



Agenda

Quarterly Community Provider Network (CPN) Meeting

When: Time: 7:30 AM – 9:00 AM**
Date: January 15, 2019

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

The agenda for the meeting is as follows:

I.	CALL TO ORDER and INTRODUCTIONS	Christine Gordon, BSN, PHN, DHCS-MT
II.	REVIEW and APPROVAL of Previous Meeting Minutes	Christine Gordon, BSN, PHN, DHCS-MT
III.	GUEST SPEAKER	
	- Emergency Preparedness (Wildfires) “Getting to Zero” (HIV)	Dr. Christopher Farnitano, MD Medical Director, Hospital and Health Services
IV.	REGULAR REPORTS	
	CCHP Updates: - Legislative / CCHP Update - Maternal Mental Health - Dashboard - CCHP Benefits update - Diabetes Prevention Program - Quality - Mammography - Pharmacy - Review Care Matters - Utilization Management - Current & Upcoming UM enhancements	Jose Yasul, MD Medical Director, CCHP
V.	OTHER	
	- Language Line/Interpreter Services - Reminders ➤ Initial Health Assessment (IHA) ➤ USPSTF Update: intimate Violence ➤ Prior Authorization Changes	Sharron A. Mackey, M.H.S., M.P.A. Interim Chief Executive Officer Christine Gordon, BSN, PHN, DHCS-MT
VI.	CLAIMS Q&A	Claims Unit Staff

Our next scheduled meeting is April 16, 2019

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

CPN Quarterly Meeting

CONFIDENTIAL – Protected by California Evidence Code 1157

CONTRA COSTA HEALTH PLAN
West County
Quarterly Community Provider Network (CPN)
Meeting Minutes – January 15, 2019

Attending:

CCHP Staff: Jose Yasul, MD, Medical Director; Christine Gordon, RN, BSN, DHCS-MT; Christopher Farnitano, MD, Public Health Officer, Hospital and Health Services; Delaina Gillaspy, Secretary

CPN Providers: Sara Bottomley, NP; Kim Ceci, MD; Jess “Jeffrey” Chubbs, NP; Erica Lipschultz, FNOP; Mimi Ogawa, MD; Paterson Rene, PA; Katherine Roller, NP; Christine Salera, NP; Audrey Schaps, NP; Nathan Stern, MD; Laurie Trombla, PA; Jennifer Turner; Andrew Wallach, MD; Katherine Winter, MD; Xiao Yang, MD

Discussion	Action	Accountable
Meeting called to order at 7:41 A.M.		Christine Gordon, RN, BSN, DHCS-MT
I. Agenda was approved with no revisions.		Jose Yasul, MD Medical Director, CCHP
II. Reminders • 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 Partner Violence (IPV) - 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 Authorization Process Changes: Urgent and Routine authorization request. - o eFax system- operation to improve authorization transmission. - o Review CPN Care Matter Bulletin, page 10 for more details.		Christine Gordon, RN, BSN, DHCS-MT
III. Guest Speaker Public Health Officer Update for Community Provider Network • Objective - o Review recommendations regarding wildfire smoke events and air quality response. - o Review Getting to Zero Campaign to eliminate the HIV epidemic.		Dr. Christopher Farnitano, MD Public Health Officer

• <u>Emergency Preparedness (Wildfires)</u> - o 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. - o 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. - o 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/wildfire_may2016.pdf - o <u>"Getting to Zero" (HIV)</u> - o Eliminating the HIV epidemic in Contra Costa County - o Goal: 90-90-90 by 2021 - o 90% of people with HIV know their diagnosis - o 90% of diagnosed HIV+ prescribes antivirals - o 90% of HIV+ on meds virally suppressed - o = 72% virally suppressed compared to 80-80-80=52.2% - o 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 - o V3 Key Initiatives ▪ PrEP (Pre-Exposure Prophylaxis) expansion ▪ RAPID (Rapid ART Program for HIV Diagnoses) ▪ Retention in Care - o New HIV diagnoses per year in Contra Costa County ▪ 2014: 107 ▪ 2015: 92 ▪ 2016: 121 ▪ 2018: 87* (preliminary data) ▪ Goal <50 by 2021 ▪ (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.		
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- 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. Quality • Mammography - o CCHP will be checking all data to see which members are due for Mammogram. - o CCHP will be sending out a list for Mammography to all PCPs according to DHCS guidelines.		Jose Yasul, MD Medical Director, CCHP

Pharmacy • Review Care Matters Provider Bulletin - o 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 - o Program has been doing well. - o 20% decrease of opiate and benzo - o Cancer/Hospice members should not be a part of Opiate Program. Utilization Management • Current & Upcoming UM Enhancements - o eFax system (no more fax machines) - o Hired New Utilization Director - o 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.		

AB 2193: Maternal Mental Health (Maienschein, 2017)

Frequently Asked Questions

General Overview

Maternal Mental Health

California Department of Public Health notes that 1 in 5 women (and families) are suffering from maternal depression in California annually. Maternal mental health disorders include depression, the range of anxiety disorders (including general anxiety disorder, OCD with reoccurring unwanted thoughts and birth related PTSD). These disorders generally go undiagnosed and untreated across the U.S. Untreated depression and anxiety during pregnancy can lead to pre-term birth. When depression is untreated during the postpartum period, because a mother is unable to interact with her infant in expected manner, this lack of early engagement can interfere with critical brain development, impacting the child over his or her lifetime. These disorders, impact mothers, children, fathers, employers and our communities.

Task Force

In 2014, ACR 148 authored by the Women's Caucus, called for the formation of a multi-stakeholder taskforce to address this crisis. The California Task Force on Maternal Mental Health was formed with financial support from The California Endowment and the California Health Care Foundation. The task force issued a [report](#) including recommend actions to the public and legislature last year.

Cost of Doing Nothing

The report estimates the cost of untreated maternal mental health disorders on California's society is an astounding 2.25 billion dollars a year.

This Bill

AB 2193 requires obstetric providers to confirm screening has already occurred or screen women for these disorders at least once during pregnancy or the postpartum period. The bill also recognizes the role that health insurers and health plans can provide by develop maternal mental health programs to support patients and providers.

1. What do you mean by screening? Is screening once enough?

Health care providers have patient answer a short questionnaire like the PHQ-9 or EPDS (developed specifically for pregnancy/postpartum).

It's easy to administer. A provider should first explain that these disorders are common and all patients are screened and provided help when the results indicate they may be struggling with depression or anxiety.

This bill requires providers to confirm screening has occurred or screen directly, once during the perinatal period. The bill doesn't prohibit providers from screening more frequently.

2. What do the medical societies say about this? Why do we need to mandate clinical care?

American College of Obstetrics and Gynecology and US Preventive Services Task Force recommend screening as of 2015 and 2016 respectively, however clinical adoption of clinical care guidelines can take up to 20 years according to the federal Agency for Health Care Research and Quality (AHRQ).

Given the prevalence of these disorders and the cost to our communities and state of not treating them the Maternal Mental Health Task Force set an aggressive goal to see 80% of women screened by the year 2021.

3. What providers are being asked to screen? Why aren't pediatricians being asked to screen?

The Task Force report notes that obstetric providers, because they provide a mother with primary care provider during pregnancy and the early postpartum period are best positioned and must be responsible for screening patients and developing treatment plans. This includes Ob/Gyns, nurse midwives and primary care providers.

[ER doctors are specifically noted as exempt from screening in the bill due to a requested amendment from a critical trade association.]

4. What exactly will the bill require health plans and health insurers to do?

The task force report recognized health insurers and plans are in a unique role to assist patients and providers. Health plans and insurers are already required to provide coverage for screening and treatment however patients often struggle to access in-network care. AB 2193 provides health plans and insurers leeway to develop a program that will "promote quality and cost-effective outcomes." A critical step in the right direction.

Contra Costa County

Pre-Exposure Prophylaxis (PrEP) Guidelines

Identifying Persons in Whom to Consider for PrEP

- Public Health recommends that medical providers routinely ask all adolescent and adult patients if they have sex with men, women or both men and women.
- Providers should ensure that all of their male and transgender patients who have sex with men know about PrEP.

Guidelines for Initiating PrEP in HIV-uninfected Persons

Medical providers should recommend that patients initiate PrEP if they meet the following criteria:

1. MSM or transgender persons who have sex with men if the patient has any of the following risks:
 - Diagnosis of rectal gonorrhea or early syphilis in the prior 12 months.
 - Methamphetamine or popper use in the prior 12 months.
 - History of providing sex for money or drugs in the prior 12 months.
2. Persons in ongoing sexual relationships with a person living with HIV who is not on anti-retroviral therapy (ART) OR is on ART but is not virologically suppressed OR who is within 6 months of initiating ART.

Medical providers should discuss initiating PrEP with patients who have any of the following risks:

1. MSM and transgender persons who have sex with men if the patient has either of the following risks:
 - Condom-less anal sex outside of a long-term, mutually monogamous relationship with a man who is HIV negative. Unprotected receptive anal sex is associated with a higher risk of HIV acquisition than unprotected insertive anal sex, and some authorities recommend PrEP to all men who have unprotected receptive anal intercourse outside of a mutually monogamous relationship with an HIV-uninfected partner.
 - Diagnosis of urethral gonorrhea or rectal chlamydial infection in the prior 12 months.

2. Persons in HIV-serodiscordant relationships in which the female partner is trying to get pregnant.
3. Persons in ongoing sexual relationships with HIV-infected persons who are on ART and are virologically suppressed.
4. Women who exchange sex for money or drugs.
5. Persons who inject drugs that are not prescribed by a medical provider.
6. Persons seeking a prescription for PrEP.
7. Persons completing a course of anti-retrovirals for non-occupational exposure (PEP) to HIV infection.

As with all medical therapies, patients and their medical providers ultimately need to decide what treatments and preventive measures are best for them. Providers should evaluate patients' knowledge and readiness to initiate PrEP prior to prescribing Tenofovir and Emtricitabine, and should counsel and educate patients to facilitate their success taking PrEP. Medical providers should refer to national guidelines (see below) for information on how to prescribe PrEP and monitor persons on PrEP.¹

- CDC's PrEP Clinical Guidelines are available at: <https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf>
- Manufacturer copayment assistance and medication assistance programs are available. More information is available at: <https://www.gileadadvancingaccess.com>
- The Patient Advocate Foundation (PAF) Co-Pay Program can provide grants to help with high deductibles or prescription co-pays. More information is available at: <https://www.copays.org/diseases/hiv-aids-and-prevention>
- You can find a list of providers who prescribe PrEP near your area at: PleasePrEPMe.org

References:

1. Centers for Disease Control and Prevention: US Public Health Service: Preexposure prophylaxis for the prevention of HIV infection in the United States—2017 Update: a clinical practice guideline. <https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-prep-guidelines-2017.pdf>. Published March 2018.
2. Buchbinder SP, Glidden DV, Liu AY, et al. HIV pre-exposure prophylaxis in men who have sex with men and transgender women: a secondary analysis of a phase 3 randomized controlled efficacy trial. *The Lancet. Infectious diseases*. 2014; 14(6):468-475.

County Health Officer Update for Community Provider Network

Contra Costa County

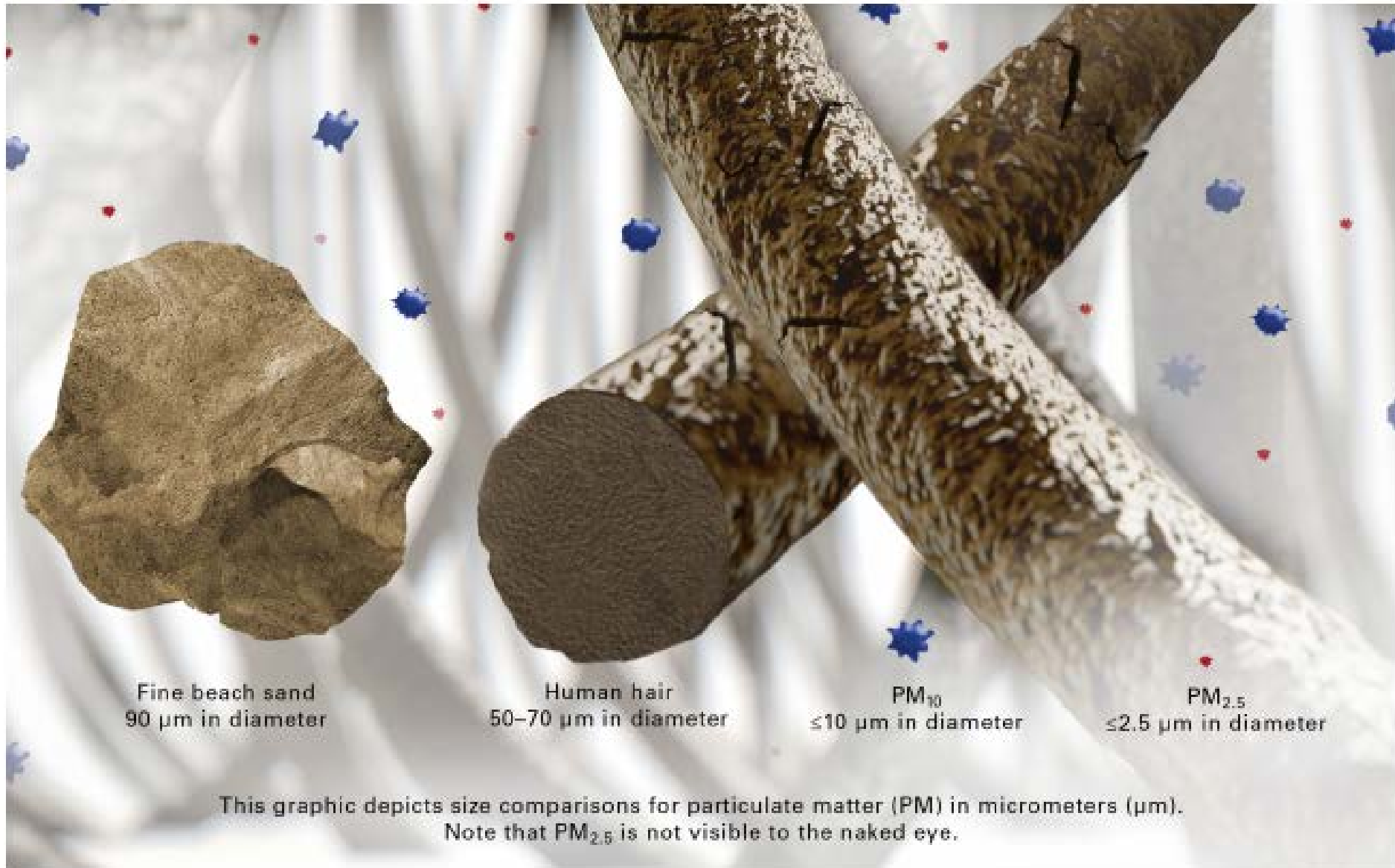
Chris Farnitano, MD

January, 2019

Objectives

- Review recommendations regarding wildfire smoke events and air quality response
- Review Getting To Zero campaign to eliminate the HIV epidemic
- Answer questions about public health issues and the role of the public health department and the county health officer

Wildfire smoke contains high levels of PM_{2.5}



Wildfire smoke contains high levels of PM2.5

- Triggers lung inflammation:
 - Asthma attacks
 - COPD flares
 - Congestive Heart Failure exacerbations
- Increased risk of myocardial infarction
- Increase risk in pregnant women of low birth weight and preterm delivery
- Children and elderly more susceptible

IF YOU SMELL OR SEE SMOKE:

- Minimize outdoor activities, even if you're healthy.
- Children, the elderly and people with respiratory or heart conditions should especially avoid being outdoors when air quality is poor.
- Stay indoors with doors and windows closed as much as possible.
- Those with asthma should follow their management plan.
- If you are coughing, short of breath, or have other symptoms you think are caused by smoke, contact your health care provider.



Wildfire Smoke Health Tips

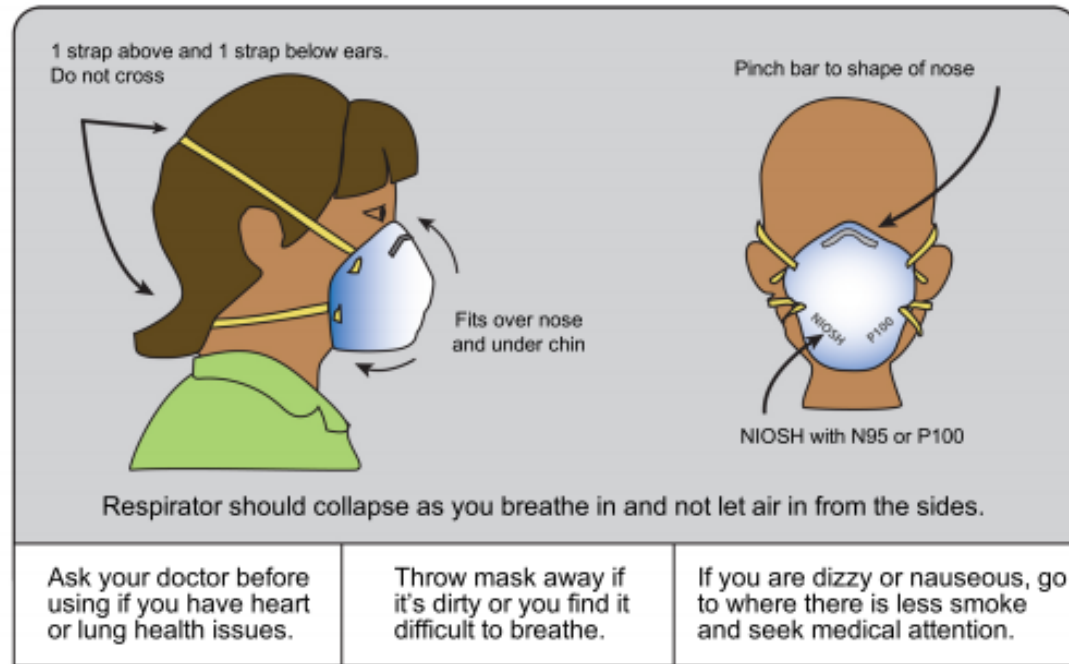
- For air quality in your area visit sparetheair.org or airnow.gov
- purpleair.gov = hyper local, private data, use with a grain of salt
- **Stay inside** if possible. People should also minimize outdoor activities and exercise when smoke is present.
- Keep indoor air as clean as possible by closing windows and doors. If it's hot, run the air conditioner, but remember to keep the fresh-air intake closed and the filter clean to prevent smoke from outside getting inside.
- If you don't have an air conditioner and it's too hot to stay inside, seek shelter somewhere with air conditioning, such as a shopping mall or library. When driving, keep car windows and vents closed.
- Air filters with a MERV rating of 12 or higher are preferred
- N95 Masks are recommended only for those who cannot avoid prolonged outdoor activity (homeless individuals, certain occupations)

Cloth (wet or dry), paper masks, and tissues will **NOT** filter out wildfire smoke. Look for respirators (masks) marked NIOSH with N95 or P100. They can be found online, or in hardware, home repair, or drugstores.

* Respirators are not designed to fit children. Facial hair prevents proper fit and reduces effectiveness.

N95 Masks:

- not for kids
- not with beards
- can increase work of breathing
- not a substitute for staying indoors



Use a respirator only after first trying other, more effective methods to avoid smoke. That includes staying indoors and reducing activity. When possible, people at risk should move away from the smoke area.

Wildfire Smoke

A Guide for Public Health Officials

Revised May 2016

For more information:

https://www3.epa.gov/airnow/wildfire_may2016.pdf



Become a Disaster Healthcare Volunteer

Welcome to the Disaster Healthcare Volunteers Site



Username:

Password:

[Log In](#)

>> [Forgot Username or Password?](#)

>> [Not Registered?](#)

>>

>> If you have already completed the registration process or wish to return to a registration which you've started but not completed, you can log in and update your profile.

Here you'll find the online registration system for medical and healthcare volunteers.

If you're a healthcare provider with an active license, a public health professional, or a member of a medical disaster response team in California who would like to volunteer for disaster service, you've come to the right place!

What does it take to register for disaster service?

1. During the on-line registration process, you will be asked to enter information regarding your license (if applicable).
2. Enter information about the best way to contact you, and other relevant background information.
3. Once you've registered, your credentials will be validated - before an emergency - so that you can be deployed quickly and efficiently. Your information will only be viewed by authorized system managers.

Once I'm registered, what happens next?

1. During a State or national disaster, (e.g., an earthquake severe weather event, or public health emergency), this system will be accessed by authorized medical/health officials at the State Emergency Operations Center or your county.
2. If a decision is made to request your service, you will be contacted using the information you enter on the site. If you agree to deploy, your information will be forwarded to the appropriate field operational officials.

Thank you for Volunteering!

REGISTER NOW



WHO CAN VOLUNTEER?



FAQ'S

Better yet, join the Contra Costa Medical Reserve Corps

Medical Reserve Corps

The Contra Costa County Medical Reserve Corps (MRC) was developed as part of the County's emergency planning and response system. It addresses the need for additional medical professionals to respond to a medical surge event or an event requiring the mass distribution of pharmaceuticals. Oversight is provided by the Contra Costa County Emergency Medical Services (EMS) as lead agency with support from Contra Costa Health Services.

[DONATE](#)



Getting to Zero

Eliminating the HIV epidemic
in Contra Costa County



The Goal: 90-90-90 by 2021

90% of people with HIV know their diagnosis

90% of diagnosed HIV+ prescribed antivirals

90% of HIV+ on meds virally suppressed

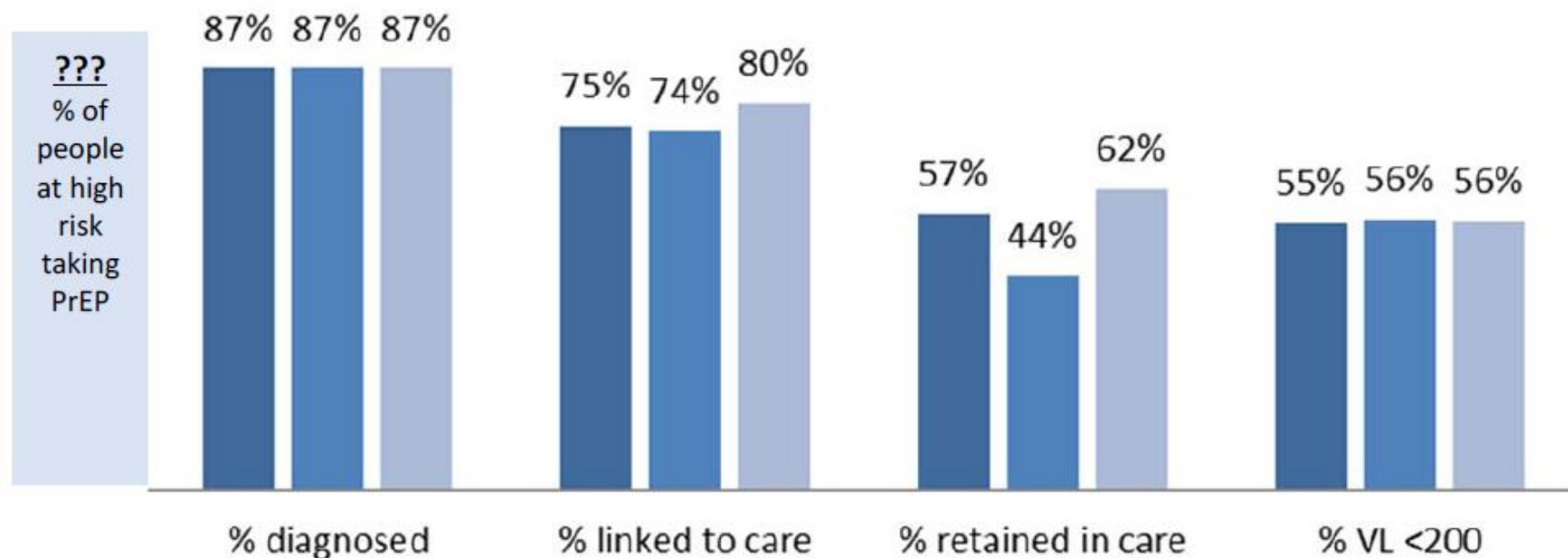
=72.9% virally suppressed

Compared with 80-80-80=52.2%

How are we doing?

HIV care continuum for US, Alameda County, Contra Costa County

■ National ■ Alameda County ■ Contra Costa County



National data are from "NHAS Update to 2020," published Dec 2016.

Alameda County data are from "HIV Surveillance Report, 2013-2015," published Feb 2017.

Contra Costa County data are from "HIV Surveillance Brief," data to 2014, published Aug 2016.

3 key initiatives:

PrEP (Pre-Exposure Prophylaxis) expansion

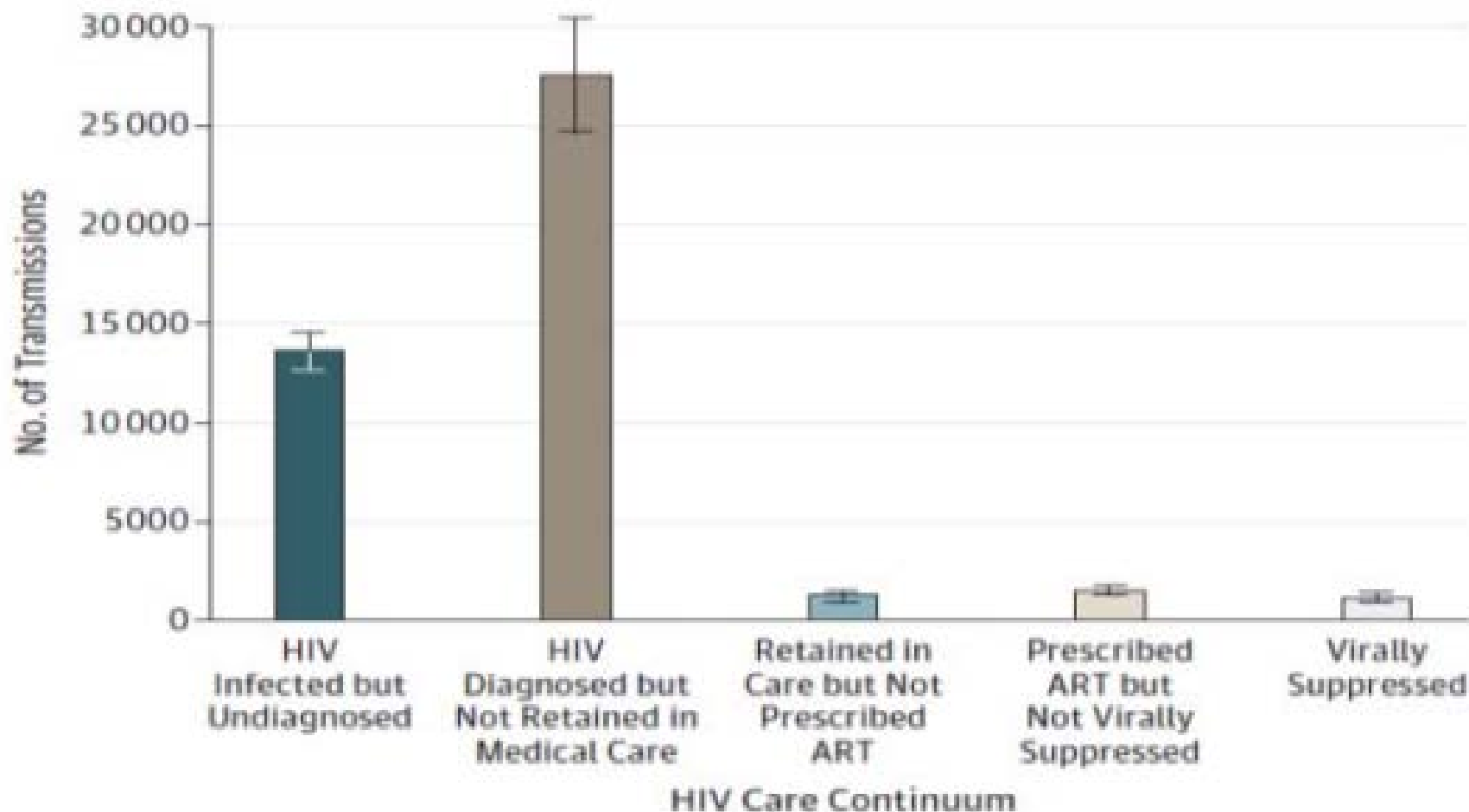
RAPID (Rapid ART Program for HIV Diagnoses)

Retention in care

Where new infections coming from?

Skarbinski et al, JAMA Int Med 2015; 175:588-596

A United States, 2009



New HIV diagnoses per year in Contra Costa County:

2014: 107

2015: 92

2016: 121

2018: 87*

goal < 50 by 2021

(50% of 2014-15 average)

*preliminary data



PrEP^{ME} CONTRA COSTA

PrEP FAQs for Providers

1. WHAT IS PrEP?

PrEP stands for pre-exposure prophylaxis. It is the use of antiretroviral medication to prevent acquisition of HIV infection. PrEP is used by HIV uninfected people who are at risk of being exposed to HIV through sexual contact or injection drug use. At present, the only medication with an FDA-approved indication for PrEP is oral tenofovir disoproxil fumarate-emtricitabine (TDF-FTC), which is available as a fixed combination tablet called **Truvada**. This medication is also commonly used in the treatment of HIV.

PrEP should be considered part of a comprehensive prevention plan that includes adherence, risk reduction counseling, HIV prevention education and provision of condoms.

2. WHAT ARE THE GUIDELINES FOR PRESCRIBING PrEP?

Two sets of guidelines for prescribing PrEP exist:

- Contra Costa County Public Health Guidelines [1] - which focuses on the identification of individuals at highest risk for HIV who would be ideal candidates for PrEP
- Centers for Disease Control (CDC) Guidelines [2], including a Clinical Providers' Supplement [3]

Find both sets of guidelines at <https://cchealth.org/hiv/prep/>

3. TO WHOM SHOULD I OFFER PrEP?

Per CDC Guidelines, PrEP may be appropriate for the following populations:

MEN WHO HAVE SEX WITH MEN	HETEROSEXUAL WOMEN & MEN	INJECTION DRUG USERS
• HIV-positive sexual partner • Recent bacterial STI • High number of sex partners • History of inconsistent or no condom use • Commercial sex work	• HIV-positive sexual partner • Recent bacterial STI • High number of sex partners • History of inconsistent or no condom use • Commercial sex work • Person living in high-prevalence area or network	• HIV-positive injecting partner • Sharing injection equipment • Recent drug treatment (but currently injecting)

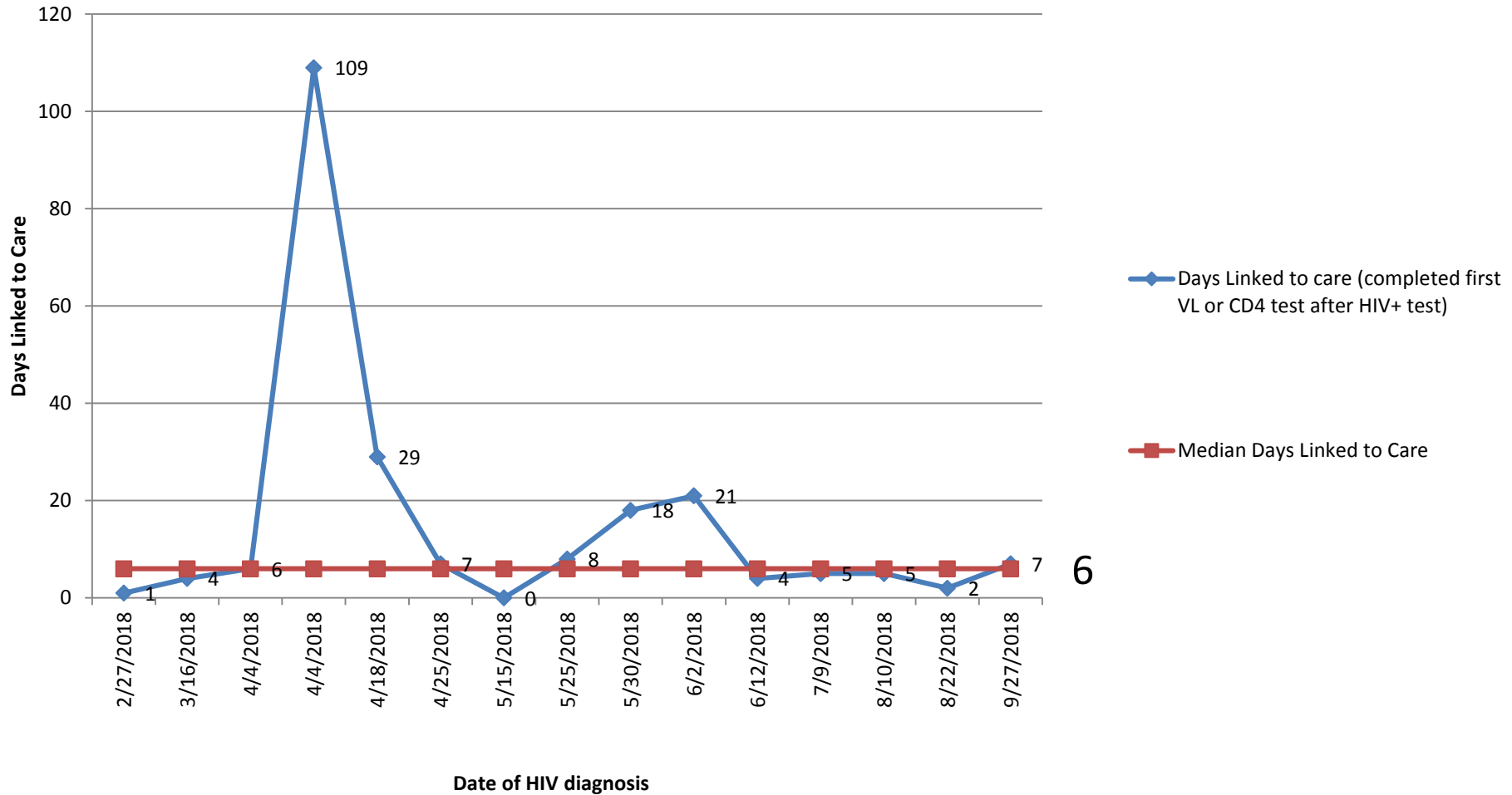
Per Contra Costa Guidelines, clinicians should also discuss PrEP with the following non-HIV- infected individuals (other than those mentioned above):

New Cases Report-Contra Costa County January 2018-December 2018

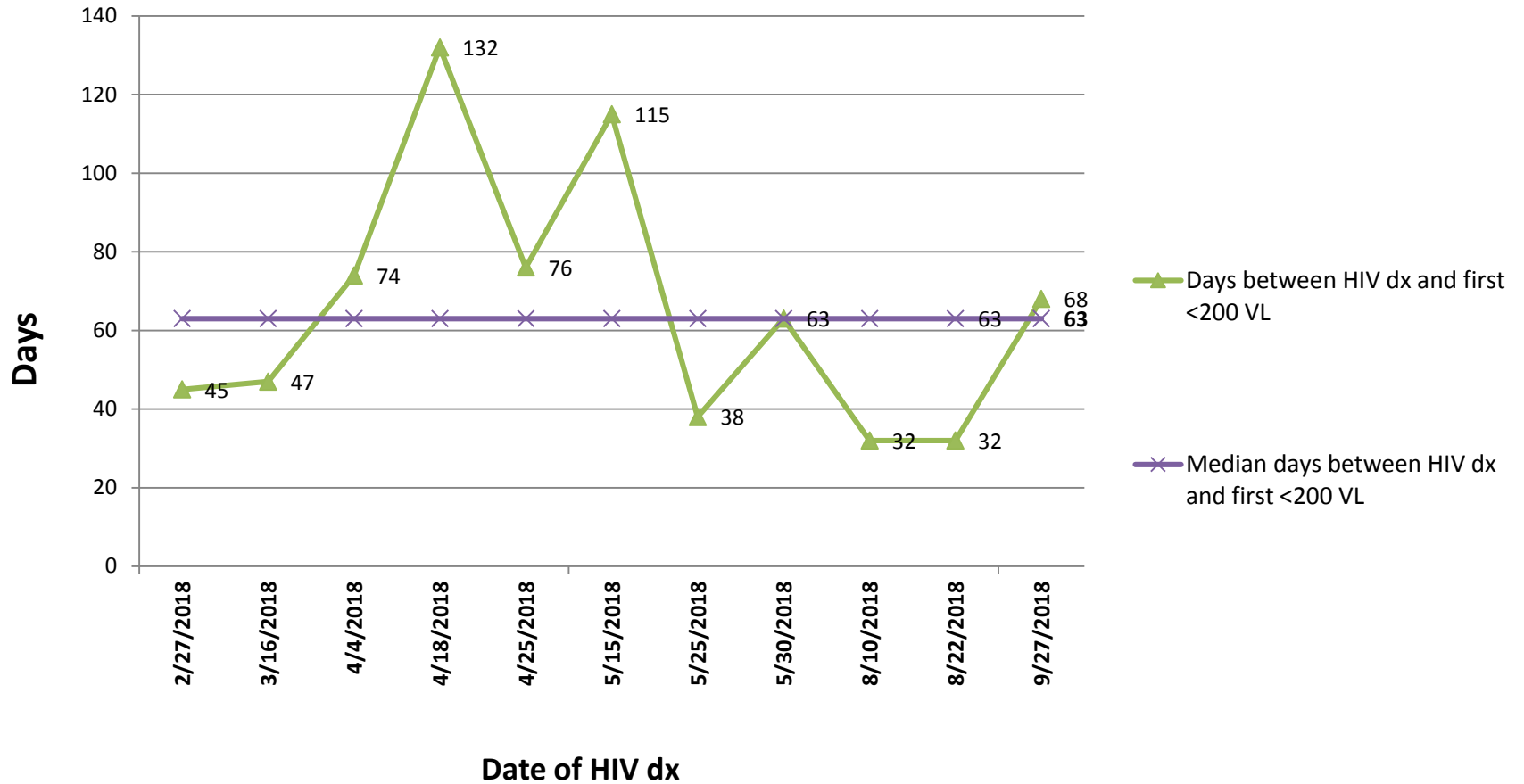
Site	CCHS	Kaiser	Planned Parent-hood	Other Counties/States	Private MD	John Muir	Community Clinics	Sutter Delta	Highland Hospital	Lifelong	Private Insurance	Alta Bates Medical Center	API	Rota Care	Total	%
New Dx Linked to Care	15	31	12	4	2	9	3	1	1	1	0	1	1	1	82	94%
New Dx not yet linked or missing linkage information	2	1	1	0	1	0	0	0	0	0	0	0	0	0	5	6%
Total Dx by site	17	32	13	4	3	9	3	1	1	1	0	1	1	1	87	100%

*A total of 87 new cases were diagnosed HIV positive in different facilities within and outside of Contra Costa County as of December 31, 2018. Out of 87 new cases, 17 were diagnosed in CCHS facilities, 32 were diagnosed in Kaiser, 13 were diagnosed in Planned Parenthood, and 9 were diagnosed in John Muir. Four cases were diagnosed in other counties and states and the rest of the cases were diagnosed in other facilities such as Lifelong, Alta Bates, private clinics and Highland Hospital. Among the 87 diagnosed, 5 were not linked to care/had missing linkage information as of December 31, 2018. Among the 5 not yet linked to care, two were diagnosed at CCHS, one was in Kaiser and the other two were diagnosed in Planned Parenthood and private clinics.

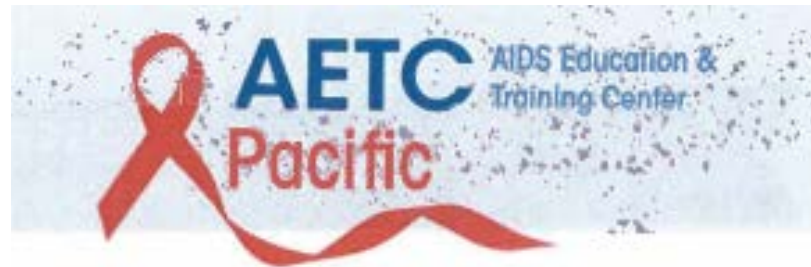
Linkage to Care for newly diagnosed HIV patients seen in CCHS January-November 2018 (n=15)



Days between HIV Dx and first viral load <200 for HIV patients seen in Positive Health Clinics January-December 2018 (n=11)



Rapid ART



Essentials: HIV testing, Rapid ART, PEP, PrEP

Updated August 2018

► Rapid ART: immediate HIV treatment after diagnosis

Rapid ART increases retention in care and viral load suppression. Disclosure and an ART Rx the same day as confirmed diagnosis is ideal, but when not possible, aim for within 5 working days.

1. New diagnosis with confirmed labs: contact HIV linkage coordinator ASAP to schedule disclosure, with same-day warm hand-off to HIV intake, education and medical visit.

2. Obtain baseline labs as soon as possible: If not done before first HIV visit, can be done the same day the ART Rx is written.

Baseline labs (priority): HIV 4th gen if only rapid test result; HIV RNA PCR viral load, HIV genotype, CD4 (Quest lymphocyte panel 4), CBC, CMP, hep B sAg/sAb/cAb, hep C Ab w/reflex, UA, GC/CT (exposed sites), RPR.

Lower priority: HLA B5701, hep A tAb, QFT TB, non-fasting lipids, HgA1C, VZV IgG, toxo IgG.

3. Perform a brief, targeted medical history and exam: check for previous ART, PrEP, PEP use, sexual/IDU exposures, co-morbidities, meds, allergies, opportunistic illness symptoms.

4. Offer an ART prescription: choose one of preferred regimens:

Truvada® (tenofovir DF/emtricitabine) + Tivicay® (dolutegravir), 1 pill each PO daily

Or Biktarvy® (bictegravir/tenofovir/emtricitabine) 1 pill PO daily

Or Symtuza™ (darunavir/cobicistat/emtricitabine/tenofovir AF) 1 pill PO daily

5. Follow-up labs and meds in 5-7 days.

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**

RAPID-CC:

Key steps in the protocol:

1. All newly diagnosed HIV+s navigated to HIV specialist within 7 days of confirmed diagnosis.

Linkage to Care Overview

- HIV/AIDS Program outreach workers get new positives from testing site to first positive health appointment
- Receive case reports on all new cases
- Clinicians: Contact our program right away with any new positives
- All new positives are called within 24 hours by MCM (Medical Case Manager)
 - If no response, assigned to an outreach worker: additional calls, home visits
- Counseling and overview of MCM program, services, and care
- Assistance making appointments to get lab work and begin treatment ASAP
- MCMs and outreach workers staff positive health clinics; meet clients there for first appointment
 - Enroll in MCM
 - Provide with urgent referrals and information: food, housing, nurse case management





Rapid-CC:

Key steps in the protocol:

Activate Linkage to Care System: Phone Referrals

Call the Contra Costa Public Health HIV/AIDS Program at 925-313-6771 from 8:00 am-5:00 pm, M-F. Ask to speak with the “Social Worker of the Day” who will process the referral.

Rapid-CC:

Key steps in the protocol:

2. Positive Health Providers/HIV specialists start ARVs on the first visit

Questions



Contra Costa County Medical Reserve Corps

VOLUNTEER APPLICATION							
Please Print or Type							
Name				Sex	Height	Weight	Eye Color
Street Address (Mailing)				City			
State	Zip	Drivers License #			Date of Birth:		
Cell Phone		Other Phone		Email:			
Languages Spoken							
Medical Professional (check one) Doctor ☐ Nurse ☐ EMT ☐ Paramedic ☐ Mental Health ☐ Non-Medical ☐ Other ☐				Disaster Healthcare Volunteer Registration I have created an account on the DHV Website: www.healthcarevolunteers.ca.gov My username is: _____			
License or Certificate/Registration Number				State License Held		Expiration Date	
Level of Participation Desired (check one)							
☐	ACTIVE	Receive notifications of ALL training opportunities, drill & exercises, emergency events, as well as non-emergency volunteer opportunities. Must attend 2 events annually.					
☐	COUNTY UNIT	Receive only notifications of training drills, exercises, and emergency					
A Criminal Background Check is required of all volunteers.							
I do hereby give the Contra Costa County Medical Reserve Corps permission to release personal information to local, state and federal emergency management agencies and other Health and Human Services agencies, as							
Signature _____						Date ____/____/____	
<i>The above information was verified by viewing a US government issued identification</i>							
Signature of CCC MRC Coordinator _____						Date ____/____/____	
Privacy Act Statement							
This information is requested by the Contra Costa County Medical Reserve Corps and is for the purpose of organizing volunteers and staff to respond to public health emergencies. It will not be utilized or released for any other purpose without your express written permission, unless required by law, and all information will be kept in a secure manner.							

Contra Costa County EMS Office:
 777 Arnold Drive , Martinez CA 94553
 Phone (925) 608-5454

Email Applications to the MRC Coordinator:
 Lisa Vajgrt-Smith
Lisa.Vajgrt-Smith@HSD.CCCounty.us

► HIV testing

■ How should I test for HIV?

Test everyone ages 13+!

Use ICD-10 code Z11.4.

- Order this lab for most people:
HIV 4th generation antibody + antigen test
For recent risk of exposure in the last month:
HIV RNA PCR test (HIV viral load)
- Offer as a normal part of labs:
"We test everyone's cholesterol, sugars, liver, kidneys and for HIV." Or: "It looks like we need to check your cholesterol and sugars again, but we haven't checked HIV yet. The HIV test is a normal part of health screening for everyone. I'm going to add it to your labs. OK?"
(*Be sure to mention you are ordering an HIV test so the patient is informed and has the chance to opt out.)

■ How do I interpret 4th gen HIV test results?

HIV Ab/Ag non-reactive: negative for HIV (2-3 week window period from exposure)	HIV Ab/Ag reactive & HIV1/2 diff reactive: chronic infection call linkage coordinator, offer rapid ART	HIV Ag only reactive & HIV1/2 neg & RNA detected: acute infection call linkage coordinator, offer rapid ART!	HIV Ab/Ag reactive & HIV1/2 neg & RNA neg: negative likely false pos Ab result but if high risk, check HIV2 DNA
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■ How do I disclose a positive result?

- Call your HIV linkage coordinator as soon as you see the result to coordinate a warm-handoff to HIV care.
- Call the patient for an in-person visit to discuss lab results. Disclose in-person ideally the same day as the confirmed result, and when not possible, aim to disclose and provide ART within 5 working days.
- When the patient is sitting, calmly and neutrally let them know.
"Your lab results show that you have HIV." Give them a few moments and listen.
"Would you be willing to share your thoughts, feelings or questions about this?"
Listen, address concerns: *"We have really good treatment to help you live as long and healthy as possible. May I introduce you to (your HIV linkage coordinator)? They will help answer questions and connect you with HIV care."*

► Rapid ART: immediate HIV treatment after diagnosis

Rapid ART increases retention in care and viral load suppression. Disclosure and an ART Rx the same day as confirmed diagnosis is ideal, but when not possible, aim for within 5 working days.

- New diagnosis with confirmed labs: contact HIV linkage coordinator ASAP** to schedule disclosure, with same-day warm hand-off to HIV intake, education and medical visit.
- Obtain baseline labs as soon as possible:** If not done before first HIV visit, can be done the same day the ART Rx is written.
Baseline labs (priority): HIV 4th gen if only rapid test result; HIV RNA PCR viral load, HIV genotype, CD4 (Quest lymphocyte panel 4), CBC, CMP, hep B sAg/sAb/cAb, hep C Ab w/reflex, UA, GC/CT (exposed sites), RPR.
Lower priority: HLA B5701, hep A tAb, QFT TB, non-fasting lipids, HgA1C, VZV IgG, toxo IgG.
- Perform a brief, targeted medical history and exam:** check for previous ART, PrEP, PEP use, sexual/IDU exposures, comorbidities, meds, allergies, opportunistic illness symptoms.
- Offer an ART prescription:** choose one of preferred regimens:

Truvada® (tenofovir DF/emtricitabine) + Tivicay® (dolutegravir), 1 pill each PO daily

Or **Biktarvy® (bictegravir/tenofovir/emtricitabine) 1 pill PO daily**

Or **Symtuza™ (darunavir/cobicistat/emtricitabine/tenofovir AF) 1 pill PO daily**

- Follow-up labs and meds in 5-7 days.**

► PEP: HIV Post-Exposure Prophylaxis

PEP should be started within 72 hours of exposure; the sooner, the better.

- Assess risk for HIV.** High risk—offer PEP: condomless receptive anal or vaginal sex, sharing needles. Consider PEP for: condomless insertive anal or vaginal sex.
- Screen for acute HIV infection:** if they have fevers, flu-like or mono-like sx's, rash, sore throat, order HIV viral load.
- Get a rapid HIV test, serum 4th gen HIV test, +/-HIV viral load, CMP, STD tests based on exposures.**
- If appropriate, prescribe 28-days of PEP.**
Preferred regimens include:

Truvada® (tenofovir DF/emtricitabine) + Tivicay® (dolutegravir), 1 pill each PO daily

Or **Biktarvy® (bictegravir/tenofovir/emtricitabine) 1 pill PO daily**
(click on med name for drug assistance programs)

- Repeat HIV 4th gen test in 6, 12, 24 weeks.**
- Offer PrEP if on-going risks.**

► PrEP: HIV Pre-Exposure Prophylaxis

For help: **PrEPline 1-855-448-7737**
(M-F 8am-3pm PST)

■ **Candidates for PrEP:** anyone requesting PrEP, has condomless anal sex, injects drugs, has recent STIs, or HIV+ partners

■ Recommended PrEP regimen:

Truvada®:

Tenofovir^{1,2} (300mg) PO Daily + Emtricitabine^{1,2} (200mg) PO once daily



Do not use Descovy®

1. Truvada side effects: headache, insomnia, nausea, vomiting, diarrhea, rash. Usually resolve in a month. Also active against Hep B, so beware of Hep B flare when stopping. Precautions also in chronic kidney disease and with nephrotoxic meds. (Renal dysfunction seen in 1-2% of patients)

2. Further information about drug interactions: <http://www.hiv-druginteractions.org/>

■ Contraindications:

- **Absolute:** acute or chronic HIV infection (Rx ART), estimated GFR < 60 by serum creatinine, unwilling to take daily meds or have lab follow-up
- **Relative:** HBV with cirrhosis/transaminitis (refer to specialist), osteoporosis or history of fragility fracture

■ Time to achieve protection:

- **7 days in rectal tissue** (anal receptive intercourse)
- **20 days in penile and cervico-vaginal tissue** (anal insertive and vaginal intercourse)
- **20 days in blood** (IDU)

■ First visit:

- ☐ **Evaluate for exposures** in the last 72 or so hours and need for PEP (post-exposure prophylaxis)
- ☐ **Evaluate for appropriateness for PrEP** discuss efficacy, side effects, support for adherence, emphasize importance of adherence, expectation for refill and follow-up
- ☐ **Labs:** BMP, 4th gen HIV test, GC/CT (throat, rectal, urine), RPR, UPreg, HepBsAg, sAb, cAb, HCV Ab
- ☐ **If symptoms of acute HIV infection in past month** (fever, flu- or mono-like symptoms, rash, sore throat), get HIV viral load (positive at 10 days). **Do not start PrEP unless viral load neg.**
- ☐ **If HIV test neg and no symptoms of acute HIV infection**, write rx for 1-month supply, no refill
- ☐ **If high-risk exposure in last 3 days**, consider Post-Exposure Prophylaxis (PEP), see previous page

■ 1-month follow-up visit:

- ☐ **Evaluate adherence and side effects.** Rx for 2-month supply, no refill.

■ Follow-up visit every 3 months:

- ☐ **4th gen HIV test, GC/CT** (throat, rectal, urine), UPreg, RPR, BMP
- ☐ **Refill** for 3-month supply only if HIV test negative; refer to immediate linkage to care if HIV test positive
- ☐ **At every visit assess** for adherence, side effects, exposures (# of partners, anal/vaginal insertive/receptive exposures, condom use, drug use), desires around sexual wellness and continued PrEP use
- ☐ **Counsel to return for HIV test if off of PrEP for > 1 week and had possible exposure**

■ Every 12 months:

- ☐ **Hepatitis C screen, U/A (check for +protein), evaluate continued desire/need for PrEP**

Reference: US Public Health Service Preexposure Prophylaxis for the Prevention of HIV Infection in the United States - 2014: A Clinical Practice Guideline. Available at <https://www.cdc.gov/hiv/pdf/guidelines/PrEPguidelines2014.pdf>.

QUESTIONS? NEED HELP? In the **Pacific Region** (Arizona, California, Hawaii, and Nevada) request free training and technical assistance from **Pacific AETC: paetc.org**, call **(415) 476-6153**, or email **paetc@ucsf.edu**.

Outside the Pacific Region contact the AETC National Coordinating Resource Center: **aidsetc.org**, call **(973) 972-5141**, or email **info@aidsetc.org**.

National HIV Consultation Line for HIV testing and care/treatment questions: 1-800-933-3413

You can reach a live consultant 6 am-5 pm PST, M-F (voicemail available after hours)
or **submit consultation requests online at nccc.ucsf.edu**.



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Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults: Screening

Release Date: October 2018

Recommendation Summary

Population	Recommendation	Grade (What's This?)
Women of reproductive age	The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services. See the Clinical Considerations section for more information on effective ongoing support services for IPV and for information on IPV in men.	B
Older or vulnerable adults	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults. See the Clinical Considerations section for suggestions for practice regarding the I statement.	I

To read the recommendation statement in *JAMA*, select [here](#).

To read the evidence summary in *JAMA*, select [here](#).

Read the Full
Recommendation
Statement



Supporting Documents

- Final Research Plan
- Final Evidence Review [PDF Version \(PDF Help\)](#)
- Evidence Summary [PDF Version \(PDF Help\)](#)

Clinical Summary

Clinical summaries are one-page documents that provide guidance to primary care clinicians for using recommendations in practice.

This summary is intended for use by primary care clinicians.

[View Clinical Summary
PDF Version \(PDF Help\)](#)

Prior Authorization Changes

Contra Costa Health Plan is introducing changes to our Urgent and Routine authorization request process. CCHP now has eFax in operation to improve authorization transmission.

In order to pave the way for an even smoother process, please always indicate whether the authorization request is **URGENT** or **ROUTINE**.

A request is considered urgent when the member faces an “imminent and serious threat” to his or her health and the standard timeframe of 5 business days for the decision-making process:

- Would be detrimental to the enrollee’s life or health, or
- Could jeopardize the enrollee’s ability to regain maximum function.

Circumstances that are not considered urgent include:

1. Late request for scheduled visit/service (e.g. appointment scheduled for the next day)
2. Routine follow-up/annual appointment
3. Ongoing continued care of an existing member
4. Retro auth request

If a request does not meet the above guidelines, **please document the reason that it does not meet the guidelines in the text notes.**

- **Urgent Requests** will be reviewed for “Urgency.”
- **Please note** that Urgent Requests may take up to 72 hours to process.
- **Please fax only one referral at a time** to promote timely processing.

CCHP’s New Authorization eFax Numbers:

- Prior Authorizations/Outpatient/Routine – 925-313-6058
- Urgent/Additional Information – 925-313-6458
- Inpatient (Hospital)/Facesheet – 925-313-6645
- Appeals – 925-313-6464
- Mental Health – 925-313-6196
- Specialty (CPAP) – 925-313-6069

If you have any questions or concerns, please contact Provider Relations at (925) 313-9500 or providerrelations@cchealth.org or contact the RN Community Liaisons at (925) 313-9527.

Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults

US Preventive Services Task Force Final Recommendation Statement

US Preventive Services Task Force

IMPORTANCE Intimate partner violence (IPV) and abuse of older or vulnerable adults are common in the United States but often remain undetected. In addition to the immediate effects of IPV, such as injury and death, there are other health consequences, many with long-term effects, including development of mental health conditions such as depression, posttraumatic stress disorder, anxiety disorders, substance abuse, and suicidal behavior; sexually transmitted infections; unintended pregnancy; and chronic pain and other disabilities. Long-term negative health effects from elder abuse include death, higher risk of nursing home placement, and adverse psychological consequences.

OBJECTIVE To update the US Preventive Services Task Force (USPSTF) 2013 recommendation on screening for IPV, elder abuse, and abuse of vulnerable adults.

EVIDENCE REVIEW The USPSTF commissioned a review of the evidence on screening for IPV in adolescents, women, and men; for elder abuse; and for abuse of vulnerable adults.

FINDINGS The USPSTF concludes with moderate certainty that screening for IPV in women of reproductive age and providing or referring women who screen positive to ongoing support services has a moderate net benefit. There is adequate evidence that available screening instruments can identify IPV in women. The evidence does not support the effectiveness of brief interventions or the provision of information about referral options in the absence of ongoing supportive intervention components. The evidence demonstrating benefit of ongoing support services is predominantly found in studies of pregnant or postpartum women. The benefits and harms of screening for elder abuse and abuse of vulnerable adults are uncertain, and the balance of benefits and harms cannot be determined.

CONCLUSIONS AND RECOMMENDATION The USPSTF recommends that clinicians screen for IPV in women of reproductive age and provide or refer women who screen positive to ongoing support services. (B recommendation) The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults. (I statement)

← Editorial page 1645

+ Author Audio Interview

← Related article page 1688 and
JAMA Patient Page page 1718

+ CME Quiz at
jamanetwork.com/learning

+ Related article at
jamainternalmedicine.com

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

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

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 Recommendations and Evidence

The USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age and provide or refer women who screen positive to ongoing support services (B recommendation) (Figure 1).

See the Clinical Considerations section for more information on effective ongoing support services for IPV and for information on IPV in men.

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for abuse and neglect in all older or vulnerable adults. (I statement)

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

Rationale

Importance

Intimate partner violence and abuse of older or vulnerable adults are common in the United States but often remain undetected. Although estimates vary, IPV (including sexual violence, physical violence, and stalking) is experienced by approximately 36% of US women and 33% of US men during their lifetime. Severe physical violence is experienced by 21% of US women and 15% of US men during their lifetime.¹ Prevalence rates vary by age, race/ethnicity, and income. Estimates also vary for prevalence of elder abuse and abuse of vulnerable adults. A 2008 nationwide survey of US adults 60 years or older found that the prevalence of any abuse or neglect in the past year was 10%.² A 2004 survey of Adult Protective Services (APS) agencies found 40 848 substantiated reports of vulnerable adult abuse (in those aged 18 to 59 years) in 19 states.³

In addition to the immediate effects of IPV, such as injury and death, there are other health consequences, many with long-term effects, including development of mental health conditions such as depression, posttraumatic stress disorder (PTSD), anxiety disorders, substance abuse, and suicidal behavior; sexually transmitted infections; unintended pregnancy; and chronic pain and other disabilities.^{4,5} Violence during pregnancy is associated with preterm birth and low birth weight⁶ and adverse effects on maternal and infant health, including postpartum mental health problems⁷ and hospitalization during infancy.⁸

Long-term negative health effects from elder abuse include death,⁹ higher risk of nursing home placement¹⁰ among those referred to APS, and adverse psychological consequences (distress, anxiety, and depression).¹¹

Detection

The USPSTF found adequate evidence that available screening instruments can identify IPV in women. The USPSTF found limited evidence about the performance of IPV screening instruments in men.

The USPSTF found inadequate evidence to assess the accuracy of screening instruments designed to detect elder abuse or abuse of vulnerable adults when there are no recognized signs and symptoms of abuse.

Benefits of Detection and Early Intervention

The USPSTF found adequate evidence that effective interventions that provide or refer women to ongoing support services can reduce violence, abuse, and physical or mental harms in women of reproductive age. However, the USPSTF found inadequate direct evidence that screening for IPV can reduce violence, abuse, and physical or mental harms.

The recommendation on screening for IPV applies to women of reproductive age because the evidence demonstrating benefit of ongoing support services is predominantly found in studies of pregnant or postpartum women. The USPSTF extrapolated the evidence pertaining to interventions with ongoing support services from pregnant and postpartum women to all women of reproductive age.

The USPSTF found no studies on screening or interventions for IPV in men.

The USPSTF found inadequate evidence that screening or early detection of elder abuse or abuse of vulnerable adults reduces exposure to abuse, physical or mental harms, or mortality in older or vulnerable adults.

Harms of Detection and Early Intervention

The USPSTF found inadequate evidence to determine the harms of screening or interventions for IPV. Limited evidence showed no adverse effects of screening or interventions for IPV. The USPSTF determined that the magnitude of the overall harms of screening and interventions for IPV can be bounded as no greater than small. When direct evidence is limited, absent, or restricted to select populations or clinical scenarios, the USPSTF may place conceptual upper or lower bounds on the magnitude of benefit or harms.

The USPSTF found inadequate evidence on the harms of screening or interventions for elder abuse or abuse of vulnerable adults.

Clinical Considerations

Patient Population Under Consideration

This recommendation applies to women of reproductive age and older or vulnerable adults without recognized signs and symptoms of abuse (Figure 2). The studies reviewed for IPV included adolescents to women in their 40s.

See below for suggestions for practice regarding men and older and vulnerable adults.

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.

Definitions of IPV and Elder Abuse

The term "intimate partner violence" refers to physical violence, sexual violence, psychological aggression (including coercive tactics, such as limiting access to financial resources), or stalking by a romantic or sexual partner, including spouses, boyfriends, girlfriends, dates, and casual "hookups." Severe physical violence includes being hit with a fist or something hard, kicked, hurt by pulling hair, slammed against something, hurt by choking or suffocating, beaten, burned on purpose, or threatened with a knife or gun.¹

The term "elder abuse" refers to acts whereby a trusted person (eg, a caregiver) causes or creates risk of harm to an older adult.¹² According to the Centers for Disease Control and Protection (CDC),

an older adult is considered to be 60 years or older.¹² The legal definition of "vulnerable adult" varies by state but is generally defined as a person who is or may be mistreated and who, because of age, disability, or both, is unable to protect him or herself.³ Types of abuse that apply to older or vulnerable adults include physical abuse, sexual abuse, emotional or psychological abuse, neglect, abandonment, and financial or material exploitation.

Assessment of Risk

Although all women of reproductive age are at potential risk for IPV and should be screened, a variety of factors increase risk of IPV, such as exposure to violence as a child, young age, unemployment,

Figure 2. Clinical Summary: Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults

Population	Women of reproductive age	Older or vulnerable adults
Recommendation	Screen for intimate partner violence (IPV) and provide or refer screen-positive women to ongoing support services Grade: B	No recommendation. Grade: I (insufficient evidence)
Risk Assessment	All women of reproductive age are at potential risk for IPV and should be screened. There are a variety of factors that increase risk of IPV, such as exposure to violence as a child, young age, unemployment, substance abuse, marital difficulties, and economic hardships. Risk factors for elder abuse include isolation and lack of social support, functional impairment, and poor physical health. For older adults, lower income and living in a shared living environment with a large number of household members (other than a spouse) are associated with an increased risk of financial and physical abuse.	
Screening Tests	Several screening instruments can be used to screen women for IPV in the past year, such as the following: Humiliation, Afraid, Rape, Kick (HARK); Hurt/Insult/Threaten/Scream (HITS); Extended Hurt/Insult/Threaten/Scream (E-HITS); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST). The USPSTF found no valid, reliable screening tools in the primary care setting to identify abuse of older or vulnerable adults without recognized signs and symptoms of abuse.	
Treatments and Interventions	Effective interventions generally included ongoing support services that focused on counseling and home visits, addressed multiple risk factors (not just IPV), or included parenting support for new mothers. Studies that only included brief interventions and provided information about referral options were generally ineffective. The USPSTF found inadequate evidence that screening or early detection of elder abuse or abuse of vulnerable adults reduces exposure to abuse, physical or mental harms, or mortality in older or vulnerable adults.	
Relevant USPSTF Recommendations	The USPSTF has made recommendations on primary care interventions for child maltreatment; screening for depression in adolescents, adults, and pregnant women; screening for alcohol misuse; and screening for drug misuse.	

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>.


JAMA

USPSTF indicates US Preventive Services Task Force.

substance abuse, marital difficulties, and economic hardships.¹³ However, the USPSTF did not identify any risk assessment tools that predict greater likelihood of IPV in populations with these risk factors.

Risk factors for elder abuse include isolation and lack of social support, functional impairment, and poor physical health.¹⁴ For older adults, lower income and living in a shared living environment with a large number of household members (other than a spouse) are associated with an increased risk of financial and physical abuse.¹⁵

Screening Tests

Several screening instruments can be used to screen women for IPV. The following instruments accurately detect IPV in the past year among adult women: Humiliation, Afraid, Rape, Kick (HARK); Hurt, Insult, Threaten, Scream (HITS); Extended-Hurt, Insult, Threaten, Scream (E-HITS); Partner Violence Screen (PVS); and Woman Abuse Screening Tool (WAST).

HARK includes 4 questions that assess emotional and physical IPV in the past year. HITS includes 4 items that assess the frequency of IPV, and E-HITS includes an additional question to assess the frequency of sexual violence. PVS includes 3 items that assess physical abuse and safety. WAST includes 8 items that assess physical and emotional IPV.

Most studies only included women who could be separated from their partners during screening, during the intervention, or both, so screening and the intervention could be delivered in private.

State and local reporting requirements vary from one jurisdiction to another, with differences in definitions, whom and what should be reported, who should report, and to whom. Some states require clinicians (including primary care providers) to report abuse to legal authorities, and most require reporting of injuries resulting from guns, knives, or other weapons.¹⁶ For elder abuse, mandatory reporting laws and regulations also vary by state; however, most states require reporting.¹⁷

The USPSTF found no valid, reliable screening tools in the primary care setting to identify IPV in men without recognized signs and symptoms of abuse.

The USPSTF found no valid, reliable screening tools in the primary care setting to identify abuse of older or vulnerable adults without recognized signs and symptoms of abuse.

Screening Interval

The USPSTF found no evidence on appropriate intervals for screening. Randomized clinical trials (RCTs) of screening and interventions for IPV often screen for current IPV or IPV in the past year.

Box. Components of Effective Ongoing Support Services for Intimate Partner Violence

Format and Content

Home visits and counseling that address multiple risk factors (beyond just IPV)

Some examples of the home visit component include

Tailored IPV-related information based on the individual's expressed needs and level of danger at each visit (eg, information addressing the cycle of violence, risk factors for homicide, choices available to the woman, safety planning, and other IPV resources in the community)

Services related to parenting, problem-solving skills, and emotional support; linking families to community services; and prevention of child abuse

Some examples of the counseling component include

Cognitive behavioral therapy aimed at reducing behavioral risks, including depression, IPV (emphasizing safety behaviors), smoking, and tobacco exposure; cognitive behavioral therapy aimed at risks specific to the individual

Duration, Frequency, and No. of Visits

Average duration ranged from 31 wk to 3 y; ongoing support services spanned the prenatal and postnatal periods

Frequency of ongoing support services varied and were often tailored to the individual or coincided with routine perinatal care visits (eg, weekly, biweekly, monthly, or quarterly)

Total average No. of sessions ranged from 4 to 14

Ongoing support services were delivered either at home or in perinatal care sites

Provider

Delivery of ongoing support services often required dedicated training and was performed by paraprofessionals; master's-level, trained social workers or psychologists; community health workers; and nurses

Abbreviation: IPV, intimate partner violence.

Interventions

No studies definitively identified which intervention components resulted in positive outcomes. However, based on the evidence from 3 studies,¹⁸⁻²⁰ effective interventions generally included ongoing support services that focused on counseling and home visits, addressed multiple risk factors (not just IPV), or included parenting support for new mothers. See the **Box** for more information about the components of effective ongoing support services. These studies were conducted in pregnant or postpartum women. Studies that only included brief interventions and provided information about referral options were generally ineffective.

Suggestions for Practice Regarding the I Statement and Other Populations

Potential Preventable Burden

Older or Vulnerable Adults | Prevalence estimates of elder abuse and abuse of vulnerable adults vary. A 2008 nationwide survey of US adults 60 years or older found that the prevalence of any abuse or potential neglect in the past year was 10%.²¹ Elder abuse has a number of long-term negative health effects, including death,⁹ higher

risk of nursing home placement¹⁰ among those referred to APS, and adverse psychological consequences (distress, anxiety, and depression).¹¹ A 2004 survey of APS agencies identified 40 848 substantiated reports of vulnerable adult abuse (in those aged 18-59 years) in 19 states.³

Women Not of Reproductive Age | Based on the age categories reported by the CDC, approximately 4% of women aged 45 to 54 years and more than 1% of women 55 years or older have experienced rape, physical violence, or stalking by an intimate partner in the past 12 months.²²

Men | More than 33% of men have experienced sexual violence, physical violence, or stalking by an intimate partner in their lifetime.¹ Approximately 34% of men report any psychological aggression by an intimate partner in their lifetime. Among men who experience sexual violence, physical violence, or stalking, more than 10% experience at least 1 form of an IPV-related adverse effect, such as feeling fearful, feeling concerned for safety, injury, missing days of work or school, and needing medical care.¹

Potential Harms

Some potential harms of screening in older or vulnerable adults, women not of reproductive age, and men are shame, guilt, self-blame, retaliation or abandonment by perpetrators, partner violence, and the repercussions of false-positive results (eg, labeling and stigma).

Current Practice

Older or Vulnerable Adults | Limited evidence suggests that screening is not commonly occurring in practice; 1 study found that more than 60% of clinicians have never asked their older adult patients about abuse.²³

Women | While not specific to age, evidence suggests that screening for IPV is not commonly occurring in practice. A recent systematic review found that rates of routine screening vary and are typically low, ranging from 2% to 50% of clinicians reporting "always" or "almost always" routinely screening for IPV.²⁴

Men | No data are available on current screening practice in men.

Additional Approaches to Prevention

The Health Resources and Services Administration (HRSA) Strategy to Address Intimate Partner Violence (2017-2020) identifies priorities for reducing IPV, including training the health care and public health workforce to address IPV.²⁵ HRSA also developed a toolkit²⁶ for clinicians and health centers to help implement screening and interventions for IPV. The National Hotline on Domestic Violence has information about local programs and resources across the country.²⁷ The Administration for Children and Families has funded a compendium of state statutes and policies on domestic violence and health care.²⁸

The CDC,²⁹ Substance Abuse and Mental Health Services Administration-HRSA Center for Integrated Health Solutions,³⁰ US Department of Veterans Affairs,³¹ Administration for Community Living,³² and the Administration on Aging's National Center for Elder Abuse³³ also have additional resources available for clinicians.

Useful Resources

The USPSTF has made recommendations on primary care interventions for child maltreatment³⁴; screening for depression in adolescents,³⁵ adults, and pregnant women³⁶; screening for alcohol misuse³⁷; and screening for drug misuse.³⁸

Other Considerations

Research Needs and Gaps

There are several key research gaps related to IPV. The USPSTF recognizes that a significant body of evidence is lacking for men. The CDC has conducted studies demonstrating the prevalence and importance of IPV in men; however, there is a lack of research on screening and interventions to prevent IPV in men. Research is needed in all areas related to the accuracy of screening tools for men, and trials are needed that examine the effectiveness (benefits and harms) of screening and interventions for IPV in the primary care setting in men without recognized signs and symptoms of abuse.

More research is also needed on the most effective characteristics of ongoing support services for reducing IPV. In particular, more RCTs that compare the benefits and harms of screening (plus ongoing support services or referral for women who screen positive) vs no screening are needed, where support services may include more frequent and intensive interventions such as home visits, cognitive behavioral therapy, or other forms that address multiple risk factors. These studies should evaluate the optimal duration, format, and method of delivery.

Trials of ongoing support services should enroll women of all ages, including nonpregnant women and women beyond reproductive age. These trials will help with understanding the types of post-screening, ongoing support services that can be most effective, and the patients for whom they are most effective.

More research is also needed in all areas related to the accuracy of screening tools in the primary care setting for elder abuse and abuse of vulnerable adults when there are no recognized signs and symptoms of abuse. High-quality RCTs are also needed on the effectiveness (benefits and harms) of screening and interventions in the primary care setting to prevent such abuse.

Discussion

Burden of Disease

Intimate partner violence is a significant public health problem. According to the CDC, 36% of US women and 33% of US men experience sexual violence, physical violence, or stalking by an intimate partner during their lifetime.¹ The prevalence of lifetime psychological aggression is 36.4% in women and 34.3% in men. Lifetime severe physical violence is experienced by 21% of women and 15% of men.¹ The most commonly reported effects of IPV include feeling fearful (61.9% of women and 18.2% of men) and concern for safety (56.6% of women and 16.7% of men).³⁹ Women and men with a history of sexual violence, stalking, or physical violence committed by an intimate partner were more likely to report experiencing asthma, irritable bowel syndrome, frequent headaches, chronic pain, difficulty sleeping, and limitations in their activities than women and men without a history of such violence.³⁹

Intimate partner violence is more common in younger women; thus, women of reproductive age have a higher prevalence of IPV than older women. Approximately 14.8% of women aged 18 to 24 years have experienced rape, physical violence, or stalking by an intimate partner in the past 12 months, compared with 8.7% of women aged 25 to 34 years, 7.3% of women aged 35 to 44 years, 4.1% of women aged 45 to 54 years, and 1.4% of women 55 years or older.²² Intimate partner violence during pregnancy can have significant negative health consequences for women and children, including depression in women, low birth weight and preterm birth, and perinatal death.^{6,7}

Abuse of older or vulnerable adults is also a significant public health problem. Estimates of prevalence vary. A nationally representative survey (N = 3005) of community-dwelling adults aged 57 to 85 years estimated that 9% had experienced verbal mistreatment, 3.5% financial mistreatment, and 0.2% physical mistreatment by a family member.⁴⁰ Among older adults, intimate partners constitute the minority of perpetrators in substantiated reports of elder abuse. According to data from a national survey of APS agencies, across all substantiated abuse reports involving a known perpetrator among adults older than 60 years (N = 2074), approximately 11% of reports involved a spouse or intimate partner. The most common perpetrators of elder abuse are adult children (about 33% of cases) and other family members (about 22% of cases).³

The USPSTF found few studies reporting on recent estimates of the prevalence of abuse in populations of vulnerable adults. The 1995–1996 National Violence Against Women Survey (N = 6273) found that women with severe disability impairments were 4 times more likely to experience sexual assault in the past year than women without disabilities.⁴¹

Scope of Review

The USPSTF commissioned a systematic evidence review to update its 2013 recommendation on screening for IPV, elder abuse, and abuse of vulnerable adults. The scope of this review is similar to that of the prior systematic review, but in the current review^{42,43} the USPSTF also examined the evidence on IPV in men and adolescents. The current review did not examine screening or interventions for perpetration of IPV.

Accuracy of Screening Tests

The review identified 15 fair-quality studies (n = 4460) assessing the accuracy of 12 different IPV screening tools. All studies enrolled adults, and most enrolled only women or a majority of women; 1 study included only men.⁴⁴ The recruitment settings varied; 5 studies recruited from emergency departments, 4 from primary care practices, 1 from urgent care, and 3 by telephone or mail survey. Most studies assessed a tool designed to identify persons experiencing IPV within the past year; however, 4 studies reported on the accuracy of 5 tools for identifying current (ongoing) abuse, 1 assessed the accuracy of detecting lifetime abuse, and 1 assessed the accuracy of a tool for predicting future (within 3 to 5 months) abuse.

Five studies reported on the accuracy of 5 different screening tools (HARK, HITS, E-HITS, PVS, and WAST) for detecting any past-year IPV in adult women. Sensitivity ranged from 64% to 87% and specificity from 80% to 95%. Most screening tools were assessed by only 1 study.

Four studies reported on the accuracy of 5 screening tools for identifying ongoing or current abuse. Across all studies, accuracy varied widely (sensitivity, 46%-94%; specificity, 38%-95%). One tool, the Ongoing Violence Assessment Tool (OVAT), had acceptable sensitivity (86%) and specificity (83%) compared with the Index of Spouse Abuse (ISA).

One study enrolling men only from an emergency department reported on the accuracy of the PVS and HITS for detecting past-year IPV; sensitivity was low for both PVS and HITS for detecting psychological abuse (30% and 35%, respectively) and physical abuse (46% for both).

The review identified 1 fair-quality study assessing the accuracy of screening for abuse in the primary care setting in older adults when abuse is not suspected.⁴⁵ Screening was conducted using the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST), which includes 15 items. Compared with the Conflict Tactics Scale (CTS) (violence/verbal aggression scales combined), the H-S/EAST had a sensitivity of 46% (95% CI, 32%-59%) and specificity of 73.2% (95% CI, 62%-82%).

The review found no studies on the effectiveness of screening questionnaires or tools in identifying abuse and neglect of vulnerable adults.

Effectiveness of Early Detection and Treatment

Overall, 3 RCTs ($n = 3759$) found no direct benefit of screening for IPV in adult women (mean age range, 34-40 years) when screening was followed by brief counseling or referral. There were no significant differences between screening and control groups over 3 to 18 months for IPV, quality of life, depression, PTSD, or health care utilization outcomes. The RCTs compared universal screening for IPV in a health care setting with no screening; 1 study enrolled participants from 10 US primary care clinics, 1 from a single New Zealand emergency department, and 1 from a variety of Canadian clinical settings (12 primary care sites, 11 emergency departments, and 3 obstetrics-gynecology clinics). No RCTs enrolled men or adolescents, and none focused on pregnant women or reported outcomes separately by pregnancy status. Women who screened positive received brief counseling and referral; the trials did not directly provide ongoing support services, and the proportion of women who received more intensive services after referral was not reported.

Eleven RCTs ($n = 6740$) evaluated an IPV intervention in adult women with screen-detected IPV or women considered at risk for IPV. Five RCTs enrolled women during the perinatal period; all reported on IPV outcomes. Of these, the studies that were effective generally involved ongoing support services, which included multiple visits with patients, addressed multiple risk factors (not just IPV), and provided a range of emotional support and behavioral and social services. Two home-visit interventions^{19,20} found lower rates of IPV in women assigned to the intervention group than in those assigned to the control group; however, the difference between groups was small (standardized mean difference, -0.04 and -0.34 , respectively), and only 1 study found a statistically significant difference (standardized mean difference, -0.34 [95% CI, -0.59 to -0.08]).¹⁹

Of the 3 RCTs enrolling pregnant women with screen-detected IPV that evaluated a counseling intervention, 2 found benefit in favor of the intervention.^{18,46} One trial only reported on subtypes of violence; the benefit was significant for some subtypes of

violence (psychological and minor physical abuse) but not others (severe physical and sexual abuse).⁴⁶

One RCT assessing an integrated behavioral counseling intervention in women with 1 or more risk factors (smoking, environmental tobacco smoke exposure, depression, and IPV) reported on birth outcomes among the subgroup with IPV at baseline; significantly fewer women in the intervention group delivered very preterm neonates (≤ 33 weeks of gestation).⁴⁷ Many women with IPV at baseline (62%) also screened positive for depression and received counseling for depression in addition to counseling for IPV. Two RCTs reported on depression, and both found benefit in favor of the intervention (only 1 found a statistically significant benefit⁴⁶); 1 of these studies also reported on PTSD symptoms and found similar scores in both groups.⁴⁸

Six RCTs enrolled nonpregnant women; 4 measured changes in overall IPV incidence and found no significant difference between groups in rates of overall IPV exposure^{49,50} or combined physical and sexual violence^{51,52}; measures of IPV were either similar between groups or slightly higher in the intervention group. Two RCTs measured changes in quality of life after an IPV intervention; in both trials, scores were similar between intervention and control groups and differences were not statistically significant.^{49,53} Interventions in nonpregnant women primarily included brief counseling, provision of information, and referrals but did not directly provide ongoing support services, and the proportion of women who received more intensive services after referral was not reported.

The review identified no eligible screening or intervention studies on IPV in men.

The review identified no eligible studies on elder abuse or abuse of vulnerable adults.

Potential Harms of Screening and Treatment

Two fair-quality RCTs reported on harms of screening and identified no adverse effects of screening. One RCT developed a specific tool, the Consequences of Screening Tool (COST), to measure the consequences of IPV screening, such as "Because the questions on partner violence were asked, I feel my home life has become (less difficult... more difficult)." Results indicated that being asked IPV screening questions was not harmful to women immediately after screening. Scores were similar across groups.

Five good- or fair-quality RCTs assessing IPV interventions reported on harms. No study found significant harms associated with the interventions. One RCT⁴⁹ assessing a brief counseling intervention surveyed women at 6 and 12 months about survey participation (including potential harms); there was no difference between groups in the percentage of women who reported potential harms, and the authors concluded no harms were associated with the intervention. Among women who reported that their abusive partner was aware of their participation in the trial, the number of negative partner behaviors (eg, got angry, made her more afraid for herself or her children, or restricted her freedom) was not significantly different between groups.

The review identified no eligible studies on IPV in men.

The review identified no eligible studies on elder abuse or abuse of vulnerable adults.

Estimate of Magnitude of Net Benefit

The USPSTF concludes with moderate certainty that screening for IPV in women of reproductive age and providing or referring women

who screen positive to ongoing support services has a moderate net benefit. There is adequate evidence that available screening instruments can identify IPV in women. The evidence does not support the effectiveness of brief interventions or the provision of information about referral options in the absence of ongoing supportive intervention components. The evidence demonstrating benefit of ongoing support services is predominantly found in studies of pregnant or postpartum women. Studies that demonstrated no clear benefit in nonpregnant women, however, did not directly provide ongoing support services. Therefore, the USPSTF extrapolated the evidence pertaining to interventions with ongoing support services in pregnant and postpartum women to all women of reproductive age. More research is needed that includes ongoing support services for women who are not pregnant or postpartum or who are beyond reproductive age.

Because of the lack of evidence, the USPSTF concludes that the benefits and harms of screening for elder abuse and abuse of vulnerable adults are uncertain and that the balance of benefits and harms cannot be determined. More research is needed.

Response to Public Comment

A draft version of this recommendation statement was posted for public comment on the USPSTF website from April 24, 2018, to May 21, 2018. The USPSTF reviewed all comments and made revisions to the recommendation as appropriate. Some comments asked for clarification about the patient population, including whether men and older women were included in the recommendation. In response, the USPSTF clarified that it examined the evidence on the benefits and harms of screening for IPV in women of all ages and in men; the recommendation is based on the available evidence. Some comments suggested screening instruments for elder abuse. The USPSTF reviewed the suggested tools; however, none of the suggested screening instruments met the USPSTF's inclusion criteria (eg, those screening tools were developed or tested in populations with recognized signs or symptoms of abuse). The USPSTF clarified the types of screening instruments that are needed in the Research Needs and Gaps section. Last, the

USPSTF added more details on the research gaps and suggested resources for practitioners.

Update of Previous USPSTF Recommendation

This recommendation replaces the 2013 USPSTF recommendation. It is consistent with the 2013 USPSTF recommendation, which was a B recommendation for women of childbearing age and an I statement for abuse in older or vulnerable adults. This recommendation incorporates new evidence since 2013 and provides additional information about the types of ongoing support services that appear to be associated with positive outcomes.

Recommendations of Others

The American Academy of Family Physicians,⁵⁴ American College of Obstetricians and Gynecologists (ACOG),⁵⁵ American Academy of Neurology,⁵⁶ American Academy of Pediatrics,⁵⁷ Institute of Medicine Committee on Preventive Services for Women,⁵⁸ and the HRSA-supported Women's Preventive Services Guidelines⁵⁹ are in favor of screening for IPV. The American Academy of Family Physicians recommends screening for IPV in all women of childbearing age and providing interventions for those who screen positive. ACOG recommends screening for IPV in all pregnant women and offering ongoing support services. The American Medical Association Code of Medical Ethics states that clinicians should routinely ask about physical, sexual, and psychological abuse.⁶⁰ The Canadian Task Force on Preventive Health Care⁶¹ and the World Health Organization⁶² indicate that current evidence does not justify universal screening for IPV. The Community Preventive Services Task Force recommends primary prevention interventions that aim to prevent or reduce IPV and sexual violence among youth.⁶³ The American Academy of Neurology⁵⁶ and ACOG⁶⁴ recommend screening for elder abuse. The Canadian Task Force on Preventive Health Care⁶¹ concludes that the current evidence is insufficient to warrant a recommendation for screening.

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CCHP Enrollment Trend Report for October 2018 (TAP2696M)

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PRODUCT	CPN	KSR	RMC	Current Month	Previous Three Month Average	Last Year Same Month	Annual Change	% of Change
1) Medi-Cal								
Medi-Cal AFDC	28,622	14,250	33,211	76,083	77,106	79,428	(3,345)	(4%)
Medi-Cal (duals)	2,275	1,672	5,498	9,445	9,282	6,761	2,684	40%
Medi-Cal (Voluntary)	172	298	128	598	608	681	(83)	(12%)
Medi-Cal Low Income Child Program	8,685	6,806	7,621	23,112	23,144	22,534	578	3%
Medi-Cal SPD	4,499	1,743	9,008	15,250	15,262	17,178	(1,928)	(11%)
Medi-Cal Expansion Transition LIHP	0	0	1	1	33	321	(320)	(100%)
Medi-Cal Expansion (New)	8,723	7,242	39,108	55,073	55,187	55,980	(907)	(2%)
Subtotal	52,976	32,011	94,575	179,562	180,622	182,883	(3,321)	(2%)
2) Medicare								
Senior Health	48	0	344	392	400	397	(5)	(1%)
Medi-Medi (Crossover)	0	0	24	24	24	29	(5)	(17%)
Subtotal	48		368	416	424	426	(10)	(2%)
3) COUNTY EMPLOYEES								
PLAN A	0	0	5,363	5,363	5,357	5,506	(143)	(3%)
PLAN B	818	0	443	1,261	1,246	1,228	33	3%
PERS	0	0	17	17	16	12	5	42%
A2 T & P	0	0	7	7	7	8	(1)	(13%)
A2 ARCCC	0	0	18	18	16	17	1	6%
Superior Court	5	0	62	67	67	77	(10)	(13%)
Subtotal	823		5,910	6,733	6,709	6,848	(115)	(2%)
4) Commercial								
In-Home Supportive Services	0	0	1,980	1,980	1,993	1,861	119	6%
Subtotal			1,980	1,980	1,993	1,861	119	6%
5) UNINSURED RECIPIENTS								
BHC ACTIVE	0	0	1	1	1	1		0%
Pending BHC/HCI (Rx Only)	0	0	2	2	1	1	1	100%
Mental Health /Short Doyle (Rx Only)	0	0	442	442	414	252	190	75%
Pending & Restricted Medi-Cal (Rx Only)	0	0	6,452	6,452	2,060	5,753	699	12%
Administrative Override (Rx Only)	0	0	98	98	95	58	40	69%
Subtotal			6,995	6,995	2,571	6,065	930	15%
CCHP MEMBER TOTAL (Less Uninsured)	53,847	32,011	102,833	188,691	63,249	194,174	(5,483)	(3%)
CCHP Managed Lives Total	53,847	32,011	109,828	195,686	195,275	200,239	(4,553)	(2%)