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San Joaquin County Public Health Services
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Child Health & Disability Prevention
CHDP
Gateway To Health Coverage

Child Health and Disability Prevention Program

Fall 2019 Newsletter

CHDP Updates

PM 160 Discontinued for FQHCs

As of September 1, 2019, FQHCs/RHCs/IHCs are no longer required to submit the Information Only PM 160 with their claims. Instead, providers will use informational lines on the claims which fulfill reporting requirements. Examples of UB-04 paper claims with the informational lines can be found for FQHCs and RHCs in the *Billing Examples* provider manual section. Instructions can also be found in the Medi-Cal Computer Media Claims (CMC) Billing and Technical Manual under the Special Billing Instructions section.

In addition, providers should no longer be ordering Information Only PM 160s as of September 1, 2019. For questions or concerns, please email CHDPTransition@conduent.com.

Updated Care Coordination Form for Foster Children

Providers seeing children in the foster care program should fill out a Foster Care Medical Contact Form for every visit.

This form has recently been updated to include important information about the health status of each child. See **Attachment A** for the new form and **Attachments B-E** for instructions.

After completion the form should be faxed to Foster Care Nursing at 209-932-2638. It can also be mailed to Foster Care Nursing, SJC Human Services Agency, PO Box 201056, Stockton, CA 95297-0106. For questions, call Pam Lam at 209-468-1408.

New Lead Recall

The California Department of Public Health (CDPH) has issued a warning to consumers not to eat **La Zagala brand Fruit Pulp Tamarind Flavor candy** due to possible lead contamination.

CDPH's food recall information sheet can be accessed here: https://www.cdph.ca.gov/Programs/CEH/DFDCS/CDPH%20Document%20Library/FDB/FoodSafetyProgram/FoodRecalls/August%202019/fdbFrLAZ1n.pdf

More information about additional requirements will be forthcoming. For questions, please call or email Surbhi Jayant, PHN at 209-468-3082 or sjayant@sjcphs.org

The Importance of Depression Screening - A Letter from Dr. Park

Mental health is intertwined with physical health and getting to know our patients from a social-emotional perspective is important to managing their entire well-being. As pediatric providers, you are experts on developmental screening and we are thankful for your early detection of developmental issues in our pediatric population. Now the CHDP program is also placing emphasis on behavioral health screening and has expanded guidelines under the pediatric preventive criteria which reflect American Academy of Pediatrics (AAP) Bright Futures Guidelines.

In particular, depression screening is required for patients 12 years and older with their annual exams. A recommended screening tool is the Patient Health Questionnaire (PHQ). The PHQ-9 asks 9 questions and is commonly used for adolescents. I know that many of you have already incorporated the PHQ-9 into your practice. The PHQ-2 is also acceptable, but a positive response should be followed with a PHQ-9. The AAP also accepts the use of several other tools for adolescent depression screening that can be found in the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit.

Maternal depression screening is required for the mothers of newborns by age 1 month and at 2 months, 4 months, and 6 months. The recommended tool is the Edinburgh Postpartum Depression Scale.

It would be nice to have an action plan in place for patients who are found to be at risk. San Joaquin County Maternal Child and Adolescent Health program has created a useful mental health resource directory. Please email gcallaway@sjcphs.org to request an electronic copy.

Childhood Lead Poisoning Prevention Week 2019

October 20-26, 2019 is Childhood Lead Poisoning Prevention Week. The theme this year is, **"Dust and dirt with lead can hurt. Keep kids away from lead where they play."** It is important to wash the child's hands often; take shoes off before going into the house; and wet-mop floors and wash toys consistently.

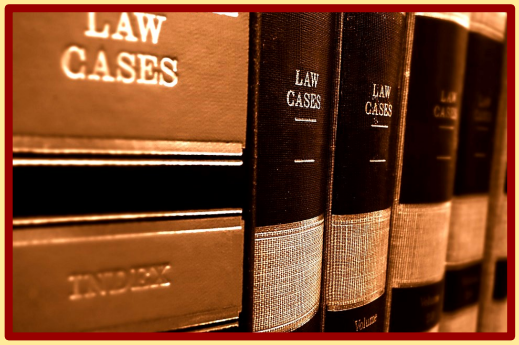
Lead can damage a child's brain and nervous system. Lead poisoning is especially dangerous for children under the age of six because of their rapidly growing and developing bodies and because they absorb more lead through the gastro-intestinal tract. Lead exposure can cause permanent learning and behavioral problems that make it difficult for children to succeed in school.

A blood lead test is the only way to know if a child has lead poisoning. California regulations require that children in a publicly funded program like Medi-Cal; who spend a lot of time in a pre-1978 place with deteriorated paint or that was recently renovated; or who are at risk of lead exposure from other sources be blood lead tested at both one and two years of age. Additionally, children three to six years old who were not tested at ages one and two years old should have a blood lead test.

For more information about lead, please visit http://clppp.sjcphs.org/. For questions regarding blood lead testing, contact Ursula Fung, Childhood Lead Poisoning Prevention Program (CLPPP) Coordinator in San Joaquin County, at 209-468-2593 or ufung@sjcphs.org.

News and Resources

Immigration Rule Change



This year, the Department of Homeland Security (DHS) officially published a rule that changes the way public charge is decided and weighted. **The change will take effect on October 15, 2019 if it is not legally challenged.** Applications must be postmarked before this date to avoid falling under the rule change. New official language "broadens the programs that the federal government will consider in public charge determinations to include previously excluded health, nutrition, and housing programs…" (Kaiser Family Foundation). These include the use of:

- Federally funded Medicaid (Medi-Cal) with certain exclusions
  - o **Those under 21 years of age, pregnant women and women up to 60 days postpartum, those requiring emergency services, those using school-based services as well as services under the Individuals with Disabilities Education Act (IDEA) can still use Medi-Cal without worrying about public charge**
- Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps)
- Any federal, state, local, or tribal cash assistance for income maintenance
- Supplemental Security Income (SSI)
- Temporary Assistance for Needy Families (TANF)

The public charge rule does not apply to refugees, asylees, lawful permanent residents applying for citizenship, and others. For more information, please see https://www.uscis.gov/legal-resources/final-rule-public-charge-ground-inadmissibility.

If you have concerns, please speak to a trusted attorney or an accredited representative.

CHDP Audiometric Training

Date: Wednesday, October 16, 2019

Time: 8:30am - 1pm

Location: Conference Room, 2233 Grand Canal Blvd. Suite 214, Stockton, 95207

The registration deadline is Tuesday, October 8th. See **Attachment F** to register.

All staff who conduct hearing screenings for CHDP children are required to attend this training every 4 years. For questions, call or email Gwen Callaway at 209-468-8918 or gcallaway@sjcphs.org.

CHDP Team

CMS Medical Director	Maggie Park, MD
CMS Administrator	Renee Sunseri, BSN, RN, PHN
CHDP Deputy Director	Surbhi Jayant, MSN, RN, PHN
CHDP Public Health Educator	Gwen Callaway, MPH
CHDP Foster Care Coordination	Pam Lam, BSN, RN, PHN Jamie Crenshaw, BSN, RN, PHN Charlene Devera, BSN, RN, PHN Christine Merin, BSN, RN, PHN Annelie Steele, BSN, RN, PHN Russell Espiritu, Sr. Office Assistant
CHDP Outreach & Support	Xia Lo, CHOW

CHDP quarterly newsletters are not intended to take the place of the CHDP Provider Manual, Provider Information Notices (PINs), or any other official correspondence from the California Department of Health Care Services. For article contributions, topic suggestions and mailing list updates, please contact Gwen Callaway at 468-8918 or gcallaway@sjcphs.org.

Health Care Program for Children in Foster Care (HCPCFC)
Foster Care Medical (Specialty) Contact Form

Attachment A

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Submit to the HCPCFC Program within 5 business days of the examination – Fax: 209-932-2638

Complete this form if child is in the foster care system. Health care providers are required to submit a HCPCFC Foster Care Medical (Specialty) Contact Form when providing care to children and youth in the foster care system. For questions, call 209-468-1408.

Patient Name (Last) (First) (Initial)	**Language**	**Date of Service** Month / Day / Year

Birthdate Month / Day / Year	**Age(yr/m)**	**Sex**	**Gender**	**Patient's County of Residence**	**Telephone #** (Home or Cell)	**Alternate Phone #** (Work or Other)

Responsible Person (Name) (Street) (Apt/Space) (City) (Zip)

Ethnic Code ☐
1-White
2-Hispanic/Latino
3-Black/African American
4-American Indian/Alaska Native
5-Asian
6-Native Hawaiian/Other Pacific Islander
7-Other

Patient Eligibility:	County Code	Aid Code	Identification Number	**Next CHDP Exam** Month / Day / Year

Is the patient a Medi-Cal Managed Care Plan enrollee? ☐ Yes ☐ No

A. Medical Assessment and Referral Section

Type of Visit:

MEDICAL ☐ **Well Child Exam** ☐ **Immunization Visit** ☐ **Sick Visit/Urgent Care** ☐ **Reproductive Health** ☐ **Follow Up**

SPECIALTY/Dental ☐ **Initial Consultation** ☐ **Follow Up**

Type (e.g. Optometry, Neurology, Cardiology, Audiology, Mental Health) _____

Height To nearest 0.1 cm	Height Percentile	**Weight** To nearest 0.1 kg	Weight Percentile	**BMI**	BMI Percentile	**Head Circumference**	Head Circ. Percentile

Blood Pressure	**Hemoglobin**	**Hematocrit**	**Vision Results** OD / OS / OU	**Hearing Results** R / L

Labs Ordered ☐ **CBC** ☐ **Lead** ☐ **Other:**_____ | **Date Labs Ordered** | **Lab Results**

Any known **allergies** to medication/food/environment? ☐ **Y** ☐ **N** Please list:_____

ASSESSMENT/DIAGNOSIS:

Depression Screening: ☐ **Y** ☐ **N** **Substance Abuse Screening:** ☐ **Y** ☐ **N** **Tool Used (if any)?** _____

MEDICATIONS/TREATMENTS:
(DOSAGE/FREQUENCY)

If prescribed psychotropic medication was a
JV220 (A) completed? ☐ **Y** ☐ **N**
Was EKG completed? ☐ **Y** ☐ **N**
Were Labs completed? ☐ **Y** ☐ **N**

DEVELOPMENTAL SCREENING/ASSESSMENT: **Completed today?** ☐ **Y** ☐ **N**

Developmental tool used, if any: (Please attach a copy) ☐ **ASQ-3** ☐ **ASQ-SE** ☐ **Other** (Specify):_____

Age appropriate development? ☐ **Y** ☐ **N** **if NO, Indicate:** ☐ **Gross** ☐ **Fine** ☐ **Speech/Language** ☐ **Social/Emotional** ☐ **Cognitive**

Physical Growth ☐ **WNL** ☐ **Delayed**

REFERRALS: (e.g. Mental Health, CCS, Speech and Hearing, IEP)

IMMUNIZATIONS
☐ **Copy of IZ Records Attached?**
Please check (☑) which immunizations have been given TODAY:

IPV	1☐	2☐	3☐	4☐	
DTaP	1☐	2☐	3☐	4☐	5☐
Td	☐				
Tdap/Booster	☐				
Hib	1☐	2☐	3☐	4☐	
MMR	1☐	2☐			
Hep B	1☐	2☐	3☐		
Hep A	1☐	2☐			
VZV	1☐	2☐			
PCV	1☐	2☐	3☐	4☐	5☐
PCV13	☐				
MenACWY	☐				
HPV	1☐	2☐	3☐		
Influenza	1☐	2☐			
Rotavirus	1☐	2☐	3☐		

Other:_____
☐ **Up to date** ☐ **Not up to date**

☐ **PPD** ☐ **TB Risk Assessment**
Date Given:_____
Date Read:_____
Results: ☐ **Negative** ☐ **Positive**
☐ **Return for PPD Read**
☐ **Lab ordered for QFT/IGRA**

B. Dental Assessment and Referral Section

☐ **Class I:** No Visible Problems
Mandated annual routine dental referral (beginning no later than age 1 and recommended every 6 months)

☐ **Class II:** Visible decay, small carious lesion or gingivitis
Needs non-urgent dental care

☐ **Class III: Urgent** – pain, abscess, large carious lesions or extensive gingivitis
Immediate treatment for urgent dental condition which can progress rapidly

☐ **Class IV: Emergent** – acute injury, oral infection or other pain
Needs immediate dental treatment within 24 hours

Fluoride Varnish Applied: ☐ Yes ☐ No, parent refused ☐ No, teeth have not erupted
☐ Other reason for not applying: _____

☐ **Dental home referral** **Referred To and Contact Number:** _____

C. Provider Information

Service Location: Office Name, Address, Telephone and Fax Number

NPI Number

Provider Name (Print Name)

Provider Signature | **Date**

Follow up appointments needed? ☐ **Y** ☐ **N** **Date/Time**_____

Revised 9/2019

Forms may also be mailed to HCPCFC, SJC Human Services Agency, P.O. Box 201056, Stockton, CA 95297-0106

Foster Care Medical (Specialty) Form: Completion Instructions

Health Care Providers:

- Submit a copy of the form, an EHR patient summary, or an equivalent via eFax to the Local HCPCFC Program when providing care to children and youth in the foster care system
- Give a copy of the form or a printout of your EHR patient summary or an equivalent to the responsible person indicated on the form.

Explanation of Form Items:

Patient Information (Demographics section)

Patient Name. Enter the patient's last name, first name and middle initial, exactly as it appears on the Benefits Identification Card (BIC), including blank spaces. If the patient's name differs in any way from the name on the BIC or is incorrect, enter the name that the patient is Also Known As (AKA).

Language. Enter the patient's primary language spoken at home. The language is critical to enable local CHDP program staff to assist families in removing barriers to diagnosis and/or treatment.

Date of Service. Enter the date the CHDP service was rendered. Use a leading zero (0) when entering dates with only one digit (for example, March 1, 2017 is entered as 03 01 17).

Birthdate. Enter the month, day and year of the patient's birth exactly as it appears on the Medi-Cal eligibility verification system. Use zeros (0) when entering dates of only one digit (for example, January 1, 2017 is entered as 01 01 17).

Age. Enter the patient's age with one of the following indicators: "yr" for years, "m" for months, "w" for weeks, or "d" for days (for example, 15yr represents 15 years of age).

Sex. Enter an "F" if the patient is female. Enter an "M" if the patient is male. This must be entered exactly as it appears on the Medi-Cal eligibility verification system.

Gender. Enter the gender the patient identifies with even if the gender is not female or male. If information is not available, leave blank.

Patient's County of Residence. Enter either the name of the county where patient lives (not county where assessment is performed) or the two-digit city code if the individual lives in Berkeley, Long Beach or Pasadena.

Telephone #. Enter residence or cellular telephone number, including area code where the responsible person can be reached during the day.

Alternate Phone #. Enter business or message telephone number, including area code where the responsible person can be reached during the day.

Responsible Person. When the patient is younger than 18 years of age and not an emancipated minor, enter the name, street address (including apartment or space number), city, and ZIP code of the legal guardian with whom the patient lives.

Patient Eligibility. Patient eligibility information on the form is completed as follows:

- COUNTY. Enter patient's two-digit county code (obtained when eligibility verification is performed).
- AID. Enter patient's two-digit aid code (obtained when eligibility verification is performed)
- IDENTIFICATION NUMBER. Enter patient's identification number from the plastic Benefits Identification Card (BIC) or
  - *Immediate Need Eligibility Document* – Gateway

Next CHDP Exam Date. Enter the month, day and year the next complete health assessment is due.

Ethnic Code. Enter the appropriate ethnic code (select one only). If the patient's ethnicity is not included in the code list, or if ethnicity is unknown, enter code 7 (Other).

B. Medical Assessment and Referral Section:

Type of Visit. Enter a check mark (✔) on the correct type of medical visit. For specialty exams, indicate type of specialty (i.e. Optometry, Neurology) and enter a check mark (✔) if specialty exam is an initial consultation or follow-up appointment.

Height. Enter patient height to the nearest 0.1cm and height percentile.

Weight. Enter patient weight to the nearest 0.1kg and weight percentile.

BMI. Enter patient BMI and BMI percentile.

Head Circumference. Enter patient head circumference and head circumference percentile.

Blood Pressure. Enter patient blood pressure.

Hemoglobin. Enter patient hemoglobin level.

Hematocrit. Enter patient hematocrit level.

Vision Results. Enter patient vision results for left, right and both eyes. If not completed, indicate reason (i.e. N/A, unable).

Hearing Results. Enter patient hearing results indicating passed, within normal limits (WNL) or failed. If not completed, indicate reason (i.e. N/A, unable).

Labs Ordered. Enter a check mark (✔) if CBC, Lead or other labs ordered. For other labs ordered, enter type of lab (i.e. TSH).

- *Date Labs Ordered.* Enter the date labs ordered.
- *Lab Results.* Enter lab results and attach a copy of results if available.

Allergies. Enter a check mark (✔) if patient has any known allergies to medication, food or environment. If yes, enter all allergies.

Assessment/Diagnosis. Enter assessment findings including any known or suspected diagnoses.

Depression Screening. Enter a check mark (✔) in the appropriate box indicating if a screen was completed or not. If so, indicate tool used, if any.

Substance Abuse Screening. Enter a check mark (✔) in the appropriate box indicating if a screen was completed or not. If so, indicate tool used, if any.

Medications/Treatments. If patient was prescribed any medication(s), enter the name, dosage and frequency of the medication(s). Enter any treatments rendered during the visit or future treatment(s) needed.

- *Psychotropic medication.* If patient is prescribed a psychotropic medication, enter a check mark (✔) indicating if the following were completed or not:
  - A JV220 (A)
  - An EKG
  - Labs

Developmental Screening/Assessment. Enter a check mark (✔) indicating if a developmental screen/assessment was completed at time of visit or not. If yes, indicate the type of tool used. If other than an Ages and Stages Questionnaire (ASQ), enter a check mark (✔) in *Other* and specify tool used. Attach any completed developmental screen/assessment.

- *Age Appropriate Development.* Enter a check mark (✔) in the appropriate box. If no, enter a check mark (✔) where development is not appropriate. Mark all that apply.
- *Physical Growth.* Enter a check mark (✔) in the appropriate box. If physical growth is not WNL, enter a check mark (▯) in *Delayed* and enter an explanation.

Referrals. Enter referrals made at time of visit or pending referrals to any provider or agency. Indicate the name(s) and telephone number(s) of the provider(s) the patient was referred to.

Immunizations. Enter a check mark (✔) if immunization records are attached.

- Enter a check mark (✔) for all immunizations given at time of visit.
- Enter a check mark (✔) indicating whether or not patient is up-to-date with immunizations.
- Enter a check mark (✔) if a TB risk assessment was completed.
- Enter a check mark (✔) if a PPD was given/read at time of visit.
  - If PPD given, enter date and a check mark (✔) on *Return for PPD Read.*
  - If PPD read, enter date and indicate result.
- Enter a check mark (✔) if QuantiFERON (QFT)/ Interferon-Gamma Release Assays (IGRA) labs ordered.

C. Dental Assessment and Referral Section

Class I. Enter a check mark (✔) on the *Class I: No Visible Problems* box if the patient has no visible problems and by checking this box you are indicating the patient is being referred for the *mandated annual routine dental referral*.

Class II. Enter a check mark (✔) on the *Class II: Visible decay box* if the patient has visible decay, small carious lesions or gingivitis and by checking this box you are indicating the patient is being referred for a *non-urgent dental care* referral.

Class III. Enter a check mark (✔) on the *Class III: Urgent* box if the patient has pain, abscess, large carious lesions or extensive gingivitis and by checking this box you are indicating the patient is being referred for *immediate treatment due to an urgent dental condition*.

Class IV. Enter a check mark (✔) on the *Class IV: Emergent acute injury* box if the patient has an acute injury, oral infection or other pain and by checking this box you are indicating the patient is being referred for *immediate dental treatment to be seen within 24 hours*.

Fluoride Varnish Applied. Enter a check mark (✔) on the *Yes* box if the patient had fluoride varnish applied during visit on date of service listed above.

- Enter a check mark (✔) on either of the No boxes if parent refused or teeth have not erupted if fluoride varnish was not applied.
- Enter a check mark (✔) on the Other reason box and state reason for not applying fluoride varnish in the space provided.

Dental home referral. Enter a check mark (✔) on the *Dental home referral* box if the patient has no dental home.

Note: A referral for a routine dental visit still needs to be made if the patient has no dental problems (Class I) and is 1 year of age or younger and has erupted teeth. Be sure to check (✔) Class I box.

Referred To and Contact Number. Enter the name and telephone number of the dental provider or agency you referred the patient or enter the patient's dental home provider information.

- If the patient does not have a dental home, be sure to enter a check mark (✔) on the *Dental home referral* box and enter the name and telephone number of the dental provider or agency you referred the patient.

D. Provider Information

Service Location. Enter the following information on the appropriate line:

- Line 1: Business Name
- Line 2: Street address
- Line 3: City, State and nine-digit ZIP code
- Line 4: Telephone number, including area code

A provider stamp is acceptable.

Follow up appointments. Enter a check mark (✔) if a follow up appointment is needed. If so, enter date/time of next appointment, if scheduled. If not scheduled, indicate when the patient should follow-up (i.e. 3 months).

NPI Number. Enter the provider National Provider Identifier (NPI) number in the appropriate line.
Provider Name. Print legibly or type the provider's name that rendered the services.

Provider Signature. Provider or a designated representative must sign.

Date. Enter the date of signature.

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Audiometric Screening Training Registration Form

October 16, 2019

8:30am – 1:00pm

Conference Room

Children's Medical Services

2233 Grand Canal Blvd.,

Ste. 214, Stockton 95207

*Lunch will not be provided

- **Bring your office's audiometers.**
- Fill out one form per participant—please write legibly.
- The training will include instruction on vision screening background and techniques as well as requirements for screening CHDP children.
- There will be a presentation and hands-on practice.
- Any staff from a San Joaquin County CHDP provider office may attend.
- Staff must be certified by CHDP every 4 years.

Registration Deadline: October 8, 2019 (***register early—seating is limited***)

****Participants MUST bring the audiometers used for screening in their offices****

Name: _____ Phone: _____ Email: _____

Office Name: _____ City: _____ Zip: _____

Fax form to: (209) 953-3632

OR

Mail form to: P.O. Box 2009, Stockton, CA 95201-2009

For more information, contact Gwen Callaway, CHDP Health Educator, at 209-468-8918 or gcallaway@sjcphs.org