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	**07-01-2022**
Title: **Health Questionnaire – MHP and DMC-ODS (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 beneficiary's relevant physical health conditions and history as well as review the current source of medical treatment. In addition, the HQ allows the Specialty Mental Health Plan (MHP) and/or the Drug Medi-Cal Organized Delivery System (DMC-ODS) Provider to determine if a referral to a Primary Health Care Provider might be appropriate or warranted. Even with the CalAIM documentation reform assessment changes, Medical Conditions and Medications are still required to be addressed during the beneficiary assessment. The HQ will be used to capture the required elements. CalAIM addresses Medical Conditions and Medication under Domain 4 within the Core Assessment and within Dimension 2 on the American Society of Addiction Medicine (ASAM)/Substance Use Disorder (SUD) Assessment.

DETAILS:

Procedure:

1. MHP Providers: The two HQ versions, Adult and Child, are driven by selection of the beneficiary'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 beneficiary'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. DMC-ODS Providers: The Adult HQ is the only one used regardless of age and an age range is not marked.

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

4. The clinician/personal service coordinator or medication support staff are responsible for ensuring the HQ is completed as part of the EHR for all beneficiaries and is initiated upon admission to the MHP and/or DMC-ODS. 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 for assessment or nursing medication support service codes.

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

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

7. The time period for providers to complete an initial Health Questionnaire (HQ) is up to clinical discretion; however, providers shall complete HQ within a reasonable time and in accordance with generally accepted standards of practice. Sacramento County considers it best practice to complete the assessment within 90 days, unless there is documentation of any issues (i.e., acuity, homelessness, difficulty with engagement) that prove to be a barrier to completion. HQ not completed during these timelines will not result in recoupments.

8. New onset problems should be added to the problem list, annual updates to the Health Questionnaire are not required.

Required Reporting Items:

The following items are required elements under CalAIM assessment domains and must be addressed in the HQ.

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

2. Efforts to provide information and support to ensure that linkage has been made. If the beneficiary and/or caregiver indicates that they currently do not have a Primary Care Physician (PCP). If the beneficiary has not had a visit with a PCP within the past twelve (12) months this should be included as an item on the problem list.

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

4. Pre-natal and peri-natal events and a complete developmental history for completion of the Child/Youth HQ.

5. Women's Health History if the beneficiary is pregnant, as required by DMC-ODS.

GENERAL PROVISIONS:

The Adult Health Questionnaire (AHQ) shall include the following information. All areas are optional unless identified as (required).

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 beneficiary's identified gender 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 beneficiary is currently seeing a primary care physician.

4. Last Doctor Visit
   Indicate the timeframe from the last doctor's visit as reported by the beneficiary. 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 beneficiary in the preceding 12 months. Provide details for the ER visits.

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

7. General Medical Conditions **(Required)**
   Identify any known medical conditions (past or present) that the beneficiary has ever experienced. Indicate the **onset** and **details** and describe the medical conditions and current treatment the beneficiary is receiving.

8. Gender specific questions
   Choose the beneficiary's gender specific questions. Provide information describing any existing health conditions, dates (to the best knowledge of the beneficiary/caregiver) and current treatments. The gender specific questions are generated based on the beneficiary's identified gender 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 beneficiary has any dental problems, ever had oral surgery or has any dental problems.

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

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

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

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

7. General medical conditions **(Required)**
   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. Include any over the counter and non-psychiatric medications.

8. Hospitalization
   Indicate "yes", "no", or "unknown" to identify if the beneficiary has had any ER visits. Describe any ER visits and details. Indicate "yes", "no", or "unknown" if beneficiary 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 beneficiary has had surgeries. Describe any surgeries providing details. Describe any NICU experiences and specifics.

9. Pregnancy Information **(Required)**
   Indicate 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 during which prenatal care was started; the mother's age at start of pregnancy and duration of pregnancy (months); mother's health or any known conditions that affected the mother during pregnancy; if AOD exposure in-utero, and any complications of pregnancy; trauma during pregnancy; premature birth. Mark "unknown" if the information is not known and describe the rationale.

10. Labor/Delivery/Birth History **(Required)**
    Indicate the duration of labor, anesthesia used; medication used during birth; child's birth weight and length; amount of time mother and child spent in the hospital; whether or not the child was breast fed and for how long; and 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 **(Required)**
    Identify any known birthing complications. Comment and explain in detail any complications as needed.

12. Neonate **(Required)**
    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 **(Required)**
    Indicate the age in which each event occurred and explain if necessary. Indicate if there were any developmental tools used to support beneficiary in developmental assessment. Indicate "yes", "no", or "unknown" if the beneficiary 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; date and time frame from the last of visual exam; any details of visual problems; whether or not the child wears glasses or contact lenses.

17. Hearing
    Indicate “yes”, “no”, or “unknown” if the child has any hearing problems; 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, or 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
- BHIN 22-019

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:

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