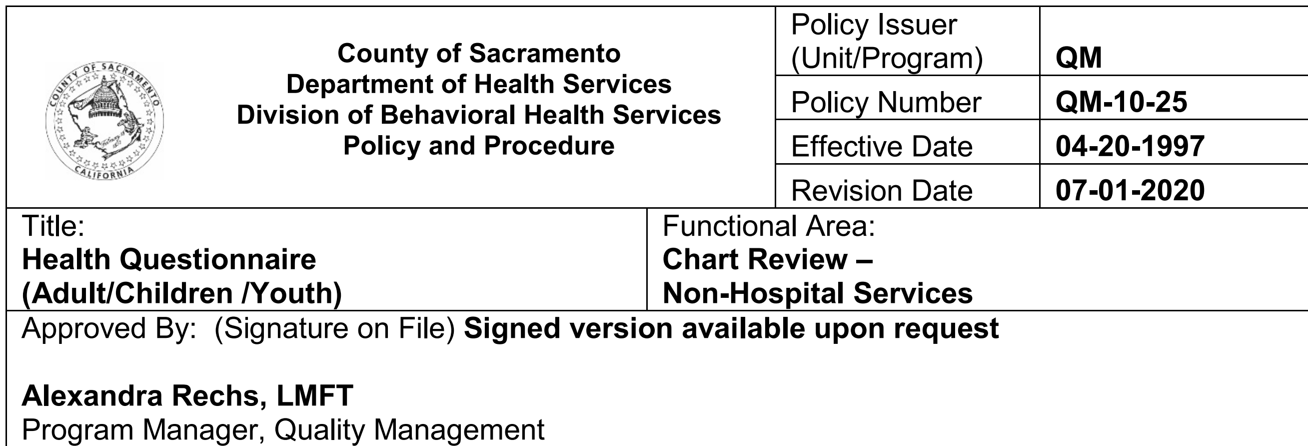

County of Sacramento Department of Health Services Division of Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	**QM**
	Policy Number	**QM-10-25**
	Effective Date	**04-20-1997**
	Revision Date	**07-01-2020**
Title: **Health Questionnaire (Adult/Children /Youth)**	Functional Area: **Chart Review – Non-Hospital Services**	
Approved By: (Signature on File) **Signed version available upon request** **Alexandra Rechs, LMFT** Program Manager, Quality Management		

PURPOSE:

The purpose of the electronic Health Questionnaire (HQ) is to provide an opportunity to review the client's relevant physical health conditions and history as well as review the current source of medical treatment. In addition, the HQ allows the Provider to determine if a referral to a Primary Health Care Provider might be appropriate or warranted.

DETAILS:

Procedure:

1. The two HQ versions, Adult and Child, are driven by selection of the client's age range on the Core Assessment. As an example, if selecting ages 16-24 (Adult), 25-59 or 60+ age range would complete the Adult HQ; while ages 0-5, 6-15 or 16-24 (Child) would select the Child HQ. For legally emancipated Minors (age 15 and up) and minors in Short Term Residential Therapeutic Program (STRTP) placement or foster care ages 16 and up who are 1)mature enough to participate in the services provided and 2) are aware of their physical healthcare history, the clinician/personal service coordinator shall select the age on the Core Assessment that best meets the individual's needs (children/TAY, adult) to enable the HQ based on the client's selected age range (i.e., Ages 16-24 (Adult) and may opt for the completion of the Adult HQ in lieu of the Child/Youth HQ).

2. The completed HQ is part of the Electronic Health Record (EHR) in the Clinical Workstation (CWS) as part of the client's chart.

3. The clinician/personal service coordinator or medication support staff are responsible for having a completed HQ as part of the EHR for all clients initiated upon admission to the Mental Health Plan (MHP) Provider's program. Parents or caregivers may provide the clinician/personal service coordinator with information to complete the HQ. See the *Staff Billing Privileges Matrix* for the classifications that are able to bill the assessment or nursing medication support service codes to capture time spent working on the HQ.

4. The HQ must be completed at start of services within 60 days of the Assessment Start Date, otherwise they risk fiscal disallowance.

5. The provider shall review the HQ with the client and/or parent/caregiver to ensure that all areas are completed and accurate.

6. The HQ update must be completed annually in conjunction with the rest of the clinical bundle. For Programs that are contractually required to request for re-authorization, the process may include

additional steps of submitting the Clinical Bundle including an updated HQ. Refer to the Program's contract for specific requirements.

7. The most recent HQ information may be re-entered upon re-opening a client to the same Provider, if the last HQ had been completed within last 6 months.

8. When current health concerns are evident, the provider refers the client to a Primary Health Care Provider or the attending Psychiatrist for physical evaluation and documents this referral in the Progress Notes.

9. The MHP prohibits inappropriate mental health service referrals to a primary care provider for clients who meet Specialty Mental Health Services' medical necessity criteria. Disputes should be referred to the appropriate county MHP medical director or designee.

Required Reporting Items:

The following items must be addressed in the HQ. These elements are part of the required MHP audit protocol and contract for a complete assessment.

1. Relevant physical health conditions must be identified and updated as appropriate with referral to a Primary Care Physician as needed or appropriate.

2. If the client and/or caregiver indicates that they currently do not have a Primary Care Physician, the provider must make efforts to provide information and support to ensure that linkage has been made.

3. Allergies and adverse reaction(s) to medications, or lack of known allergies.

4. Child/Youth HQ must include pre-natal and peri-natal events and a complete developmental history.

GENERAL PROVISIONS:

The Adult Health Questionnaire (AHQ) shall include the following information.

1. Date
   The date the form is completed. If it takes more than one day to complete the form, this date should reflect the date the form was started.

2. Gender
   This is pre-populated based on the client's identified gender assigned at birth in the, "Update Client Data" section of the chart. Based on this selection, applicable information will be pre-populated by Avatar.

3. Currently seeing a primary physician
   Identify with a "yes' or "no" if the client is currently seeing by a primary physician.

4. Last Doctor Visit
   Indicate the timeframe from the last doctor's visit as reported by the client. In addition, specify the reason for the last doctor visit.

5. ER visits
   Mark either "yes", "no" or "unknown" to identify any ER visits conveyed by the client in the preceding 12 months. Provide details for the ER visits.

6. Last Colon Screening
   Indicate the timeframe from the client's last Colon Screening or if they have never had a Colon Screening.

7. Conditions
   Identify any known medical conditions that the client has ever experienced. Indicate the **onset** and **details** and describe the medical conditions and current treatment the client is receiving.

8. Gender specific questions
   Choose the client's gender specific questions. Provide information describing any existing health conditions, dates (to the best knowledge of the client/caregiver) and current treatments. The gender specific questions are generated based on the client's identified gender assigned at birth in the "Update Client Data" section of the chart.

9. Dental
   Indicate the timeframe from the last visit to the dentist and whether "yes", "no" or "unknown" if the client has any dental problems, ever had oral surgery or has any dental problems.

10. Hearing
    Indicate "yes", "no" or "unknown" if the client has any hearing problems. Provide details on the hearing problems. Indicate the timeframe from the last hearing test and provide details on the hearing test and hearing issues.

11. Vision
    Indicate "yes", "no" or "unknown" if the client has any visual problems, timeframe from the last exam and whether "yes", "no" or "unknown" if the client wears any type of corrective lenses/ contacts, and provide any details on vision problems.

12. Caffeine and Tobacco
    Indicate the client's caffeine intake and/or tobacco intake, select the client's smoking habits and identified tabacco products that the client uses. Solicit whether client is interested in a smoking cessation program. Provide detail on tobacco use.

The Child/Youth Health Questionnaire (CHQ) shall include the following information.

1. Date
   The date the form is completed. If it takes more than one day to complete the form, this date should reflect the date the form was started.

2. Sources of Information/Relationship/Phone
   Identify the name of the person providing the information for the CHQ/Youth form, the relationship to the child and /or other source of information.

3. Last physical
   Provide information related to the child's last physical exam, and provide with date if known.

4. Current weight/length/height
   Provide information related to the child's current length, height and weight at time of completion of this form.

5. Physical growth on target
   Solicit from the parent/caregiver information to describe if the child's physical growth is on target. Mark either "yes", "no" or "unknown".

6. Immunizations up to date

Indicate whether or not the child's immunizations are up to date.

7. General medical conditions
   Select all general medical conditions that the child and caregiver identify. Provide comments on the general medical condition and / or reasons for all unknowns and plan for follow-up. Mark either "yes", "no", or "unknown" to identify any known medical problems or conditions that you feel the doctor should know about. Comment on the medical problems. Indicate "yes", "no", or "unknown" to identify if the child/youth has ever experienced any: history of auto accident and/or injury, broken bones, accident prone, episodes of easy bruising, bleeding or any other medical problems or conditions and any family medical history. Provide comments when applicable or indicate "None" in the comment box.

8. Hospitalization
   Indicate "yes", "no", or "unknown" to identify if the client has had any ER visits. Describe any ER visits and details. Indicate "yes", "no", or "unknown" if client has had recent medical hospitalizations. Describe any past medical (not psychiatric) hospitalizations and reasons the child has been hospitalized. Indicate "yes", "no", or "unknown" if the client has had surgeries. Describe any surgeries providing details. Describe any NICU experiences and specifics.

9. Pregnancy Information
   Indicated circumstances surrounding the mother's health during pregnancy by addressing following areas: Describe if pregnancy was planned and describe any relevant comments on pregnancy planning. Trimester prenatal care was started. Indicate the mother's age at start of pregnancy and duration of pregnancy (months). Describe the mother's health or any known conditions that affected the mother during pregnancy. Indicate if AOD exposure in-utero, and any complications of pregnancy. Indicate if there was any trauma during pregnancy, and it was a premature birth. Mark "unknown" if the information is not known and describe the rationale.

10. Labor/Delivery/Birth History
    Describe the duration of labor, anesthesia used; Describe any medication used during birth. Child's birth weight and length; Amount of time mother and child spent in the hospital; Indicate whether or not the child was breast fed and for how long; and indicate any other difficulties or peculiarities related to the delivery, appearance or behavior at birth or during pregnancy. Indicate the name and address of the hospital.

11. Birthing Complications
    Identify any known birthing complications. Comment and explain in detail any complications as needed.

12. Neonate
    Identify any known problems during the first 30 days of life and describe the neonatal issues. Comment on pregnancy issues as needed.

13. Developmental History
    Indicate the age in which each event occurred and explain if necessary. Indicate if there were any developmental tools used to support client in developmental assessment. Indicate "yes", "no", or "unknown" if the client is meeting developmental milestones or is failure to thrive.

14. Behavior
    Identify any Infant/toddler behaviors known problems during the first 3 years of life. Comment or explain as needed.

15. Dental

Indicate “yes”, “no”, or “unknown” whether or not the child has ever seen the dentist. Enter date (if known) of last exam and timeframe from last visit to the dentist. Indicate and describe if child ever had oral surgery (extractions) or if there are dental problems.

16. Vision
    Indicate “yes”, “no”, or “unknown” if the child has any visual problems, the date and time frame from the last of visual exam. Describe any details of visual problems. Describe whether or not the child wears glasses or contact lenses.

17. Hearing
    Indicate “yes”, “no”, or “unknown” if the child has any hearing problems, and describe the details of hearing problems. Indicate whether or not the child has had a hearing test and the results. Indicate whether or not the child has tubes in his/her ears and/or has chronic hear infections. Indicate if the child wears hearing aids.

REFERENCE(S)/ATTACHMENTS:

- Staff Billing Privileges Matrix

RELATED POLICIES:

- QM-10-26 Core Assessment
- QM 10-29 Mental Status Exam
- QM-10-30 Progress Notes

DISTRIBUTION:

Enter X	DL Name
X	Mental Health Staff
X	Adult Contract Providers
X	Children’s Contract Providers
X	Substance Use Prevention and Treatment
X	DHS Human Resources
	Specific grant/specialty resource

CONTACT INFORMATION:

- Quality Management Information
  QMInformation@saccounty.net