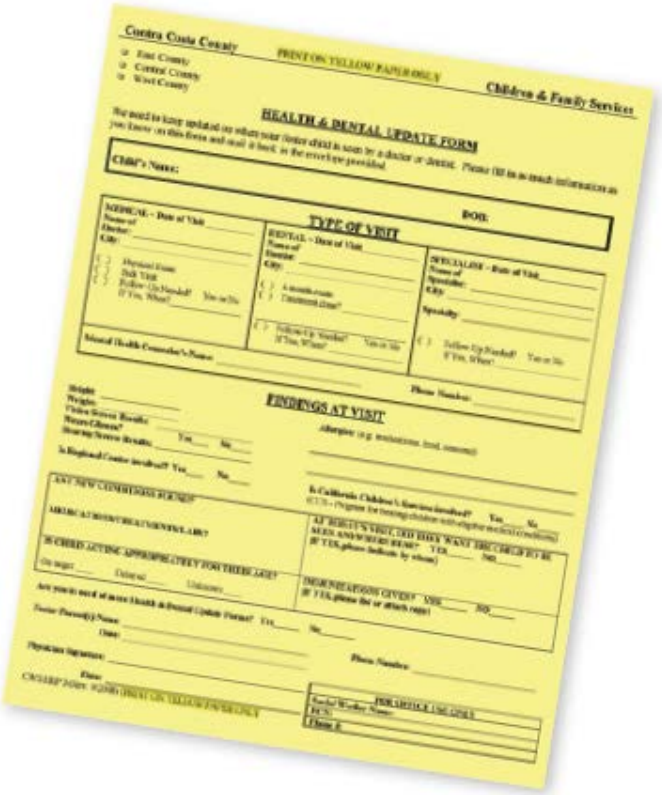
- HEP information can be sent directly back to hep@ehsd.cccounty.us.
- A courtesy call to the SW after you have seen a child on their caseload is always appreciated. Helpful information to share includes: any new or ongoing health concerns, updates on child's overall health and disposition, any concerns about mental health, and any follow up care needed.
- Please note that social workers utilize evidence based decision making tools. Social workers can be overridden by supervisor and/or manager, as the decision of the agency.
- Social Workers depend on medical staff to provide medical basis that impact safety. The social worker does not necessarily know medical terms, implications, etc. It is helpful to explain medical circumstances simply, as the social worker will be conveying information in a court report.

Collaboration

- CHWs are in place to assist parents and caregivers with making medical appointments and insurance issues
- PHNs are assigned to all youth who are prescribed Psychotropic Medications and some Foster Youth who have other chronic or serious medical issues.
- HEP clerks can verify that a child is a Foster Youth and/or that caregiver bringing the child in to the appt is the current Foster Parent

Health and Education Passport

- The Health and Education Passport (HEP) is a record of all obtainable health and education information for children in foster care from birth to present that is recorded in CWS/CMS.
- The HEP accompanies the child throughout out-of-home placement.
- Caregivers are encouraged to bring the HEP to appointments and get the Health Update Form completed.
- Electronic versions are available.


Contra Costa County

Children & Family Services

HEALTH & DENTAL UPDATE FORM

TYPE OF VISIT

FINDINGS AT VISIT

Authorization for Treatment and to Release Information

Signed at Detention:

- Authorization of Medical Treatment and an at Detention.
  - This forms authorize most forms of medical and dental care for the child
- Authorization to Release Information
  - Authorizes disclosure of medical and mental health information to Contra Costa County Employment and Human Services Department and Health Services Department.

Mandated Reporting

Two Types of Reporters

Mandated Reporter

- Required to report child abuse, by law
- Liable if they fail to report
- Immune from liability

Discretionary Reporter

- Not required by law
- Not liable if they fail to report

Requirements of a Mandated Reporter

"A mandated reporter is required to report child abuse if he or she, in their *professional capacity*, or *within the scope of his or her employment* has knowledge of, or observes a child whom the mandated reporter *knows or reasonably suspects* has been the victim of child abuse or neglect."

The Child Abuse and Neglect Reporting Act, Penal Code §11166

Child Abuse is…

- Physical Abuse
  - Includes unlawful corporal punishment
- Neglect
  - General
  - Severe
- Sexual Abuse
  - Assault
  - Exploitation
- Emotional Abuse

Penal Code 11165.1-11165.5, 11166.05

Penal Code 11165.1-11165.5, 11166.05

What is not Child Abuse?

Children Fighting

Consensual teenage sex

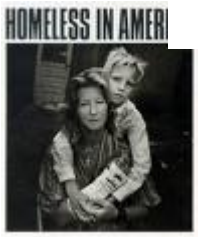
Past child abuse of an adult

"Spanking"

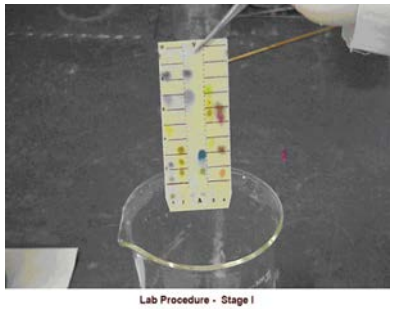
*reportable

Refusal of medical treatment

reportable if it puts child in danger



Homelessness



Positive toxicology at birth

Cultural Differences

"Cultural and religious child rearing practices and beliefs which differ from the general community standards shall not in themselves create a need for child welfare services unless the practice presents a specific danger to the physical or emotional safety of the child."

Welfare and Institutions Code §16509

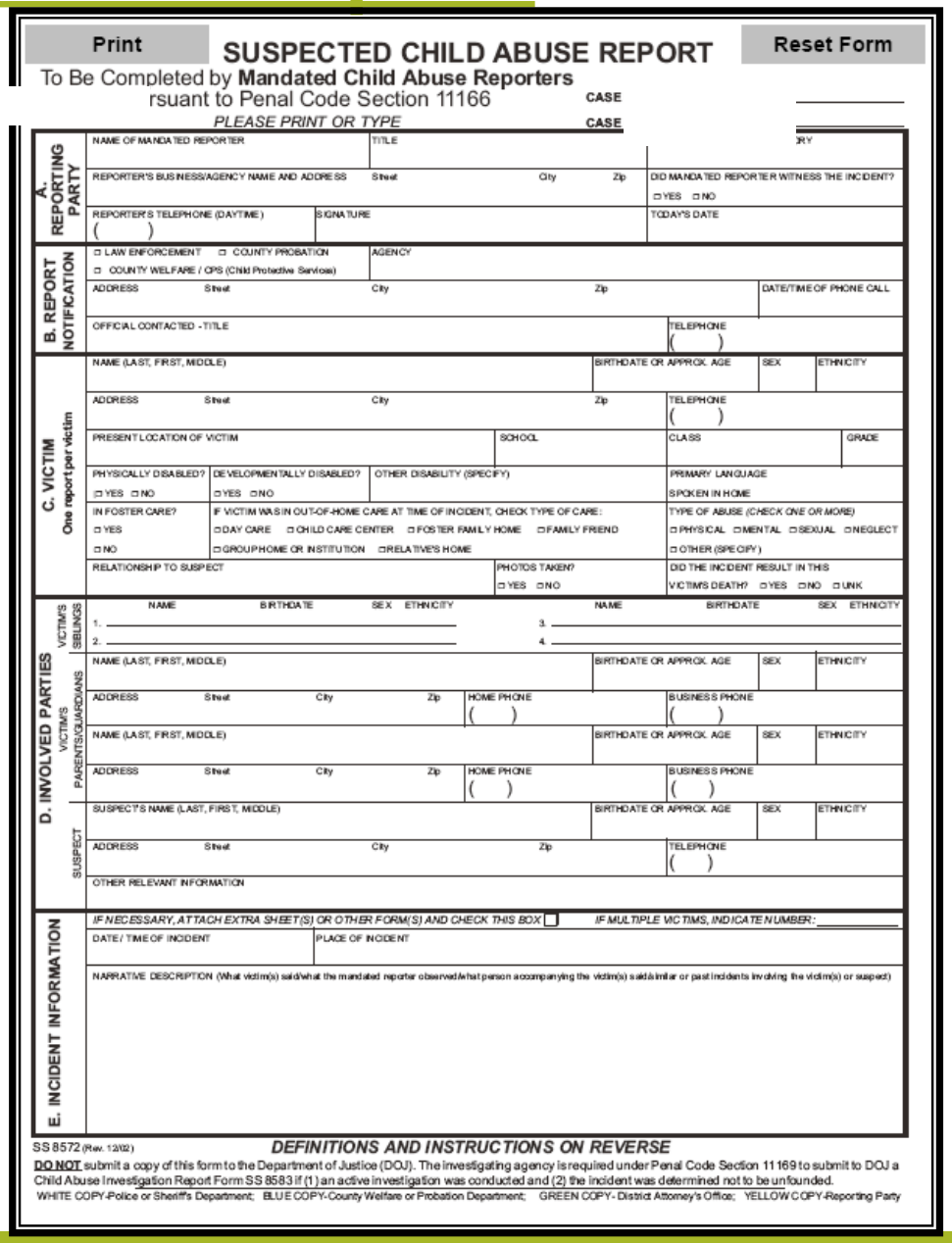
Reporting Procedures

immediately or as soon as is practicably possible

within thirty-six hours

Suspected Child Abuse Report

SS 8572 or SCAR



Print

SUSPECTED CHILD ABUSE REPORT

Reset Form

To Be Completed by **Mandated Child Abuse Reporters**
rsuant to Penal Code Section 11166

CASE

PLEASE PRINT OR TYPE

CASE

A. REPORTING PARTY

NAME OF MANDATED REPORTER | TITLE | ORY

REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS | Street | City | Zip | DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO

REPORTER'S TELEPHONE (DAYTIME) ( ) | SIGNATURE | TODAY'S DATE

B. REPORT NOTIFICATION

☐ LAW ENFORCEMENT ☐ COUNTY PROBATION ☐ COUNTY WELFARE / CPS (Child Protective Services) | AGENCY

ADDRESS | Street | City | Zip | DATE/TIME OF PHONE CALL

OFFICIAL CONTACTED - TITLE | TELEPHONE ( )

C. VICTIM One report per victim

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | TELEPHONE ( )

PRESENT LOCATION OF VICTIM | SCHOOL | CLASS | GRADE

PHYSICALLY DISABLED? ☐ YES ☐ NO | DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO | OTHER DISABILITY (SPECIFY) | PRIMARY LANGUAGE SPOKEN IN HOME

IN FOSTER CARE? ☐ YES ☐ NO | IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ FAMILY FRIEND ☐ GROUP HOME OR INSTITUTION ☐ RELATIVE'S HOME | TYPE OF ABUSE (CHECK ONE OR MORE) ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ☐ NEGLECT ☐ OTHER (SPECIFY)

RELATIONSHIP TO SUSPECT | PHOTOS TAKEN? ☐ YES ☐ NO | DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME | BIRTHDATE | SEX | ETHNICITY

1. | 3.

2. | 4.

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | HOME PHONE ( ) | BUSINESS PHONE ( )

NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | HOME PHONE ( ) | BUSINESS PHONE ( )

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE) | BIRTHDATE OR APPROX. AGE | SEX | ETHNICITY

ADDRESS | Street | City | Zip | TELEPHONE ( )

OTHER RELEVANT INFORMATION

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ | *IF MULTIPLE VICTIMS, INDICATE NUMBER:*

DATE / TIME OF INCIDENT | PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

Anonymity and Confidentiality

- A mandated reporter is required to give their name when making the report over the phone and sign the SCAR form

- The identity of a reporter of suspected child abuse is confidential

Penal Code §11167

Resources for Foster Youth and Families

- Caregiver Liaison
- Youth Partner (ages 10+)
- Respite
- Kinship Support (Lilliput and Uplift Family Services)
- Mental Health Referrals, EFC
- Substance Abuse programs
- Continuing Foster and Kinship Care Education classes/training
- Caregiver Support Groups


QUESTIONS???

Trauma Screenings and Trauma-Informed Care Provider Trainings

The California Department of Health Care Services (DHCS), in partnership with the California Office of the Surgeon General, is creating a first-in-the-nation statewide effort to screen patients for Adverse Childhood Experiences (ACEs) that lead to trauma and the increased likelihood of ACEs-Associated Health Conditions due to toxic stress. The bold goal of this initiative is to reduce ACEs and toxic stress by half in one generation.

All providers are encouraged to receive training to screen patients for ACEs. By screening for ACEs, providers can better determine the likelihood a patient is at increased health risk due to a toxic stress response, which can inform patient treatment and encourage the use of trauma-informed care. Detecting ACEs early and connecting patients to interventions, resources, and other supports can improve the health and well-being of individuals and families.

Beginning on January 1, 2020, DHCS will pay Medi-Cal providers $29 per trauma screening for children and adults with Medi-Cal coverage. By July 2020, providers must self-attest that the training has been completed to be eligible to continue receiving Medi-Cal payment for conducting ACEs screenings.

Provider Training

The ACEs Aware initiative offers Medi-Cal providers training, clinical protocols, and payment for screening children and adults for ACEs.

Training to screen for ACEs is available at the ACEs Aware website. The two-hour online curriculum is easy to access for a wide range of health care professionals and will provide Continuing Medical Education (CME) and Maintenance of Certification (MOC) credits.

For more information visit the DHCS website at
https://www.dhcs.ca.gov/provgovpart/Pages/TraumaCare.aspx

Enviar a: Servicios al Afiliado
Plan de Salud de Contra Costa
Member Services
595 Center Ave., Ste. 100
Martinez, CA 94553
Llamar o enviar un fax a:
1-877-661-6230, opción 2
Fax: 925-313-6047
Email:
member.services@hsd.cccounty.us
www.contracostahealthplan.org

Formulario de Queja o Apelación para el Afiliado

Nombre del afiliado _____ Fecha de nacimiento _____

Número de identificación del afiliado _____ Teléfono _____

Dirección _____

Información necesaria para presentar una queja

Fecha del servicio _____ Lugar del servicio _____

Descripción breve de la queja (Por favor describa el caso de la manera más detallada posible, incluyendo los nombres de las personas involucradas, las circunstancias que causaron el conflicto, y cualquier información que considere pertinente para la queja):

_____
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Qué medida solicita?

_____
_____
_____
_____
_____

Información necesaria para presentar una apelación

- Las solicitudes de Apelación/Reconsideración pueden ser presentadas ante el Plan de Salud por el afiliado si ha recibido una carta de Notificación de Decisión relativa a una denegación de un reclamo o una demora, modificación o denegación de un servicio solicitado.
- La solicitud puede efectuarse por teléfono o enlínea ***pero su seguimiento debe realizarse por escrito con la firma del afiliado o su representante legal.***
- Para nuestros afiliados de Medi-Cal esta solicitud debe presentarse dentro de los 60 días siguientes a la recepción de una Notificación de Decisión.
- Para nuestros afiliados Comerciales, la solicitud debe efectuarse dentro de los 180 días siguientes a la recepción de una Notificación de Decisión.

Fecha de la carta de Notificación de Decisión: _____

Descripción de una Apelación Normal

Por favor, describa el caso de la manera más detallada posible, incluida la fecha de la denegación del reclamo o servicio y cualquier información adicional que usted considere importante considerar. El Plan de Salud tiene 30 días para responder su apelación y usted recibirá una notificación definitiva de resolución.

_____

_____

_____

_____

_____

_____

Descripción de una Apelación Urgente

Si considera que una espera de 30 días para que el Plan de Salud responda será perjudicial para su salud, tiene la posibilidad de recibir una respuesta en 72 horas. Al presentar su apelación, mencione los motivos por los cuales la espera afectará su salud. Asegúrese de solicitar una "apelación urgente". Por favor, describa el caso de la manera más detallada posible, incluida la fecha de la denegación del reclamo o servicio y cualquier información adicional que usted considere importante considerar. El Plan de Salud tiene 72 horas para responder su apelación urgente y usted recibirá una notificación definitiva de resolución:

_____

_____

_____

_____

_____

_____

_____

Autorizo que toda la información relativa a esta queja, que podrá incluir datos de historia clínica e información médica, sea divulgada al Plan de Salud de Contra Costa con la expresa finalidad de resolver esta queja.

Firma del afiliado _____ Fecha _____

Vínculo _____ Fecha _____ Teléfono _____

Nombre de la persona que presenta la queja

Si no fuera firmada por el afiliado, o el tutor del afiliado, no podremos tramitar la queja sin la conformidad expresa del afiliado.

Si lo prefiere, puede imprimir este formulario y presentarlo por escrito a

Contra Costa Health Plan
Member Services Dept.
Attn: Grievance/Appeal
595 Center Ave. Ste 100
Martinez, CA 94553

Email: member.services@hsd.cccounty.us
www.contracostahealthplan.org

CÓMO PRESENTAR UNA QUEJA ANTE EL DEPARTAMENTO DE ATENCIÓN MÉDICA ADMINISTRADA (DMHC)

El Departamento de Atención Médica Administrada de California es la entidad responsable de regular los planes de servicio de atención médica. Si tiene alguna queja contra su plan de salud, primero debe comunicarse telefónicamente con el plan al **1-877-661-6230 (oprima 2)** y seguir el procedimiento de tramitación de quejas de su plan de salud antes de comunicarse con el departamento. La utilización de este procedimiento de queja no veda ningún derecho o recurso legalpotencial que usted pueda tener a su disposición. Si necesita ayuda con una queja relacionada con una emergencia, una queja que no ha sido resuelta satisfactoriamente por su plan de salud, o una queja que haya permanecido sin resolver por más de 30 días, puede llamar al departamento para solicitar asistencia.

Es posible que además cumpla con los requisitos para una Revisión médica independiente (IMR, por sus siglas en inglés). Si usted cumple con los requisitos para una IMR, el proceso de IMR proporcionará una revisión imparcial de las decisiones médicas adoptadas por el plan de salud en relación con la necesidad médica de un servicio o tratamiento propuesto, decisiones relativas a la cobertura de tratamientos que son de naturaleza experimental o de investigación y controversias respecto del pago de servicios médicos de emergencia o de urgencia. El departamento cuenta con un número de teléfono gratuito **(1-888-HMO-2219)** y una línea TDD **(1-877-688-9891)** para personas con dificultades auditivas y del habla. En el sitio Web en Internet del departamento, **http://www.hmohelp.ca.gov** encontrará formularios de reclamos, formularios de solicitud de IMR e instrucciones en línea.

Mail to:
Contra Costa Health Plan
Member Services
595 Center Ave., Ste. 100
Martinez, CA 94553
Call or Fax:
1-877-661-6230, Press 2
Fax: 925-313-6047
Email:
member.services@hsd.cccounty.us
www.contracostahealthplan.org

Member Grievance or Appeals Form

Member Name:_____ Date of Birth: _____

Member Identification Number:_____ Phone:_____

Address: _____

Information needed to file a Grievance

Date of Service:_____ Location of Service: _____

Briefly Describe Complaint (Please include as much detail as possible including names of the people involved, the circumstances leading up to the conflict, and any information you feel is important to the complaint):

What action are you requesting?

Over for additional Information

Information Needed to File an Appeal

- Appeal/Reconsideration requests can be made to the Health Plan by the member if they have received a Notice of Action (NOA) letter concerning a denial of a claim or a delay, modification or denial of a requested service.
- The request can be made by phone or on-line ***but must be followed up in writing and signed by the member or the member's legal representative.***
- For our Medi-Cal members this request must be made within 60 days of receipt of a NOA.
- For our Commercial member this request must be made within 180 of a receipt of a NOA.

Date of Notice of Action (NOA) Denial Letter: _____

Description of a Regular Appeal

Please include as much detail as possible including date of the denial of the claim or service and any additional information you feel is important to consider. The Health Plan has 30 days to respond to your appeal and you will get a final notice of resolution:

Description of an Expedited Appeal

If you think waiting 30 days for the Health Plan to respond, will hurt your health, you might be able to get a response within 72 hours. When filing your appeal, say why waiting will hurt your health. Make sure you ask for an "expedited appeal". Please include as much detail as possible including date of the denial of service and any additional information you feel is important to consider. The Health Plan has 72 hours to respond to your expedited appeal and you will get a final notice of resolution:

I authorize that all information pertaining to this grievance/appeal, possibly including medical records and clinical information, be shared with the Contra Costa Health Plan for the express purpose of resolution of this grievance.

Member Signature Date

Name of Person Submitting Grievance/Appeal Relationship Date Phone

If not signed by member or member's legal guardian, we will be unable to process grievance/appeal without member's explicit agreement.

If your prefer you may print out this form and submit it in writing to:

Contra Costa Health Plan
Member Services Dept.
Attn: Grievance / Appeal
595 Center Ave. Ste. 100
Martinez, CA 94553

Email: member.services@hsd.cccounty.us
www.contracostahealthplan.org

FILING A COMPLAINT WITH DEPARTMENT OF MANAGED HEALTH CARE (DMHC)

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-877-661-6230 (press 2)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available for you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Screening for Abdominal Aortic Aneurysm
US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

IMPORTANCE An abdominal aortic aneurysm (AAA) is typically defined as aortic enlargement with a diameter of 3.0 cm or larger. The prevalence of AAA has declined over the past 2 decades among screened men 65 years or older in various European countries. The current prevalence of AAA in the United States is unclear because of the low uptake of screening. Most AAAs are asymptomatic until they rupture. Although the risk for rupture varies greatly by aneurysm size, the associated risk for death with rupture is as high as 81%.

OBJECTIVE To update its 2014 recommendation, the USPSTF commissioned a review of the evidence on the effectiveness of 1-time and repeated screening for AAA, the associated harms of screening, and the benefits and harms of available treatments for small AAAs (3.0-5.4 cm in diameter) identified through screening.

POPULATION This recommendation applies to asymptomatic adults 50 years or older. However, the randomized trial evidence focuses almost entirely on men aged 65 to 75 years.

EVIDENCE ASSESSMENT Based on a review of the evidence, the USPSTF concludes with moderate certainty that screening for AAA in men aged 65 to 75 years who have ever smoked is of moderate net benefit. The USPSTF concludes with moderate certainty that screening for AAA in men aged 65 to 75 years who have never smoked is of small net benefit. The USPSTF concludes that the evidence is insufficient to determine the net benefit of screening for AAA in women aged 65 to 75 years who have ever smoked or have a family history of AAA. The USPSTF concludes with moderate certainty that the harms of screening for AAA in women aged 65 to 75 years who have never smoked and have no family history of AAA outweigh the benefits.

RECOMMENDATIONS The USPSTF recommends 1-time screening for AAA with ultrasonography in men aged 65 to 75 years who have ever smoked. (B recommendation) The USPSTF recommends that clinicians selectively offer screening for AAA with ultrasonography in men aged 65 to 75 years who have never smoked rather than routinely screening all men in this group. (C recommendation) The USPSTF recommends against routine screening for AAA with ultrasonography in women who have never smoked and have no family history of AAA. (D recommendation) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for AAA with ultrasonography in women aged 65 to 75 years who have ever smoked or have a family history of AAA. (I statement)

Editorial page 2177

Related article page 2219 and JAMA Patient Page page 2256

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Summary of Recommendations

The USPSTF recommends 1-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men aged 65 to 75 years who have ever smoked.	B recommendation
The USPSTF recommends that clinicians selectively offer screening for AAA with ultrasonography in men aged 65 to 75 years who have never smoked rather than routinely screening all men in this group. Evidence indicates that the net benefit of screening all men in this group is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of evidence relevant to the patient's medical history, family history, other risk factors, and personal values.	C recommendation
The USPSTF recommends against routine screening for AAA with ultrasonography in women who have never smoked and have no family history of AAA.	D recommendation
The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for AAA with ultrasonography in women aged 65 to 75 years who have ever smoked or have a family history of AAA.	I statement

See the Figure for a more detailed summary of the recommendation for clinicians. See the "Practice Considerations" section for more information on each of these populations. USPSTF indicates US Preventive Services Task Force.

Importance

An AAA is typically defined as aortic enlargement with a diameter of 3.0 cm or larger. The prevalence of AAA has declined over the past 2 decades among screened men 65 years or older in various countries such as the United Kingdom, New Zealand, Sweden, and Denmark.[1-10] Population-based studies in men older than 60 years have found an AAA prevalence ranging from 1.2% to 3.3%.[1-10] The reduction in prevalence is attributed to the decrease in smoking prevalence over time. Previous prevalence rates of AAA reported in population-based screening studies ranged from 1.6% to 7.2% of the general population 60 to 65 years or older.[1] The current prevalence of AAA in the United States is unclear because of the low uptake of screening.[1] Most AAAs are asymptomatic until they rupture. Although the risk for rupture varies greatly by aneurysm size, the associated risk for death with rupture is as high as 81%.[1,11]

USPSTF Assessment of Magnitude of Net Benefit

The USPSTF concludes with moderate certainty that screening for AAA in men aged 65 to 75 years who have ever smoked is of **moderate net benefit** (**Figure** and **Table**; see the eFigure in the Supplement for explanation of USPSTF grades and levels of evidence).

The USPSTF concludes with moderate certainty that screening for AAA in men aged 65 to 75 years who have never smoked is of **small net benefit** (Figure and Table).

The USPSTF concludes that the **evidence is insufficient to determine the net benefit** of screening for AAA in women aged 65 to 75 years who have ever smoked or have a family history of AAA (Figure and Table).

The USPSTF concludes with moderate certainty that the **harms** of screening for AAA in women aged 65 to 75 years who have never smoked and have no family history of AAA **outweigh the benefits** (Figure and Table).

For more details on the methods the USPSTF uses to determine the net benefit, see the USPSTF Procedure Manual.[12]

Practice Considerations

Patient Population Under Consideration

Based on the scope of the evidence review, this recommendation applies to asymptomatic adults 50 years or older. However, the randomized trial evidence focuses almost entirely on men aged 65 to 75 years. In this Recommendation Statement, the recommendations are stratified by "men" and "women," although the net benefit estimates are driven by biologic sex (ie, male/female) rather than gender identity. Persons should consider their sex at birth to determine which recommendation best applies to them.

Assessment of Risk

Important risk factors for AAA include older age, male sex, smoking, and having a first-degree relative with an AAA.[13-16] Other risk factors include a history of other vascular aneurysms, coronary artery disease, cerebrovascular disease, atherosclerosis, hypercholesterolemia, and hypertension.[17-19] Factors associated with a reduced risk include African American race, Hispanic ethnicity, Asian ethnicity, and diabetes.[13,20-24] Risk factors for AAA rupture include older age, female sex, smoking, and elevated blood pressure.[1] Clinicians should consider the presence of comorbid conditions and not offering screening if patients are unable to undergo surgical intervention or have a reduced life expectancy.

Smoking Status

Epidemiologic literature commonly defines an "ever smoker" as someone who has smoked 100 or more cigarettes. Indirect evidence shows that smoking is the strongest predictor of AAA prevalence, growth, and rupture rates.[1] There is a dose-response relationship, as greater smoking exposure is associated with an increased risk for AAA.[1]

Figure. Clinician Summary: Screening for Abdominal Aortic Aneurysm

December 2019

What does the USPSTF recommend?	**For men aged 65 to 75 years who have ever smoked: Grade B** Perform 1-time screening for abdominal aortic aneurysm (AAA) with ultrasonography in men who have a history of smoking.
	For men aged 65 to 75 years who have never smoked: Grade C Selectively offer screening to men who do not have a history of smoking, rather than routinely screening all men in this group.
	For women who have never smoked and have no family history of AAA: Grade D Do not screen women who have never smoked and do not have a family history of AAA.
	For women aged 65 to 75 years who have ever smoked or have a family history of AAA: I statement Evidence is insufficient to assess the balance of benefits and harms of screening for AAA with ultrasonography in women aged 65 to 75 years who have ever smoked or have a family history of AAA.
To whom does this recommendation apply?	Asymptomatic adults
What's new?	This recommendation is consistent with the 2014 USPSTF recommendation. Family history (first-degree relative) of AAA has been added as a risk factor for screening decisions in women.
How to implement this recommendation?	1. Assess risk. Risk factors for AAA include older age, male sex, smoking, and having a first-degree relative with an AAA. The recommendation varies based on a patient's sex, age, and smoking history. "Ever smoker" is commonly defined as smoking 100 or more cigarettes. 2. Screen. Abdominal duplex ultrasonography is the standard approach for AAA screening. a. Screen men aged 65 to 75 years who have ever smoked. b. Selectively offer screening to men aged 65 to 75 years who have never smoked. Evidence shows that the overall benefit for screening all men in this group is small. To determine whether this service is appropriate, patients and clinicians should consider the patient's medical history, family history, other risk factors, and personal values. For those who screen positive, treatment of AAA will depend on aneurysm size, the risk of rupture, and the risk of operative mortality.
How often?	One-time screening
What are other relevant USPSTF recommendations?	The USPSTF has made recommendations on screening for carotid artery stenosis and screening for peripheral arterial disease. These recommendations are available at https://www.uspreventiveservicestaskforce.org.

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.

AAA indicates abdominal aortic aneurysm; USPSTF, US Preventive Services Task Force.

Family History

Family history of AAA in a first-degree relative doubles the risk of developing AAA.[25] The risk of developing an AAA is stronger with a female first-degree relative (odds ratio [OR], 4.32) than with a male first-degree relative (OR, 1.61).[1,25] However, evidence is lacking on whether persons with family history experience a different natural history or surgical outcomes than those without such a history.[1]

Screening Tests

The primary method of screening for AAA is conventional abdominal duplex ultrasonography.[26] Screening with ultrasonography is noninvasive, is simple to perform, has high sensitivity (94%-100%) and specificity (98%-100%) for detecting AAA,[1,27-31] and does not expose patients to radiation. Computed tomography is an accurate tool for identifying AAA; however, it is not recommended as a screening method because of the potential for harms from radiation exposure.[1] Physical examination has been used in practice but has low sensitivity (39%-68%) and specificity (75%) and is not recommended for screening.[32]

Screening Intervals

Evidence is adequate to support 1-time screening for men who have ever smoked. All of the population-based randomized clinical trials (RCTs) of AAA screening used a 1-time screening approach; 7 fair- to good-quality cohort studies and 1 fair-quality case-control study (n = 6785) show that AAA-associated mortality over 5 to 12 years is rare (<3%) in men with initially normal results on ultrasonography (defined as an AAA <3 cm in diameter).[1]

Treatment

Treatment of AAA depends on aneurysm size, the risk of rupture, and the risk of operative mortality. Larger size is associated with an increased risk of rupture. The annual risk for rupture is nearly 0% for persons with AAAs between 3.0 and 3.9 cm in diameter, 1% for those with AAAs between 4.0 and 4.9 cm in diameter, and 11% for those with AAAs between 5.0 and 5.9 cm in diameter.[1] Surgical repair is standard practice for men with an AAA of 5.5 cm or larger in diameter or an AAA larger than 4.0 cm in diameter that has rapidly increased in size (defined as an increase of 1.0 cm in diameter over a 1-year period). Endovascular aneurysm repair (EVAR) has become the most common approach for elective AAA repair. Open repair is a time-tested, effective treatment for AAA. In the United States, 80% of intact AAA repairs and 52% of ruptured AAA repairs are performed using EVAR.[1]

The majority of screen-detected AAAs (≥90%) are between 3.0 and 5.5 cm in diameter and thus below the usual threshold for

Table. Summary of USPSTF Rationale[a]

	Men		Women	
Rationale	Ever Smoked	Never Smoked	Ever Smoked or Family History	Never Smoked and No Family History
Detection	There is adequate evidence that ultrasonography is a safe and accurate screening test for AAA	There is adequate evidence that ultrasonography is a safe and accurate screening test for AAA	There is adequate evidence that ultrasonography is a safe and accurate screening test for AAA	There is adequate evidence that ultrasonography is a safe and accurate screening test for AAA
Benefits of early detection and treatment (based on direct or indirect evidence)	There is adequate evidence that 1-time screening for AAA with ultrasonography results in a moderate benefit in men aged 65 to 75 y who have ever smoked	There is adequate evidence that 1-time screening for AAA with ultrasonography results in a small benefit in men aged 65 to 75 y who have never smoked	There is inadequate evidence to conclude whether 1-time screening for AAA with ultrasonography is beneficial in women aged 65 to 75 y who have ever smoked or have a family history of AAA	There is adequate evidence that 1-time screening for AAA with ultrasonography results in no benefit in women who have never smoked and have no family history of AAA
Harms of early detection and treatment	There is adequate evidence that the harms associated with 1-time screening for AAA with ultrasonography are small to moderate	There is adequate evidence that the harms associated with 1-time screening for AAA with ultrasonography are small to moderate	There is adequate evidence that the harms associated with 1-time screening for AAA with ultrasonography are small to moderate	There is adequate evidence that the harms associated with 1-time screening for AAA with ultrasonography are small to moderate
USPSTF assessment	There is moderate certainty that screening for AAA with ultrasonography in men aged 65 to 75 y who have ever smoked has a moderate net benefit	There is moderate certainty that screening for AAA with ultrasonography in men aged 65 to 75 y who have never smoked has a small net benefit	The benefits and harms of screening for AAA with ultrasonography in women aged 65 to 75 y who have ever smoked or have a family history of AAA are uncertain, and the balance of benefits and harms cannot be determined	There is moderate certainty that the harms of screening for AAA with ultrasonography in women who have never smoked and have no family history of AAA outweigh the benefits

Abbreviations: AAA, abdominal aortic aneurysm; USPSTF, US Preventive Services Task Force.

[a] See the eFigure in the Supplement for explanation of USPSTF grades and levels of evidence.

surgery. The current standard of care for patients with stable smaller aneurysms is to maintain ultrasound surveillance at regular intervals because the risk of rupture is small. Recommended surveillance intervals for monitoring the growth of small AAAs vary across guideline groups, and adherence with surveillance guidelines has been reported to be as low as 65%.[1] Repairing smaller aneurysms with a lower risk of rupture increases the harms and reduces the benefits of screening.

Suggestions for Practice Regarding the I Statement

Potential Preventable Burden

The estimated prevalence of AAA in women is reportedly less than that in men.[1] The Chichester trial reported a prevalence in women that was one-sixth of the prevalence in men (1.3% vs 7.6%), and most AAA-related deaths occurred in women 80 years or older (70% vs <50% in men).[33] In women, small AAAs have an increased risk of rupture, and rupture at an older age than in men.[1] Studies estimate that one-fourth to one-third of women have an AAA with a diameter below the current 5.5-cm threshold at the time of rupture.[1]

Potential Harms

Operative mortality associated with AAA is higher in women than in men. Women had higher 30-day mortality rates (2.31%) than men (1.37%) after EVAR procedures (OR, 1.67 [95% CI, 1.38-2.04]) and open repair (5.37% vs 2.82%; OR, 1.76 [95% CI, 1.35-2.30]).[1,34] Women also experience higher rates of other harms, such as major surgical complications and hospital readmission, after elective open repair or EVAR compared with men.[1]

Current Practice

Evidence is insufficient to accurately characterize current practice patterns related to screening for AAA in women.

The standard of care for elective repair is that patients with an AAA of 5.5 cm or larger in diameter should be referred for surgical intervention with either open repair or EVAR.[1] This recommendation is based on RCTs conducted in men. The AAA size needed for surgical intervention in women may differ. As a result, guidelines from the Society for Vascular Surgery recommend repairing AAAs between 5.0 and 5.4 cm in diameter in women.[26] However, concerns about poorer surgical outcomes in women, who have more complex anatomy and smaller blood vessels, have led some to caution against lowering the threshold for surgical intervention in women.[1]

Update of Previous USPSTF Recommendation

This recommendation incorporates new evidence and replaces the 2014 USPSTF recommendation.[35] It is consistent with the 2014 USPSTF recommendation, which was a B recommendation for 1-time screening for AAA with ultrasonography in asymptomatic men aged 65 to 75 years who have ever smoked, a C recommendation for selective screening in men aged 65 to 75 years who have never smoked, a D recommendation against routine screening in asymptomatic women who have never smoked, and an I statement for women aged 65 to 75 years who have ever smoked.

Supporting Evidence

Scope of Review

The USPSTF commissioned a systematic evidence review to update its 2014 recommendation on screening for AAA. The USPSTF examined evidence regarding the effectiveness of 1-time and repeated screening for AAA, the associated harms of screening, and

the benefits and harms of available treatments for small AAAs (3.0-5.4 cm in diameter) identified through screening.

Accuracy of Screening Tests and Risk Assessment

Ultrasonography is the primary method used to screen for AAA in primary care because of its high sensitivity (94%-100%) and specificity (98%-100%).[1] It is also noninvasive, is simple to perform, and does not expose patients to radiation.

Benefits of Early Detection and Treatment

Screening

Four large, population-based RCTs (n = 134 271) that predominantly enrolled men 65 years or older examined the effectiveness of 1-time screening for AAA: the good-quality Multicenter Aneurysm Screening Study (MASS) (n = 67 800)[36]; the good-quality Viborg County, Denmark, screening trial (n = 12 639)[13]; the fair-quality Chichester, United Kingdom, screening trial (n = 15 382)[37]; and the fair-quality Western Australia screening trial (n = 38 480).[38] Reported mean (or median) ages ranged from 67.7 to 72.6 years; the oldest participants were aged 83 years.[1] The Western Australia screening trial[38] reported outcomes by smoking status in the screened group. The trial was underpowered to detect differences in subpopulations. No comparisons in the unscreened group were reported.[1,39] None of the 4 population-based screening RCTs reported family history of AAA in the trial populations.[1]

The prevalence of AAA in male screening participants ranged from 4.0% to 7.6% across the studies. Most screen-detected AAAs were small (≤4 to 4.5 cm in diameter); 0.3% to 0.6% of screened participants had an AAA measuring 5 cm or larger or 5.5 cm or larger in diameter.[1] Two of the population-based screening trials analyzed AAA-associated mortality by age. The Viborg trial found similar risk reduction in AAA-related mortality in screening men aged 64 to 65 years compared with men aged 66 to 73 years.[13] The Western Australia trial found no AAA-associated mortality benefit in men aged 65 to 74 years (rate ratio, 0.92 [95% CI, 0.62-1.36]) at 12.8-year follow-up; results were similar to findings for men aged 64 to 83 years.[1,38]

As noted previously, only the Chichester trial included women (aged 65-80 years). It found a low prevalence of AAA in women (1.3%), and 75% of screen-detected AAAs in women were 3.0 to 3.9 cm in diameter. Rupture rates (0.2% in both groups), AAA-specific mortality (0.06% vs 0.04% in both groups), and all-cause mortality (10.7% vs 10.2%) at 5 years did not statistically significantly differ between the invitation-to-screening and control groups.[1,33] The trial was underpowered to draw definitive conclusions about health outcomes in women. Although the risk for rupture at a smaller aneurysm diameter seems to be higher in women than in men,[1,40] the overall rupture rate in women is low. In the Chichester trial, more than two-thirds of deaths from AAA occurred in women 80 years or older.[1,33]

Pooled analysis of AAA-related mortality from the 4 trials showed a statistically significant 35% reduction associated with invitation to screening (Peto OR, 0.65 [95% CI, 0.57-0.74]; I^2 = 80%).[1] The number needed to screen was 305 men (95% CI, 248-411) to prevent 1 AAA death. The MASS and Viborg trials each found a statistically significant reduction in AAA-related mortality in the groups invited to screening compared with the control groups up to 13 years after screening (hazard ratio [HR], 0.58 [95% CI, 0.49-0.69] and 0.34 [95% CI, 0.20-0.57], respectively).[13,36] The Chichester trial reported an HR of less than 1 (HR, 0.89 [95% CI, 0.60-1.32]), but it was not statistically significant.[1,37] Pooled analysis of all available trials also showed no effect on all-cause mortality (relative risk, 0.99 [95% CI, 0.98-1.00]; I^2 = 0%).[1] Of the individual trials, only MASS showed a statistically significant benefit of screening for all-cause mortality at up to 15-year follow-up (HR, 0.97 [95% CI, 0.95-0.99]).[1] Invitation to screening was associated with a statistically significant reduced rate of rupture in the pooled analysis of the 4 trials (Peto OR, 0.62 [95% CI, 0.55-0.70]; I^2 = 53%).[1] The number needed to screen was 246 men (95% CI, 207-311) to prevent 1 AAA rupture. Pooled results of the trials showed a reduction in emergency surgery in the invited-to-screening group (Peto OR, 0.57 [95% CI, 0.48-0.68]; I^2 = 27%).[1] Screening 1000 men for AAA would decrease the number of emergency operations by 2 (95% CI, 2-2).[1]

Treatment

Four trials evaluated early surgical intervention compared with surveillance of smaller aneurysms (4-5.4 cm in diameter).[41-44] Two good-quality open repair trials (n = 2226) and 2 fair-quality EVAR trials (n = 1088) showed no differences in all-cause and AAA-related mortality. However, there was a reduction in rupture rate with early open surgery compared with surveillance for small AAAs[12,16,37,38] in the Aneurysm Detection and Management (ADAM) Veterans Affairs trial (relative risk, 0.18 [95% CI, 0.04-0.81]) and the UK Small Aneurysm Trial (UKSAT) (relative risk, 0.51 [95% CI, 0.26-0.99]).[1,41,42] Individual patient data meta-analysis of the 2 early open vs surveillance trials (ADAM and UKSAT) reported no differences in all-cause mortality effect by sex or age.[1,36,37] The UKSAT trial reported no difference in all-cause mortality by smoking status; there were no analyses stratifying by family history or race/ethnicity.[1]

Seven pharmacotherapy RCTs (n = 1553) of antibiotics, antihypertensive medications (eg, angiotensin-converting enzyme inhibitors, calcium channel blockers, and propranolol), and a mast cell stabilizer showed no significant effect on AAA growth compared with placebo.[1]

Harms of Screening and Treatment

An individual's risk for death related to elective surgery for AAA is lower than that related to emergency surgery for aneurysm rupture. However, the increase in the overall rates of detection and surgery in the screening groups still potentially represents a harm. The extent of overdiagnosis and overtreatment is difficult to estimate.

Each of the 4 older screening trials and a more recent population-based screening RCT (n = 18 614), the Viborg Vascular (VIVA) trial, showed an increase in elective operations in the intervention vs control group.[1,45] There were approximately 40% more operations in the invitation-to-screen group than in the control group (5 studies; n = 175 085; Peto OR, 1.44 [95% CI, 1.34-1.55]), driven primarily by an increase in elective operations (5 studies; n = 175 085; Peto OR, 1.75 [95% CI, 1.61-1.90]).[1] There was no statistically significant difference in 30-day mortality rates between the invited and control groups for either elective or emergency operations at 12- to 15-year follow-up.[1]

Five studies (n = 2734) reported mixed results on quality-of-life outcomes.[1] Overall, there were no substantial differences on

quality-of-life measures or anxiety or depression scores at up to 12 months of follow-up between patients who screened positive for an AAA and patients who screened negative or were unscreened.[1]

Two trials of early open repair vs surveillance (ADAM and UKSAT trials) reported a 50% higher rate of procedures in the early intervention group, with no difference in 30-day operative mortality.[1,41,42] Readmission rates at 30 days were similar, and major surgical complications were lower in the early intervention group. Analysis of quality-of-life measures showed mixed results; although there was generally a decline in both groups over time, there were no statistically significant differences between the groups for up to 1 to 2 years. Only the ADAM trial showed higher general health scores in the early repair group in the first 2 years, but this difference did not persist over time.[1] One trial reported an increased incidence of impotence in the early repair group at up to 4 years' follow-up.[1]

Registry harms data were generally comparable to the findings of the 2 trials, with the exception of reintervention rates, which were higher in the registries than in the ADAM trial.[1]

Two trials of early EVAR vs surveillance reported approximately 100% more procedures in the early intervention group and similarly rare 30-day operative mortality rates between the groups.[1,43,44] In the Comparison of Surveillance vs Aortic Endografting for Small Aneurysm Repair (CAESAR) trial, the early intervention group had a higher percentage of patients with any adverse events (19% vs 5%; $P < .01$), any major morbidity related to repair at 30 days (18% vs 6%; $P = .01$), endoleaks at 1 year (12% vs 2%; $P = .028$), and reintervention (6% vs 0%; $P = .03$) but similar rates of any major morbidity over the trial duration (3.3% vs 2.8%; $P = .99$).[1,43] The Positive Impact of Endovascular Options for Treating Aneurysms Early (PIVOTAL) trial reported similar rates of adverse events at 30 days (12% vs 10%) and at 1 year (26% vs 35%), as well as reintervention (3.7% vs 4.6%).[1,44] Reported complication rates from registry data were generally comparable with rates reported in the above trials for 30-day operative mortality and reintervention.[1]

Two propranolol trials reported high discontinuation rates related to adverse events (38% and 60% of participants in the propranolol groups withdrew from the trials). Other medications (eg, angiotensin-converting enzyme inhibitors, calcium channel blockers, and antibiotics) seemed well tolerated based on rare trial withdrawals reported from 1 to 2 studies per drug class.[1]

Response to Public Comment

A draft version of this recommendation statement was posted for public comment on the USPSTF website from June 18 to July 15, 2019. Some comments expressed concerns about the harms of screening. In response, the USPSTF added information about overtreatment as a harm of screening to the Supporting Evidence section and added information about comorbid conditions to the Practice Considerations section. Some comments urged more research in diverse populations. The USPSTF clarified its call for research in the Research Needs and Gaps section. Some comments suggested expanding the populations for whom screening is recommended. The USPSTF did not expand the scope of its recommendation beyond the populations justified by its review of the current evidence and recommends research about the benefits and harms of screening in these groups.

Research Needs and Gaps

Addressing several key research gaps could help inform the benefit of screening for AAA in US-based populations[1]:

- Although evidence shows that women who smoke or have a family history are at increased risk for AAA compared with nonsmoking women without a family history, evidence is insufficient that screening this population confers a net benefit. Ideally, appropriately powered RCTs among women with risk factors could answer these critical gaps in the evidence on screening for AAA. In the absence of new trial data, high-quality, well-calibrated modeling studies based on reliable data on the harms and benefits of screening in women who smoke or in men and women with a family history of AAA may be informative.
- Well-conducted cohort studies examining rescreening benefits (including growth rates and health outcomes) are needed for persons who initially screen negative for AAA to determine the benefit and timing of additional screening ultrasonography.
- External validation of risk prediction models that have already been developed will allow policy makers to assess their value for making more individualized screening recommendations.
- Epidemiologic studies on the current prevalence of AAA in the United States, including in subpopulations, would help inform the applicability of older population-based screening trials to the current US population.
- Well-designed studies, RCTs, or registry data on the thresholds for repair of AAA in women may inform the benefits and harms of screening in women, as evidence suggests that AAAs in women may rupture at a smaller size than in men.
- Studies examining systems approaches to improving implementation of evidence-based AAA screening in the United States are needed.
- Studies examining the efficacy of screening and treatment in diverse populations (eg, older adults, women, and racial/ethnic groups) are needed to inform the need for specific recommendations in subpopulations of Americans.

Recommendations of Others

The American College of Cardiology and the American Heart Association jointly recommend 1-time screening for AAA with physical examination and ultrasonography in men aged 65 to 75 years who have ever smoked or in men 60 years or older who are the sibling or offspring of a person with AAA. These organizations do not recommend screening for AAA in men who have never smoked or in women.[46] The Society for Vascular Surgery recommends 1-time ultrasonography screening for AAA in all men and women aged 65 to 75 years with a history of tobacco use, men 55 years or older with a family history of AAA, and women 65 years or older who have smoked or have a family history of AAA.[47] The American College of Preventive Medicine recommends 1-time screening in men aged 65 to 75 years who have ever smoked; it does not recommend routine screening in women.[48]

ARTICLE INFORMATION

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

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Additional Information: The 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.

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CONTRA COSTA COUNTY

CALIFORNIA CHILDREN'S SERVICES

WHAT IS CCS?

California Children's Services (CCS)

- a State program for children with certain diseases or health problems.
- *Children up to 21 years old* can get the health care and services they need.
- CCS will connect with doctors and trained health care people who know how to care for a child with special health care needs.

Retrieved from the CCS State Website:
http://www.dhcs.ca.gov/services/ccs/Pages/default.aspx

WHAT IS CCS?

- Health Care provided by *CCS-PANELED SPECIALISTS*
- Some children are followed by CCS-approved

  SPECIAL CARE CENTERS (SCC)
- Currently provides services in:
  - CALIFORNIA: ~200,000 CHILDREN
  - CONTRA COSTA COUNTY: 4,100 CASES
- Services *TERMINATE AT AGE 21 YEARS*
  - Refer to *Genetically Handicapped Persons Program (GHPP)*

CCS HISTORY

- Established in 1927 by State Legislature; Older than Medi-Cal, Medicare, CHDP, WIC.

- A Statewide program for

CHILDREN < 21 YEARS OF AGE with serious medical conditions or physical disabilities that may be improved or corrected.

WHAT ARE CCS BENEFITS?

- Diagnosis of and/or Treatment for CCS Medically Eligible condition(s)

- REHABILITATIVE SERVICES WITH A PEDIATRIC PHYSICAL/OCCUPATIONAL THERAPIST:
  - School-Based Medical Therapy Program
  - or Vendored Therapy Services.

- *CARE COORDINATION /*
- *NURSE CASE MANAGEMENT (NCM)*

Of the eligible condition(s) by a Public Health Nurse

CCS ELIGIBILITY Must Meet Four:

1) **AGE**: under 21 years old
2) **MEDICALLY ELIGIBLE (ME)**: as determined by CCS Medical Consultant, per **CCR, Title 22**
3) **RESIDENTIAL ELIGIBILITY (RE)**: California resident
4) **FINANCIAL ELIGIBILITY (FE)**:
   a. For prepaid plans/no insurance adjusted gross income (AGI) must be less than $40K; or
   b. Income greater than $40K, out-of-pocket family medical expense are over 20% of adjusted gross income.

CCS ELIGIBILITY

- (Continued) Financial Eligibility (FE):
  - Meet financial screening requirements for children with:
    - *Share-of-Cost or Restricted Medi-Cal;*
    - *Full-Scope Medi-Cal or*
    - *Optional Targeted Low Income Children Program* coverage

    (formerly Healthy Families).
- ***Senate Bill 75** Effective May 2016*
  - *Full Scope Medi-Cal* for individuals < 19 YEARS OF AGE,

    who do not meet satisfactory Immigration Status,

    but meet all other eligibility requirements for the Medi-Cal program.

REFERRALS TO CCS

From:

- Providers
- Parents
- Schools

- Documents for Referrals (New & Re-Referrals):
  - Medical Report(s) stating medical diagnosis with supporting lab and/or imaging results
  - Completed CCS application

MEDICAL CASE MANAGEMENT DIAGNOSTIC SERVICES

- Tests, Specialty Evaluation, Imaging for a Condition likely to be *CCS Medically Eligible* (ME)
- Rule Out Abnormal Newborn Screen Tests
- High Risk Infant Follow-up (HRIF):
  - Developmental Tests
  - Neurology Test
  - Ophthalmology, Audiology
  - Hospital-based Program

MEDICAL CASE MANAGEMENT TREATMENT SERVICES

- TREATMENT REQUEST: Review, Authorize or Deny by County CCS Medical Consultants;
- TRANSPLANT REQUEST: State Review
- AUTHORIZE Durable Medical Equipments (DME), Medications, Supplies, Medical Foods, and Enteral Nutrition Products.
- For MEDICALLY ELIGIBLE Conditions i.e.:

  Cystic Fibrosis, Cerebral Palsy

  Heart Disease, Cancer

  Trauma injuries, Hearing Loss

  Drug/Poison if Life Threatening

  Burns.

MEDICAL CASE MANAGEMENT
Nurse Case Management

- Nine (9) Public Health Nurses (PHN)
  - (PHNs are Registered Nurses (RNs))
- Medical Determination, if consultant is unavailable
- Annual Case Reviews
- Authorize Requested Medical Services
- Care Coordination:
  - Providers, Discharge Planners, Resources
  - Regional Center of the East Bay (RCEB), Early Start, School Districts
- Identification of Needs and Referral to Appropriate Resources

Medical Therapy Program (MTP)

- Physical Therapy (PT) & Occupational Therapy (OT) Services
- School-Based MTP:
  - *Physiatrist Assessment* for DME, Botox, Ankle Foot Orthotics (AFOs) for Cerebral Palsy and other Neuromuscular Disorders.
  - Located in: San Pablo, Alamo, Concord, Antioch, and Oakley
- Vendored Therapy
- No Financial Eligibility Requirement for children whose cases are open for MTP services only.

Medical Therapy Program (MTP)

- Medical Therapy Conferences (MTC)
  - The MTC is an interdisciplinary team meeting where the child's medical case management regarding the MTP eligible condition is determined. This includes PT, OT and recommendations for specialized equipment, such as orthotics/braces, wheelchairs and other assistive devices.
- MTP staff attend Individualized Educational Plan (IEP) meetings, when requested, to make sure school staff understands the child's therapy needs.
- Consultation may be provided by MTP staff to assist teachers and other school staff in making plans to meet the child's access issues and other concerns related to the child's function at school.

FAMILIES' RIGHTS

- **Appeal a Denial**
  - Families May Appeal in Writing
- **Timely Processing** of Eligibility Determination and Treatment Authorizations
- **Patient Rights -** California state laws and regulations govern the CCS program

CCS FLOW: Eligibility Process

- Referral Received: MEDICAL REPORTS ARE REQUIRED
- Medical Director Review:
  - If CCS Medically Eligible (ME), go to next step; if not, Denial
- Nurse Case Management (NCM) Review:
  - NCM reviews for approval or denial and sends to Clerk;
  - If FE (financial eligibility) review needed, Clerk sends referral to Eligibility Worker (EW).
  - Once FE review completed, back to NCM to approve the service(s).
- Clerk:
  - Activates the Case and Enters the Authorization in the system;
  - Primary Care Physicians are mailed authorization copy(ies).

N0. OF STAFF	CCS TITLE	CONTRA COSTA CCS STAFF NAME
1	ADMINISTRATOR	Krista Peterson, LCSW
2	MEDICAL DIRECTORS / CONSULTANTS	Gwen Hamilton, MD Guenter Hofstadler, MD, MPH
1	NURSE PROGRAM MANAGER	Marian Gentry, RN, BSN, PHN
1	CHIEF PEDIATRIC THERAPIST (MTU)	Beth Chew, R.P.T.
4	MTU PROGRAM SUPERVISORS	Beth Chew Emily Karr Anick Labonville Karen Sandri
1	MTU DME	Ellen Burke, O.T.
1	CLERICAL SUPERVISOR	Karen Glover
1	ADMINISTRATIVE ANALYST	Laneisha Terrell

Some of our CCS staff

NO. OF STAFF	CCS TITLE	CONTRA COSTA CCS STAFF NAME	
10	NURSE CASE MANAGERS (NCM. RN, PHN):	Sheryl Garcia Mary-Kay Massey Ryan Pacheco Catherine Cribben Jeanne Cunningham Ji-Young Woo (UCSFBCHO Liaison)	Brigitte Imhof Brenda Flowers Laura Stephens Maria Belaro
2	MEDICAL SOCIAL WORKER II	Jackie Johnston	Sharmila Wright
3 Bilingual Spanish	ELIGIBILITY WORKERS	Natalie Aguilar Olga Rojas	Maria Morales
8	CASE CLERKS	Trishia Maruri Kelene Steelman Nancy Sorahan Melinda Young	Erika Linden Jon Garcia Elizabeth Gonzales
1Bilingual Spanish	COMMUNITY HEALTH WORKER SPECIALIST	Margarita Maciel	


ome to CCS!

N0. OF STAFF	CCS TITLE	CONTRA COSTA CCS STAFF NAME
3 (*Bilingual Spanish)	ADMIN CLERKS	Anamarie Lee* Icela Castillo* Jennifer Joel
1Bilingual Spanish	MTP CLERK	Jackie Contreras
1	ACCOUNT CLERK	Hyun Jameyson
1	STUDENT INTERN	Allison Liu

Any Questions?

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WHEN SIGHT IS MEASURED
BY ONE'S
VISION of the FUTURE
WHEN MOBILITY
IS DEFINED AS
PUTTING WORDS into ACTION
when it takes
NOTHING SPECIAL
to MEET SPECIAL NEEDS
THEN WE WILL TRANSCEND
the COMMUNITY of our
DREAMS
DREAM
IS
DARE
Be a force in your community. Visit IndianaDisabilityAwareness.org to learn about smart growth, economic development, accessibility and civic and social engagement.
Indiana Governor's Council for People with Disabilities