CONTRA COSTA
HEALTH SERVICES

Contra Costa Health Plan

COMMUNITY PROVIDER NETWORK MEETING

Doctors Medical Center - San Pablo

Tuesday, April 20, 2010 7:30 AM to 9:00AM

Administration Conference Room (ACR 1st Floor)
Continental Breakfast will be served

I.	Call to order	D. Dooley, MD
II.	Approval of Minutes	D. Dooley, MD
III.	Medical Director's Report	D. Dooley, MD
	• Quality Management Director	
	• Adult Prevention Guidelines	B. Jacobs, FNP
	• Childhood Obesity Guidelines	D. Dooley, MD
	• Children's Preventive Guidelines	D. Dooley, MD
	• HEDIS/PM160	B. Jacobs, FNP
IV.	Pharmacy Program	Curt Le, Pharmacy Director
V.	Flu Update – Bulletin	B. Jacobs, FNP
	• Varnish update – guidelines	
	• Immunization - VFC	
VI.	Provider Concerns	D. Dooley, MD
VII.	Adjourn	D. Dooley, MD

Next Meeting – July 20, 2010

Administration Conference Room (ACR) is located on the 1st floor near the main entrance. Doctors San Pablo staff have asked that we park in guest and patient parking only. All other areas are permit parking only. *Thank you.*

Please RSVP: (925) 313-9500

CONTRA COSTA HEALTH PLAN
Community Provider Network – Central/East County
Meeting Minutes – April 20, 2010

Attending:
D. Dooley, MD; Beverly Jacobs, FNP; Norman Banks, MD; Olga Eaglin, PA; William Jenkins, MD; Kristof Kaminski, PA; Porshia Mack, MD; John Mahony, MD; Ina McLaughlin, PA; Esther Ruiz, NP; Thomas Smith, MD; Pamela Washington, FNP

Guests: Curt Le, Pharmacy Director

Discussion		Action	Accountable
I.	Meeting called to order at 7:45 am.		D. Dooley, MD
II.	Approval of Minutes: Minutes approved as submitted.		D. Dooley, MD
III.	**Pharmacy Program** • Reviewed formulary additions and changes listed in current Care Matters Provider Bulletin. • Insulin changes. Tru Result diabetic meter covered. Discussion with Community Providers.		Curt Le, Pharmacy Director
IV.	**Medical Director's Report** • Adult/Children's Guidelines - Draft Prevention Guidelines reviewed – current and approved. • Childhood Obesity Guidelines-Reviewed Power Point presentation documentation compiled by Dr. Dooley. Encouraging physical activity. • HEDIS/PM160-CCHP follows AAP recommendations for annual preventive visit. In September, new HEDIS measure. Track on PM160. Picked up electronically and data sent back to CCHP. If not using PM160, place data on screening page. Must be recorded in two places.		D. Dooley, MD
V.	**Flu Update:** • Care Matters article reviewed. CCHP Advice Nurse unit handled over 20,000 calls from members. • H1N1 vaccine still being given. If need more supply, contact Public Health. H1N1stock expires 2011. • New vaccine program in 5 mos. H1N1 Flu in same vaccine. • Varnish Update-Training can be provided to office staff. Contact BJ		B. Jacobs, FNP
VI.	**Provider Concerns:** Will CCHP cover Guardisil for boys?		B. Jacobs, FNP
VII.	**Adjourn:** Meeting adjourned at 9:00 am		D. Dooley, MD

Next meeting – July 27, 2010

CONTRA COSTA HEALTH SERVICES

2009 Prevention Guidelines For Adults

Contra Costa Health Plan and Contra Costa Regional Medical Center

	Age Range	18 to 25	26 to 39	40 to 49	50 to 59	60 to 64	65 to 74	75 +
Testing and Counseling	Periodic Exam Height, Weight, BMI, BP	Check yearly in all adults seen for other health care services. Offer intensive counseling BMI > 30. Treat elevated BP.						
	Alcohol Misuse	Screen and provide behavioral counseling interventions						
	Aspirin			consider for men>40, post-menopausal women, and high risk pts.				
	Cholesterol	High Risk	Men ≥35 HR Women	Screen all adults ≥ 45				
	Colon Cancer				Screen all adults age 50 to 75 years with fecal occult blood testing, sigmoidoscopy, or colonoscopy			Screen 76-85 based on risk and life expectancy Do not screen >85
	Depression Screening	Screen and provide interventions						
	Diabetes screening	Screen asymptomatic adults for diabetes who have sustained blood pressure (treated or untreated) greater than 135/80						
	HIV	Offer testing to all patients 18-65						
	Hepatitis B	Offer testing to all Prenatal and High Risk for chronic hepatitis						
	Tobacco Use	Screen and provide tobacco cessation interventions (see also Pneumovax)						
	Tuberculosis	Screen High Risk (foreign born <5 years after arrival in US, homeless, HIV-infected, IVDU, etc.)						
Vaccinations	Influenza	High Risk or Contact to High Risk			Annually age ≥ 50			
	MMR	All adults born after 1956 or who lack evidence of immunity						Not needed in those born before 1957
	Pneumovax	High Risk (asthma, smokers, COPD, heart failure, diabetes, etc.)						Once. Repeat if given before age 65
	Tetanus Diphtheria (Td) and Tetanus Diptheria Acellular Pertussis (TdaP)	Complete primary series with Td in all. Give Td booster every 10 years or at least at age 50. Give Tdap once in place of regular booster, especially to adult contacts of newborns, such as parents and grandparents. May give Tdap if ≥2 years since last Td booster						
	Varicella---Shingles	Consider giving Varivax to persons born after 1979						Give Zostavax to all adults ≥ 60
Women	Breast Cancer – Mammogram	High Risk		Mammography every 1-2 years after counseling about risks and benefits.				Screen 76-85 based on risk and life-expectancy
	Breast Cancer – BRCA Mutation Testing	Advise genetic counseling for women with family history associated with increased risk for BRCA gene mutations						
	Cervical Cancer – Pap Smear	Screen with pap 3 years after sexual onset. Repeat annually x 2 normals, then every 2-3 years. No pap needed after hysterectomy for benign indication.						May stop age > 65 with 3 normal paps and no new partners
	Chlamydia	≤25 Sexually Active	High Risk					
	HPV Vaccine	Females age 9-26						
	Osteoporosis	High Risk by FRAX calculation www.shef.ac.uk/FRAX/						Routine DEXA ≥ 65
Men	Abdominal Aortic Aneurysm (AAA)							Screen Men who Ever Smoked ≥ 65 Once with Ultrasound
	Prostate Cancer				Age 50-74 No Recommendation			> 75 Do Not Screen

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2009 Prevention Guidelines For Adults

Contra Costa Health Plan and Contra Costa Regional Medical Center

These are minimal standards for health maintenance. Nothing in these guidelines is meant to preclude more extensive screening for people with higher than average risks. These guidelines are not a substitute for clinical judgment.

ALL ADULTS	
History & Physical	**All CCHP Members** need an Initial Health Assessment (IHA) within 120 days of enrollment,which includes 1) complete History and Physical, 2) preventive care, 3) education, 4) counseling, and 5) health risk assessment using the "Staying Healthy" Assessment tool, available in English, Spanish, Chinese, Hmong, Lao, Russian, and Vietnamese, at **http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx**
Height, Weight, BMI, and BP	**All Adults:** Height once, weight annually. Screen for obesity using BMI (Body Mass Index). USPSTF 2006 (B). Screen blood pressure annually. USPSTF 2006 (A).
Alcohol Use	**All Adults:** Screen and offer behavioral counseling interventions to reduce alcohol misuse. USPSTF 2004 (B).
Aspirin	**Men ≥ age 40 years, postmenopausal women, and all with increased coronary heart disease risk (see Cholesterol section):** Discuss aspirin chemoprevention benefits and harms. USPSTF 2002 (A).
Cholesterol	**Men: age ≥35, Women: ≥45:** Screen cholesterol. USPSTF 2006 (A). **High Risk: Men 20-34; Women 20-44:** Screen cholesterol. USPSTF 2006 (B). Screen Coronary Heart Disease (CHD) Risk equivalent patients who have the following conditions: ▪ Abdominal aortic aneurysm ▪ Clinical CHD ▪Diabetes ▪ Symptomatic carotid artery disease ▪Peripheral arterial disease Calculate risk in adults with 2 or more of the following Major Risk Factors: ▪Age (men 45 years; women 55 years) ▪Cigarette smoking ▪Family history of premature CHD (CHD in male first degree relative <55 years; CHD in female first degree relative <65 years) ▪Hypertension (BP 140/90 **OR** on treatment with antihypertensive medication) ▪Low HDL cholesterol (<40) ▶ HDL < 60 mg/dL counts as a "negative" risk factor Screen High risk every ≤ 1 year, Moderate risk q 2 years, Low risk q 5 years. NCEP 2002 (expert opinion).
Colon Cancer	**All adults age 50-75:** recommend screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy ages 50-75 years. The risks and benefits of these screening methods vary. USPSTF 2008 (A) **Adults age 76-85:** screening decision depends on life-expectancy and risk. USPSTF 2008 (C). **Adults older than 85:** recommend against screening. USPSTF 2008 (D). **High risk adults** first degree relative with colon cancer before age 60, or 2 first degree relatives with colon cancer at any age start screening earlier.
Depression	**All adults:** screen for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and followup. USPSTF 2002 (B)
Diabetes Screen	**Adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg:** screen for type 2 diabetes. USPSTF 2008 (B)
HIV	**All ages 13-64:** Screen regardless of risk factors. CDC 2006. USPSTF 2007 (C) neither recommends for nor against screening normal risk adults. **Adults at High risk for HIV infection:** Screen annually. USPSTF 2006 (A). **Pregnant women:** Screen at entry to prenatal care. USPSTF 2006 (A).
Hepatitis B	**Pregnant women:** Screen at entry to prenatal care. USPSTF 2004 (A). **Adults at High Risk for Chronic Hepatitis B, CDC 2008 (Expert Opinion):** ▪ persons born in geographic regions with HBsAg prevalence of ≥2% (Asia, Africa, Eastern Europe, the Middle East, and the Pacific Islands) ▪ US born persons not vaccinated as infants whose parents were born in geographic regions with HBsAg prevalence of ≥8% ▪ injection-drug users ▪ men who have sex with men ▪ persons with elevated ALT/AST of unknown etiology ▪ persons with selected medical conditions who require immunosuppressive therapy **NOTE:** if adults at high risk do not have Hepatitis B, the CDC/ACIP recommends vaccinating them with the 3 dose series of Hepatitis B vaccine.

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Tobacco Use	**All Adults:** Screen all adults and provide tobacco cessation interventions, especially for pregnant women. Document Tobacco use status. Counsel current and recent tobacco users periodically about quitting. USPSTF 2006 (A).
Tuberculosis	**Adults at High Risk:** Foreign born (especially China, India, Mexico, the Philippines, and Vietnam) who have resided in the US < 5 years, HIV-infected, Homeless, IVDU, persons in correctional facilities. CDC 2005 (expert opinion).
IMMUNIZATIONS	
Influenza	**All adults 50 and older, all prenatal patients, and those at high risk** (those with chronic disease such as asthma, diabetes, heart disease, those in contact with children under 5 years, especially parents of newborns, and those in contact with people at high risk, such as caregivers and healthcare workers): Offer Influenza (Flu) vaccine annually. CDC/ACIP 2008 (expert opinion)
Measles, Mumps, Rubella (MMR)	**All adults born after 1956 who lack evidence of immunity:** Offer MMR vaccine. CDC/ACIP 2006 (expert opinion).
Pneumonia (Pneumovax)	**All adults 65 and older, and to all adults at increased risk for pneumococcal disease, including all people who use tobacco, or who have asthma, chronic renal disease, HIV, malignancies, or are on steroid treatment:** Offer 23 valent Pneumovax. CDC/ACIP 2008 (expert opinion).
Tetanus–Diphtheria (Td) Td–acellular Pertussis (Tdap=Adacel/Boostrix)	**All Adults:** Complete primary series of Tetanus toxoids (Td). Give tetanus boosters every 10 years or once at age 50. Give Td rather than Tdap if Tdap is not available, and for adults who already received Tdap, adults 65 years of age and older. **All persons ages 11-64:** Offer a SINGLE one-time dose of Tdap (ADACEL or BOOSTRIX) to substitute for one of the Td boosters, especially persons in contact with newborns. May give TdaP if ≥2 years after last Td booster. CDC/ACIP 2006 (expert opinion).
Varicella and Shingles (Varivax & Zostavax)	**All persons born in the United States after 1979, without evidence of immunity to varicella**: give varicella vaccine. Evidence of immunity includes any of the following: ▪ Documentation of two doses of varicella vaccine ▪ Blood tests that confirm immunity to varicella ▪ Born in the United States before 1980 **Health-care workers, pregnant women, and immunocompromised persons:** Evidence of immunity requires: ▪ Receipt from a healthcare provider of a) a diagnosis of chickenpox or b) verification of a history of chickenpox ▪ Receipt from a healthcare provider of a) a diagnosis of herpes zoster (shingles), or b) verification of a history of herpes zoster (shingles). **Shingles vaccine for All adults 60 and over:** Offer single dose. CDC/ACIP 2008 (expert opinion).
WOMEN	
Breast Cancer - Mammography	**Women ages 40-69: Screening** mammography every 1-2 years, with or without Clinical Breast Exam (CBE). Continue >69 depending on risks and life expectancy. USPSTF 2002 (B). *[NOTE: DHCS recommends clinical breast exams annually for women ≥40 years of age.]*
Breast Cancer – BRCA Mutation Genetic Counseling	**Women with family history associated with high risk for BRCA 1 or BRCA 2 genes:** Refer for genetic counseling and evaluation for BRCA test. ▪ Breast cancer diagnosed at an early age ▪ Bilateral breast cancer ▪ History of both breast and ovarian cancer ▪ Presence of breast cancer in one or more male family members ▪ Multiple cases of breast cancer in the family ▪ Both breast and ovarian cancer in the family ▪ One or more family members with two primary cancers ▪ Ashkenazi Jewish background. **Normal risk women:** Screening not recommended. USPSTF 2006 (B).
Cervical Cancer - Pap Smear	**Women 3 years after the onset of sexual activity or age 21-65:** Pap smears annually. After two normal annual Pap smears, repeat every 2-3 years. May stop in women age > 65 with 3 consecutive normal results or after hysterectomy for benign indications. USPSTF 2006 (A).

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Chlamydia	**All sexually active women age ≤25:** Screen for Chlamydia. Use urine testing if the patient is not scheduled for pelvic examination. USPSTF 2006 (A), CDC - STD 2006.
Human Papilloma Virus Vaccine (HPV)	**Females age 9 to 26:** Offer to those who have not been previously vaccinated or who have not completed the full series. CDC/ACIP 2006 (expert opinion).
Osteoporosis	**All women aged ≥ 65 and high risk women starting at age 60:** Determine risk using online FRAX calculator at http://www.shef.ac.uk/FRAX/ **High Risk**= FRAX risk for hip fracture >3%, or for non-vertebral fracture >20% Screen using DEXA or bone densitometry testing. USPSTF 2002 (B).
MEN	
Abdominal Aortic Aneurysm (AAA)	**Men aged 65 to 75 who have ever smoked:** Screen once for Abdominal Aortic Aneurysm with ultrasonography. USPSTF 2005 (B).
Prostate Cancer	**Men younger than age 75: No recommendation.** Evidence insufficient that screening or treatment benefits men with prostate cancer. Discuss and document discussion of prostate cancer screening with men 50 years or older, and earlier with high risk patients as appropriate. USPSTF 2008 (I). **Men age ≥75: Recommend against screening.** USPSTF 2008 (D)

The U.S. Preventive Services Task Force Ratings (USPSTF)

USPSTF grades its recommendations according to one of five classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms). CCHP and CCRMC generally recommend interventions with grade A or B ratings, and recommend against interventions with grade D ratings.

A.— The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. *The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.*

B.— The USPSTF recommends that clinicians provide [the service] to eligible patients. *The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.*

C.— The USPSTF makes no recommendation for or against routine provision of [the service]. *The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.*

D.— The USPSTF recommends against routinely providing [the service] to asymptomatic patients. *The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.*

I.— The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. *Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.*

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REFERENCE INTERNET CITATIONS

- U.S. Preventive Services Task Force: Grade Definitions after May 2007. Accessed 4 March 2009 at http://www.ahrq.gov/clinic/uspstf/gradespost.htm#drec
- National Institutes of Health. National Heart, Lung, and Blood Institute. National Cholesterol Education Program. Detection, Evaluation and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). 2002. Accessed 4 March 2009 at http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3_rpt.htm
- Centers for Disease Control and Prevention. Controlling Tuberculosis in the United States. Accessed 4 March 2009 at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5412a1.htm
- Centers for Disease Control and Prevention. 2006 Sexually Transmitted Disease Treatment Guidelines. Accessed 4 March 2009 at http://www.cdc.gov/std/treatment/default.htm
- Centers for Disease Control and Prevention. Testing and Public Health Management of Persons With Chronic Hepatitis B Virus Infection. Accessed 4 March 2009 at http://www.cdc.gov/hepatitis/HBV/TestingChronic.htm
- Centers for Disease Control and Prevention. Advisory Committee on Immunization Practices (ACIP). Recommended Adult Immunization Schedule 2009. Accessed 4 March 2009 at http://www.cdc.gov/mmwr/PDF/wk/mm5753-Immunization.pdf
- "Staying Healthy" Assessment Resources. State of California, Department of Health Services, Office of Clinical Preventive Medicine. Accessed 4 March 2009 at http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

ADULT PREVENTION GUIDELINES GROUP

The Prevention Guidelines for Adults Group consisted of CCRMC primary providers and CCHP medical consultants. The guideline was approved at CCRMC's Ambulatory Policy Committee in April 2009, sent out in draft form to all CCRMC and CPN primary providers for further comments, and approved in its final form at CCHP's July 2009 Quality Council.

Participants included: Jan Diamond MD, Troy Kaji MD, and John Lee MD.
Reviewers included: CCHP Quality Council, CCRMC Ambulatory Policy Committee, Ann Harvey MD, Erika Jenssen, MPH, Sharon Jones MD, Laura Miller, RN, NP, John Yu MD, J. Gene Zimmerman MD

For further inquiries about this clinical guideline, please contact Troy Kaji MD at tkaji@hsd.cccounty.us

Newborn to 30 Month Checkups

DRAFT

Screening Requirements	under 1 week	1 mo.	2 mo.	4 mo.	6 mo.	9 mo.	12 mo.	15 mo.	18 mo.	24 mo.	30 mo.
History & Physical Examination	X	X	X	X	X	X	X	X	X	X	X
Dental Screening	X	X	X	X	X	X	X	X	X	Refer	
Developmental-Behavioral Assessment	X	X	X	X	X	X	X	X	X	X	X
Height, Weight, & Head/BMI (24+ mo.)	X	X	X	X	X	X	X	X	X	BMI	BMI
Nutritional Assessment = N WIC Assessment/Referral = W	Assess and refer at each visit										
Anticipatory Guidance	X	X	X	X	X	X	X	X	X	X	X
IHEBA									X	X	X
Physical Activity Assessment/Counseling	X	X	X	X	X	X	X	X	X	X	X
Safety Counseling	Assess at each visit										
Update Immunization Status	Assess at each visit										
Vision & Hearing Screening	Assess at each visit - Test as needed										
Patients at Risk											
Blood Lead Risk Assessment							X				
Blood Test for Lead							X			X	
Blood Test for Hemoglobin level						X		X		X	X
Cholesterol Screening										Assess	
Secondhand Smoke Exposure	Assess and Counsel at each visit										
TB Risk Assessment			Assess				Administer TB test if needed				
Ages	under 1 week	1 mo.	2 mo.	4 mo.	6 mo.	9 mo.	12 mo.	15 mo.	18 mo.	24 mo.	30 mo.

REFERENCES

- American Academy of Pediatrics, Recommendations for Preventive Pediatric Health Care. PEDIATRICS Vol. 105 No. 3 March 2000, pp. 645-646
- CHDP - Children's Medical Services. Health Assessment Guidelines, Revised April 24, 2001.
- MMWR. Recommended Immunization Schedules for persons aged 0-18 years-United States, 2007.
- Pickering LK, ed. Red Book: 2006 Report of the Committee of Infectious Disease. 27th ed. Elk Grove Village, IL: American Academy of Pediatrics, 2006.

- Child who ~~have~~ has not received all the recommended screenings/tests/procedures at an earlier age should be brought up to date as appropriate.
- Review immunization status at all visits. Administer immunization per the American Academy of Pediatrics Immunization schedule.

DRAFT

Children Adolescence: 3 - 20 Year Checkups

Screening Requirements	3 yr	4 yr	5 yr	6 yr	7-8 yr	9-10 yr	11 yr	12 yr	13 yr	14 yr	15 yr	16 yr	17-20 yr
History & Physical Exam	X	X	X	X	X	X	X	X	X	X	X	X	X
Dental Screening/Referral	Refer												
Developmental-Behavioral Assessment	Assess at every visit												
Anticipatory Guidance	Age appropriate												
Healthy Education Behavioral Assessment			X		X			X	X	X	X	X	X
Height, Weight, Blood Pressure, BMI	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutritional Assessment/ Counseling = N WIC Assessment/Referral = W	WIC	WIC	N	N	N	N	N	N	N	N	N	N	N
Physical Activity Assessment/Counseling	Assess and Counsel at each visit												
Safety Counseling	Assess and Counsel at each visit												
Update Immunization Status	Assess at each visit												
Urine Dipstick			X					Test if symptomatic / sexually active					
Vision & Hearing Screening	X	X	X	X	X	X	X	X	X	X	X	X	X
Patients at Risk													
Blood Test & Risk Assessment for Lead	X	X	X										
Cholesterol Screening													
Blood Test for Hemoglobin level	X	X			Annually for menstruating patients						X	X	X
Secondhand Smoke Exposure	X	X	X	X	X	X	X						
TB Risk Assessment/Test								Assess & Administer skin test as needed					
Sexually Active Females													
Screen for STD/Chlamydia/HIV								Annually if sexually active					
Folic Acid Supple Nutrition													
Pap Smear								If sexually active for 3 years					
Ages	3 yr	4 yr	5 yr	6 yr	7-8 yr	9-10 yr	11 yr	12 yr	13 yr	14 yr	15 yr	16 yr	17-20 yr

2007 AMA Expert Committee Recommendations:

Assessment, Prevention &Treatment of Child & Adolescent Overweight

ROLE OF THE PROVIDER:

- **Screen weight status using BMI percentile**
- **Deliver obesity prevention messages to all children/adolescents *(regardless of weight)***
- **Order appropriate laboratory tests**
- **Follow-up and /or refer**

2/10 ACadiz, MS, RD

Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity - 2007

- An Implementation Guide from the Childhood Obesity Action Network -

Overview:

In 2005, the AMA, HRSA and CDC convened an Expert Committee to revise the 1997 childhood obesity recommendations. Representatives from 15 healthcare organizations submitted nominations for the experts who would compose the three writing groups (assessment, prevention, treatment). The initial recommendations were released on June 6, 2007 in a document titled "Appendix: Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity" (www.ama-assn.org/ama/pub/category/11759.html)

In 2006, the National Initiative for Children's Healthcare Quality (NICHQ) launched the Childhood Obesity Action Network (COAN). With more than 40 healthcare organizations and 600 health professionals, the network is aimed at rapidly sharing knowledge, successful practices and innovation. This Implementation Guide is the first of a series of products designed for healthcare professionals by COAN to accelerate improvement in the prevention and treatment of childhood obesity.

The Implementation Guide combines key aspects of the Expert Committee Recommendations summary released on June 6, 2007 and practice tools identified in 2006 by NICHQ from primary care groups that have successfully developed obesity care strategies (www.NICHQ.org). These tools were developed before the 2007 Expert Recommendations and there may be some inconsistencies such as the term *overweight* instead of *obesity* for BMI ≥ 95%ile. The tools are intended as a source of ideas and to facilitate implementation. As tools are updated or new tools developed based on the Expert Recommendations, the Implementation Guide will be updated. The Implementation Guide defines 3 key steps to the implementation of the 2007 Expert Committee Recommendations:

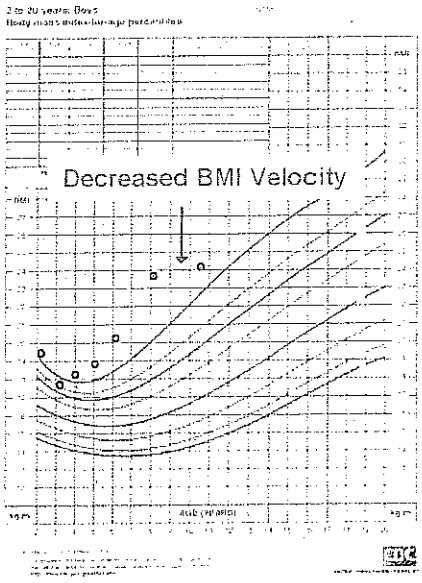
- **Step 1 – Obesity Prevention at Well Care Visits** (Assessment & Prevention)
- **Step 2 – Prevention Plus Visits** (Treatment)
- **Step 3 – Going Beyond Your Practice** (Prevention & Treatment)

Step 1 – Obesity Prevention at Well Care Visits (Assessment & Prevention)

Action Steps	Expert Recommendations	Action Network Tips and Tools
Assess all children for obesity at all well care visits 2-18 years	Physicians and allied health professional should perform, at a minimum, a yearly assessment.	A presentation for your staff and colleagues can help implement obesity prevention in your practice.
Use Body Mass Index (BMI) to screen for obesity	▪ **Accurately measure height and weight** ▪ **Calculate BMI** BMI (English):[weight (lb) ÷ height (in) ÷ height (in)] x 703 BMI (metric):[weight (kg) ÷ height (cm) ÷ height (cm)] x 10,000 ▪ **Plot BMI on BMI growth chart** ▪ Not recommended: skinfold thickness, waist circumference	BMI is very sensitive to measurement errors, particularly height. Having a standard measurement protocol as well as training can improve accuracy. BMI calculation tools are also helpful. Use the CDC BMI %ile-for-age growth charts.
Make a weight category diagnosis using BMI percentile	▪ < 5%ile Underweight ▪ 5-84%ile Healthy Weight ▪ 85-94%ile Overweight ▪ 95-98%ile Obesity ▪ ≥ 99%ile	Until the BMI 99%ile is added to the growth charts, Table 1 can be used to determine the 99%ile cut-points. **Physicians should exercise judgement when choosing how to inform the family. Using more neutral terms such as *weight, excess weight, body mass index, BMI, or risk for diabetes and heart disease* can reduce the risk of stigmatization or harm to self-esteem.**
Measure blood pressure	▪ Use a cuff large enough to cover 80% of the upper arm ▪ Measure pulse in the standard manner	Diagnose hypertension using NHLBI tables. An abbreviated table is shown below (Table 2).
Take a focused family history	▪ Obesity ▪ Type 2 diabetes ▪ Cardiovascular disease (hypertension, cholesterol) ▪ Early deaths from heart disease or stroke	A child with one obese parent has a 3 fold increased risk of becoming obese. This risk increases to 13 fold with 2 obese parents. Using a clinical documentation tool can be helpful.

Take a focused review of systems	Take a focused review of systems	See Table 3. Using a clinical documentation tool can be helpful.
Assess behaviors and attitudes	**Diet Behaviors** ▪ Sweetened-beverage consumption ▪ Fruit and vegetable consumption ▪ Frequency of eating out and family meals ▪ Consumption of excessive portion sizes ▪ Daily breakfast consumption **Physical Activity Behaviors** ▪ Amount of moderate physical activity ▪ Level of screen time and other sedentary activities **Attitudes** ▪ Self-perception or concern about weight ▪ Readiness to change ▪ Successes, barriers and challenges	Using behavioral risk assessment tools can facilitate history taking and save clinician time.
Perform a thorough physical examination	Perform a thorough physical examination	See Table 3. Using a clinical documentation tool can be helpful.
Order the appropriate laboratory tests	**BMI 85-94%ile Without Risk Factors** ▪ Fasting Lipid Profile **BMI 85-94%ile Age 10 Years & Older With Risk Factors** ▪ Fasting Lipid Profile ▪ ALT and AST ▪ Fasting Glucose **BMI ≥ 95%ile Age 10 Years & Older** ▪ Fasting Lipid Profile ▪ ALT and AST ▪ Fasting Glucose ▪ Other tests as indicated by health risks	Consider ordering ALT, AST and glucose tests beginning at 10 years of age and then periodically (every 2 years). Provider decision support tools can be helpful when choosing assessment and treatment options. Delivering lab results can be one way to open the conversation about weight and health with a family.
Give consistent evidence-based messages for all children regardless of weight	▪ Limit sugar-sweetened beverages ▪ Eat at least 5 servings of fruits and vegetables ▪ Moderate to vigorous physical activity for at least 60 minutes a day ▪ Limit screen time to no more than 2 hours/day ▪ Remove television from children's bedrooms ▪ Eat breakfast every day ▪ Limit eating out, especially at fast food ▪ Have regular family meals ▪ Limit portion sizes	An example from the Maine Collaborative: ▪ 5 fruits and vegetables ▪ 2 hours or less of TV per day ▪ 1 hour or more physical activity ▪ 0 servings of sweetened beverages Exam and waiting room posters and family education materials can help deliver these messages and facilitate dialogue. Encourage an authoritative parenting style in support of increased physical activity and reduced TV viewing. Discourage a restrictive parenting style regarding child eating. Encourage parents to be good role models and address as a family issue rather than the child's problem.
Use Empathize/Elicit - Provide - Elicit to improve the effectiveness of your counseling	Assess self-efficacy and readiness to change. Use Empathize/Elicit - Provide - Elicit to improve the effectiveness of your counseling. **Empathize/Elicit** ▪ Reflect ▪ What is your understanding? ▪ What do you want to know? ▪ How ready are you to make a change (1-10 scale)? **Provide** ▪ Advice or information ▪ Choices or options **Elicit** ▪ What do you make of that? ▪ Where does that leave you?	A possible dialogue: **Empathize/Elicit** "Yours child's height and weight may put him/her at increased risk for developing diabetes and heart disease at a very early age." "What do make of this?" "Would you be interested in talking more about ways to reduce your child's risk?" **Provide** "Some different ways to reduce your child's risk are…" "Do any of these seem like something your family could work on or do you have other ideas?" **Elicit** "Where does that leave you?" "What might you need to be successful?" Communication guidelines can helpful when developing communication skills.

Step 2 – Prevention Plus Visits (Treatment)

Action Steps	Expert Recommendations	Action Network Tips and Tools
Develop an office based approach for follow up of overweight and obese children	A staged approach to treatment is recommended for ages 2-19 whose BMI is 85-94%ile with risk factors and all whose BMI is ≥ 95%ile. In general, treatment begins with Stage 1 Prevention Plus (Table 4) and progresses to the next stage if there has been no improvement in weight/BMI or velocity after 3-6 months and the family is willing/ready. The recommended weight loss targets are shown in Table 5. **Stage 1 - Prevention Plus** ▪ Family visits with physician or health professional who has had some training in pediatric weight management/behavioral counseling. ▪ Can be individual or group visits. ▪ Frequency - individualized to family needs and risk factors, consider monthly. ▪ **Behavioral Goals** – – Decrease screen time to 2 hr/day or fewer – No sugar-sweetened beverages – Consume at least 5 servings of fruits and vegetables daily – Be physically active 1 hour or more daily – Prepare more meals at home as a family (the goal is 5-6 times a week) – Limit meals outside the home – Eat a healthy breakfast daily – Involve the whole family in lifestyle changes – More focused attention to lifestyle changes and more frequent follow-up distinguishes Prevention Plus from Prevention Counseling ▪ **Weight Goal** – weight maintenance or a decrease in BMI velocity. The long term BMI goal is <85%ile although some children can be healthy with a BMI 85-94%ile. ▪ Advance to Stage 2 (Structured Weight Management) if no improvement in weight/BMI or velocity in 3-6 months and family willing/ready to make changes.	Prevention Plus visits may include: ▪ Health education materials ▪ Behavioral risk assessment and self-monitoring tools ▪ Action planning and goal setting tools ▪ Clinical documentation tools ▪ Counseling protocols ▪ Other health professionals such as dietitians, psychologists and health educators Besides behavioral and weight goals, improving self-esteem and self efficacy (confidence) are important outcomes. Although weight maintenance is a good goal, more commonly, a slower weight gain reflected in a decreased BMI velocity is the outcome seen in lower intensity behavioral interventions such as Prevention Plus. Measuring and plotting BMI after 3-6 months is an important step to determine the effectiveness of obesity treatment. 
Use motivational interviewing at Prevention Plus visits for ambivalent families and to improve the success of action planning	Use patient-centered counseling – motivational interviewing	Research suggests that motivational interviewing may be an effective approach to address childhood obesity prevention and treatment. Motivational interviewing is particularly effective for ambivalent families but can also be used for action planning. Instead of telling patients what changes to make, you elicit "change talk" from them, taking their ideas, strengths, and barriers into account. Communication guidelines and communication training can be helpful with skill development.
Develop a reimbursement strategy for Prevention Plus visits		Coding strategies can help with reimbursement for Prevention Plus visits. Advocacy through professional organizations to address reimbursement policies is another strategy.

Step 3 – Going Beyond Your Practice (Prevention & Treatment)

Action Steps	Expert Recommendations	Action Network Tips and Tools
Advocate for improved access to fresh fruits and vegetables and safe physical activity in your community and schools	The Expert Committee recommends that physicians, allied healthcare professionals, and professional organizations advocate for: ▪ The federal government to increase physical activity at school through intervention programs as early as grade 1 through the end of high school and college, and through creating school environments that support physical activity in general. ▪ Supporting efforts to preserve and enhance parks as areas for physical activity, informing local development initiatives regarding the inclusion of walking and bicycle paths, and promoting families' use of local physical activity options by making information and suggestions about physical activity alternatives available in doctors' offices.	Physicians and health professionals can play a key role in advocating for policy and built environment changes to support healthy eating and physical activity in communities, child care settings, and schools (including after-school programs). Advocacy tools and resources can be helpful in advocacy efforts. Partnering with others and using evidence-based strategies are also critical to the success of multi-faceted community interventions.
Identify and promote community services which encourage healthy eating and physical activity	Promote physical activity at school and in child care settings (including after school programs), by asking children and parents about activity in these settings during routine office visits.	Public Health Departments and Parks and Recreation are good places to start looking for community programs and resources. You can work on developing your own partnerships with community organizations (Physical Activity Directory template and/or referral forms).
Identify or develop more intensive weight management interventions for your families who do not respond to Prevention Plus	The Expert Committee recommends the following staged approach for children between the ages of 2 and 19 years whose BMI is 85-94%ile with risk factors and all whose BMI is ≥ 95%ile: ▪ **Stage 2 - Structured Weight Management** (Family visits with physician or health professional specifically trained in weight management. Monthly visits can be individual or group.) ▪ **Stage 3 - Comprehensive, Multidisciplinary Intervention** (Multidisciplinary team with experience in childhood obesity. Frequency is often weekly for 8-12 weeks with follow up.) ▪ **Stage 4 - Tertiary Care Intervention** (Medications - sibutramine, orlistat, Very-low-calorie diets, weight control surgery - gastric bypass or banding.) Recommended for select patients only when provided by experienced programs with established clinical or research protocols. Gastric banding is in clinical trials and not currently FDA approved.	Stage 2 could be done without a tertiary care center if community professionals from different disciplines collaborated. For example, if a physician provided the medical assessment, a dietitian provided classes, and the local YMCA provided an exercise program. Partnering with your community tertiary care center can be an effective strategy to develop or link to more intensive weight management interventions (Stages 3 and 4) as well as referral protocols to care for families who do not respond to Prevention Plus visits. Provider decision support tools can be helpful when choosing appropriate treatment and referral options. Weight management protocols and curriculum can also be helpful when getting started.
Join the Childhood Obesity Action Network to learn from your colleagues and accelerate progress		The Childhood Obesity Action Network has launched "The Healthcare Campaign to Stop the Epidemic." Join the network (www.NICHQ.org) to learn from our national obesity experts, share what you have learned and access the tools in this guide. *Together we can make a difference!*

Implementation Guide Authors: Scott Gee, MD, Victoria Rogers, MD, Lenna Liu, MD, MPH, Jane McGrath, MD
Implementation Guide Contact: obesity@nichq.org

Table 1 – BMI 99%ile Cut-Points (kg/m^2)

Age (Years)	Boys	Girls
5	20.1	21.5
6	21.6	23.0
7	23.6	24.6
8	25.6	26.4
9	27.6	28.2
10	29.3	29.9
11	30.7	31.5
12	31.8	33.1
13	32.6	34.6
14	33.2	36.0
15	33.6	37.5
16	33.9	39.1
17	34.4	40.8

Table 2 – Abbreviated NHLBI Blood Pressure Table

Blood Pressure 95% by Age, Sex and Height %

AGE	BOYS HEIGHT %		GIRLS HEIGHT %	
	50%	90%	50%	90%
2 Yr	106/61	109/63	105/63	108/65
5 Yr	112/72	115/74	110/72	112/73
8 Yr	116/78	119/79	115/76	118/78
11 Yr	121/80	124/82	121/79	123/81
14 Yr	128/82	132/84	126/82	129/84
17 Yr	136/87	139/88	129/84	131/85

Pediatrics Vol. 114 No. 2 August 2004 pp. 555-576

Table 3 – Symptoms and Signs of Conditions Associated with Obesity

Symptoms	Signs
➢ **Anxiety, school avoidance, social isolation** (Depression) ➢ **Polyuria, polydipsia, weight loss** (Type 2 diabetes mellitus) ➢ **Headaches** (Pseudotumor cerebri) ➢ **Night breathing difficulties** (Sleep apnea, hypoventilation syndrome, asthma) ➢ **Daytime sleepiness** (Sleep apnea, hypoventilation syndrome, depression) ➢ **Abdominal pain** (Gastroesophageal reflux, Gall bladder disease, Constipation) ➢ **Hip or knee pain** (Slipped capital femoral epiphysis) ➢ **Oligomenorrhea or amenorrhea** (Polycystic ovary syndrome)	➢ **Poor linear growth** (Hypothyroidism, Cushing's, Prader-Willi syndrome) ➢ **Dysmorphic features** (Genetic disorders, including Prader--Willi syndrome) ➢ **Acanthosis nigricans** (NIDDM, insulin resistance) ➢ **Hirsutism and Excessive Acne** (Polycystic ovary syndrome) ➢ **Violaceous striae** (Cushing's syndrome) ➢ **Papilledema, cranial nerve VI paralysis** (Pseudotumor cerebri) ➢ **Tonsillar hypertrophy** (Sleep apnea) ➢ **Abdominal tenderness** (Gall bladder disease, GERD, NAFLD) ➢ **Hepatomegaly** (Nonalcoholic fatty liver disease (NAFLD)) ➢ **Undescended testicle** (Prader-Willi syndrome) ➢ **Limited hip range of motion** (Slipped capital femoral epiphysis) ➢ **Lower leg bowing** (Blount's disease)

Table 4 – A Staged Approach to Obesity Treatment

	BMI 85-94%ile No Risks	BMI 85-94%ile With Risks	BMI 95-98%ile	BMI >= 99%ile
Age 2-5 Years	Prevention Counseling	**Initial:** Stage 1 **Highest:** Stage 2	**Initial:** Stage 1 **Highest:** Stage 3	**Initial:** Stage 1 **Highest:** Stage 3
Age 6-11 Years	Prevention Counseling	**Initial:** Stage 1 **Highest:** Stage 2	**Initial:** Stage 1 **Highest:** Stage 3	**Initial:** Stage 1-3 **Highest:** Stage 3
Age 12-18 Years	Prevention Counseling	**Initial:** Stage 1 **Highest:** Stage 3	**Initial:** Stage 1 **Highest:** Stage 4	**Initial:** Stage 1-3 **Highest:** Stage 4

Stage 1	Prevention Plus	Primary Care Office
Stage 2	Structured Weight Management	Primary Care Office with Support
Stage 3	Comprehensive, Multidisciplinary Intervention	Pediatric Weight Management Center
Stage 4	Tertiary Care Intervention	Tertiary Care Center

Table 5 – Weight Loss Targets

	BMI 85-94%ile No Risks	BMI 85-94%ile With Risks	BMI 95-98%ile	BMI >= 99%ile
Age 2-5 Years	Maintain weight velocity	Decrease weight velocity or weight maintenance	Weight maintenance	Gradual weight loss of up to 1 pound a month if BMI is very high (>21 or 22 kg/m2)
Age 6-11 Years	Maintain weight velocity	Decrease weight velocity or weight maintenance	Weight maintenance or gradual loss (1 lb per month)	Weight loss (average is 2 pounds per week)*
Age 12-18 Years	Maintain weight velocity. After linear growth is complete, maintain weight	Decrease weight velocity or weight maintenance	Weight loss (average is 2 pounds per week)*	Weight loss (average is 2 pounds per week)*

* Excessive weight loss should be evaluated for high risk behaviors

CONTRA COSTA
HEALTH SERVICES

MEMORANDUM

CONTRA COSTA
PUBLIC HEALTH
CHILD HEALTH & DISABILITY
PREVENTION PROGRAM
597 Center Avenue, Suite 280
Martinez, California
94553-4670
PH 925 313-6150
FAX 925 313-6160

DATE: January 25, 2010

TO: CHDP Providers

FROM: Annabelle Cadiz, MS, RD
Senior Public Health Nutritionist

SUBJECT: **CHDP Provider Memo # 321**
TIP SHEET - Glucose & Cholesterol Screening; Referral & Care Management for Children ≥ 5 Years of Age & BMI ≥ 85%ile

The prevalence of childhood overweight and obesity has been increasing at an alarming rate in Contra Costa County as evidenced by Contra Costa's rank of third highest amongst other Bay Area counties for children 5 - < 20 yrs. according to PedNSS, 2008. Childhood overweight has significant adverse effects on the present and future health of children and adolescents. The most common clinical conditions associated with childhood overweight are type 2 diabetes and dyslipidemia.

CHDP Provider Information Notice (PIN) No.: 05-16

The purpose of this Provider Information Notice is to ensure that overweight children and adolescents are screened for the above mentioned common clinical conditions with the addition of two screening tests, namely- fasting blood glucose and cholesterol as added CHDP benefits. The CHDP recommended screening age starts at age five years and older, and this is much earlier than 10 years old as per the AMA Expert Committee Guidelines-2007.

Tip Sheet

The tip sheet summarizing the above Information Notice is attached below - to serve as a quick reference for glucose and cholesterol screening. This tip sheet also includes a referral and care management guide for abnormal glucose and cholesterol test results.

A laminated copy of the tip sheet will be mailed to your office. Please call 925-313-6153 for any questions.

S:\PROVIDER RELATIONS\provider memos\#321 & tip sheet.doc

HEDIS Measurement
BMI Percentile
(BMI % ile)

As the HEDIS assessment period is currently evolving, there is at least one additional measure which affects most of our Community Providers, particularly those who see patients 17 yo and younger. This measure fits in well with the current awareness of Increasing obesity and the need for early identification and intervention. This evaluation Indicator is the BMI previously recommended being done on all patients between three and seventeen years. The HEDIS measurement areas stressed are specific and require some additional counseling and recommendations. All measurement areas are included on the PM160 and will be reported from that document although a few spot checks will be conducted in selected physician offices by HEDIS evaluators.

The review method is specific and requires close documentation of the office visit. The following are the numerators:

- BMI is identified during the measurement year
- Documentation must include a note indicating the date on which the BMI was documented, and evidence of either of the following:
  - BMI percentile
  - BMI percentile plotted on age-growth chart*

*to be compliant the BMI % ile must <u>also</u> be recorded elsewhere in the medical record

Medical Record for Nutrition and Physical activity identification:

- A Documentation must include a note indicating the date and at least one of the following:
  - Discussion of current nutrition behaviors
  - Check list indicating nutrition addressed
  - Counseling or referral for nutrition education
  - Member received educational materials on education
  - Anticipatory guidance for nutrition

- <u>B</u> Documenting of counseling for physical activity or referral for such during the measurement year must be identified in the medical record review.

  Documentation must include a note indicating the date and at least one of the following:
  - Discussion of current physical activity behaviors (i.e., exercise class, sports activities or sports exam participation)
  - Checklist indicating physical activity addressed
  - Counseling or referral for physical activity
  - Member has received educational materials on physical activity
  - Anticipatory guidance for physical activity.

In order for materials to be visible and easily identified, as well as easily accessible for the provider, the following modifications on the PM 160 are recommended:

- A Nutrition:
  - On the PM 160, under the CHDP Assessment box, the **#3 nutrition** assessment line, in column C or D, mark if action is new or known (Nutrition review)

B Physical Activity
  - On the PM 160 under the CHDP Assessment box, #4 anticipatory guidance/ Health Education line, in column C or D mark if action is new or known (indicating physical activity

In box above the wt/ht and BMI recording and BP boxes, mark the following:

Code 98	Nutrition counseling	(CPT) Z5020
99	Physical exercise	(CPT) Z6918

These codes are important to record for intervention.

[redacted]

DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

STAPLE HERE

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NO. | L.A. Code

BIRTHDATE Mo. Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Mo. Day Year

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

Ethnic Code: 1-American Indian, 2-Asian, 3-Black, 4-Filipino, 5-Mex. Amer./Hispanic, 6-White, 7-Other, 8-Pacific Islander

CHDP ASSESSMENT

Indicate outcome for each screening procedure

	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: NEW C	KNOWN D	DATE OF SERVICE Mo. Day Year / FEES
01 HISTORY and PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT		✓		3✓	
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION PE		✓		3✓	
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					12

FOLLOW UP CODES

1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED

REFERRED TO: | TELEPHONE NUMBER

REFERRED TO: | TELEPHONE NUMBER

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

Dx obesity (3)

CODE	OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES	CODE	OTHER TESTS
98	Nutrition counseling			
99	Exercise			

HEIGHT IN INCHES	WEIGHT LBS	OZS	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE
0 /4				/

HEMOGLOBIN	HEMATOCRIT	BIRTH WEIGHT LBS	OZS
	.0% %		

INFORMATION ONLY REPORTING

ROUTINE REFERRAL(S) (✓) ☐ BLOOD LEAD ☐ DENTAL

PATIENT IS A FOSTER CHILD (✓) ☐

DIAGNOSIS CODES: 1 | 2

IMMUNIZATIONS

PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☐
2. Tobacco Used by Patient Yes ☐ No ☐
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☐ No ☐

PATIENT VISIT (✓): 1-New Patient or Extended Visit ☐ 2-Routine Visit ☐

TYPE OF SCREEN (✓): 1-Initial ☐ 2-Periodic ☐

TOTAL FEES

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

HEALTH PLAN CODE / PROVIDER NUMBER

PLACE OF SERVICE

1 Enrolled in WIC 2 Referred to WIC

NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY: COUNTY | AID | IDENTIFICATION NUMBER

RENDERING PROVIDER (PRINT NAME):

SIGNATURE OF PROVIDER DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

CONFIDENTIAL SCREENING/BILLING REPORT

COPY 1 - MAIL TO MEDI-CAL CHDP

PM 160 INFORMATION ONLY 03/97

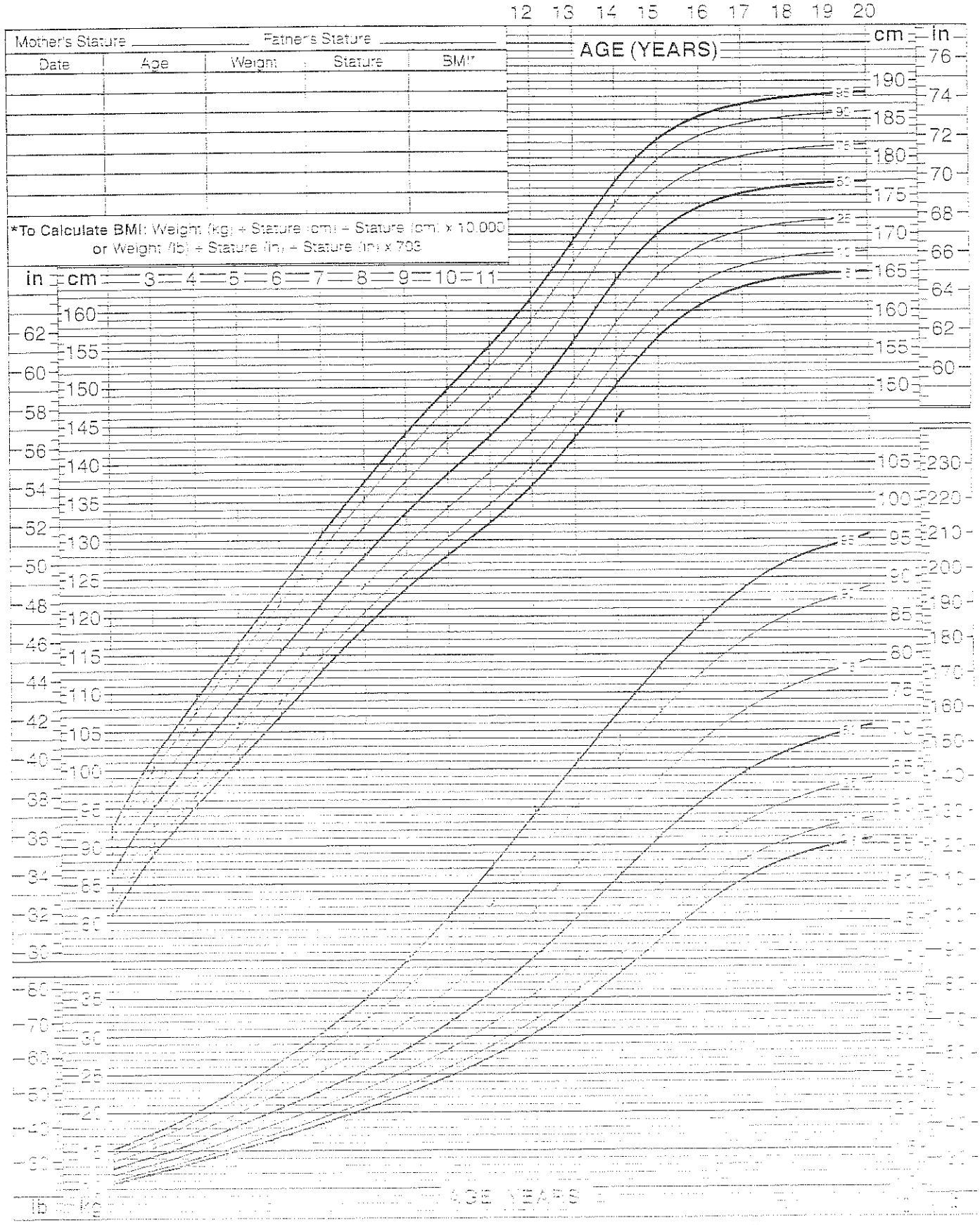
2 to 20 years: Boys
Stature-for-age and Weight-for-age percentiles

SOURCE: Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion (2000). http://www.cdc.gov/growthcharts

Mother's Stature _____ Father's Stature _____

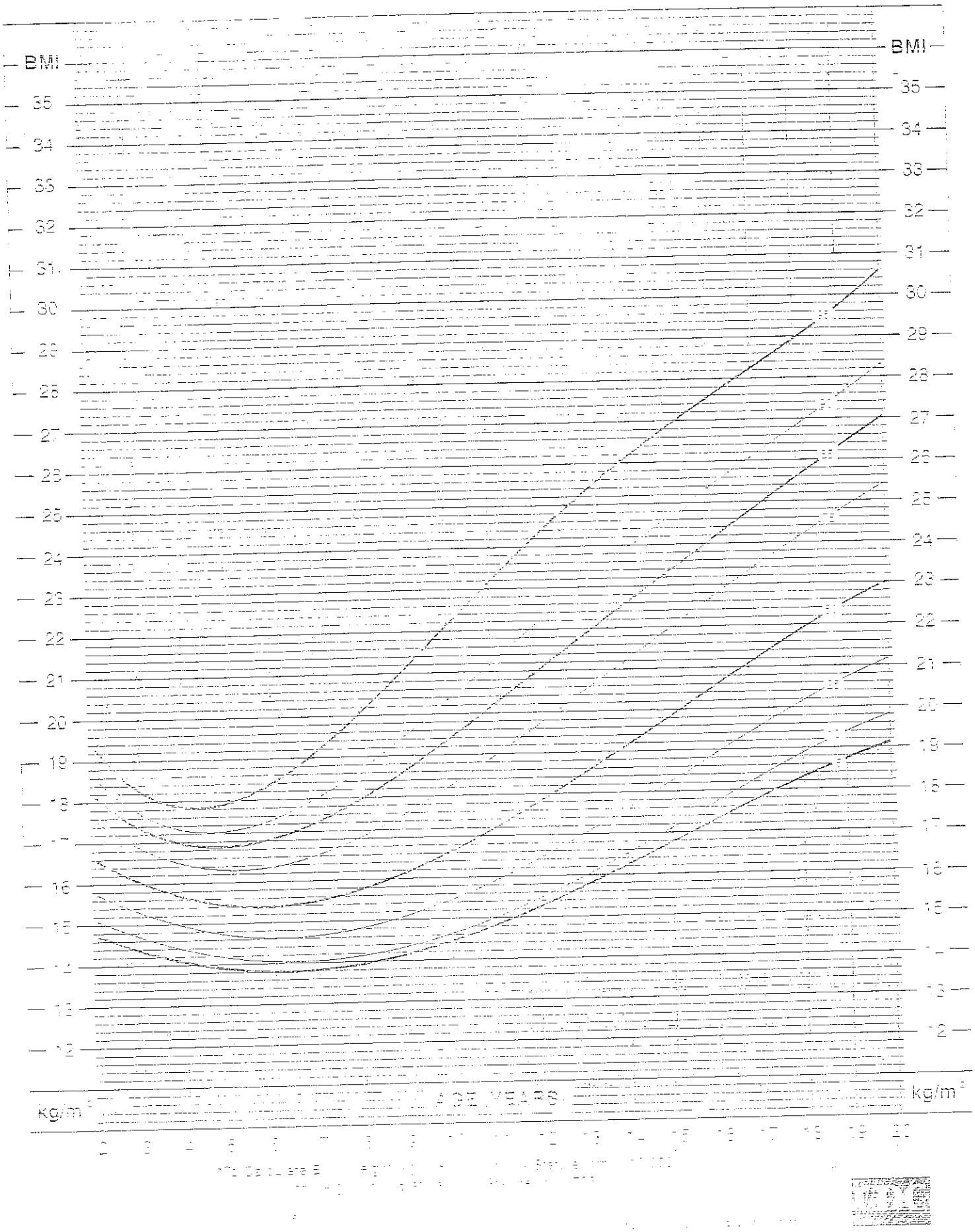
Date	Age	Weight	Stature	BMI*

*To Calculate BMI: Weight (kg) ÷ Stature (cm) ÷ Stature (cm) x 10,000
or Weight (lb) ÷ Stature (in) ÷ Stature (in) x 703



2 to 25 [illegible]

Body [illegible]


BMI
35
34
33
32
31
30
29
28
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26
25
24
23
22
21
20
19
18
17
16
15
14
13
12
kg/m²

[redacted]

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CLAIM CONTROL NUMBER • FOR STATE USE ONLY

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PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NO. | L.A. Code

BIRTHDATE Mo. Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Mo. Day Year

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

Ethnic Code: 1-American Indian, 2-Asian, 3-Black, 4-Filipino, 5-Mex. Amer./Hispanic, 6-White, 7-Other, 8-Pacific Islander

CHDP ASSESSMENT

Indicate outcome for each screening procedure

DATE OF SERVICE Mon. 9 Day 5 Year 10

FOLLOW UP CODES

1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED

	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: NEW C	KNOWN D	FEES
01 HISTORY and PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT				X	
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION PE			X		
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					12

REFERRED TO: | TELEPHONE NUMBER 39

REFERRED TO: | TELEPHONE NUMBER 45

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

CODE	OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES	$	CODE	OTHER TESTS
98	Nutri counseling	=CPT	$		
99	Exercise	=CPT	$		

DX:

BMI % ile ____

Counsel: Nutri____ Exercise____

HEIGHT IN INCHES 0 4 | WEIGHT LBS OZS | BODY MASS INDEX (BMI) PERCENTILE | BLOOD PRESSURE

HEMOGLOBIN | HEMATOCRIT .0% | % | BIRTH WEIGHT LBS OZS

INFORMATION ONLY REPORTING

ROUTINE REFERRAL(S) (✓) ☐ BLOOD LEAD ☐ DENTAL | PATIENT IS A FOSTER CHILD (✓) ☐

DIAGNOSIS CODES 1 2

IMMUNIZATIONS

PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D

PATIENT VISIT (✓): 1 New Patient or Extended Visit | 2 Routine Visit

TYPE OF SCREEN (✓): 1 Initial | 2 Periodic

TOTAL FEES

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☐
2. Tobacco Used by Patient Yes ☐ No ☐
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☐ No ☐

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

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NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

1 PARTIAL SCREEN 2 SCREENING PROCEDURE RECHECK

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY | COUNTY | AID | IDENTIFICATION NUMBER

[redacted]

RENDERING PROVIDER (PRINT NAME):

SIGNATURE OF PROVIDER | DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

CONFIDENTIAL SCREENING/BILLING REPORT

COPY 1 - MAIL TO MEDI-CAL CHDP

PM 160 INFORMATION ONLY (03/07)

CHDP Glucose & Cholesterol Screening Guide

for Children ≥ 5 Years & BMI ≥ 85%ile

Screen for Cholesterol*

(Note: child/adolescent may NOT be overweight)

If one of these risk factors is present:

a. One parent or grandparent had heart/vascular dz, heart attack/surgery or stroke at ≤ 55 years
b. One parent has a cholesterol level ≥240 mg/dl

Screen for Glucose & Cholesterol*

If two of these risk factors are present:

a. BMI also ≥ 95%ile
b. Family hx of diabetes
c. Black/Hispanic/American Indian/Asian/Pacific Islander/Native Alaskan
d. One sign of insulin resistance: acanthosis nigricans, HTN, dyslipidemia, PCOS
e. < 30 min. activity/day or consistently unbalanced diet

* Test can be done biannually

Note: If there is concern about a child < 5 years needing glucose and cholesterol screening, these tests can be ordered at any age and be reimbursed.

CHDP Referral and Care Management Guide for Children ≥ 5 Years With Abnormal Glucose and Cholesterol Test Results

Glucose
≥ 126 mg/dl
Refer to CCS for Diagnostic Evaluation

Cholesterol
≥ 170 - < 200 mg/dl
Counsel
& repeat test in one year

Cholesterol
≥ 200 mg/dl
Refer to CCS for Diagnostic Evaluation

When Both Glucose and Cholesterol Levels are Done:

IF Glucose ≤ 100 mg/dl (normal) or > 100 - < 126 mg/dl (pre-diabetes)

AND

Cholesterol Level is Equal To:

≤ 170 mg/dl
Counsel & repeat test in 1 Year

>170 - < 200 mg/dl
(Borderline ↑Cholesterol)
Counsel about borderline results and repeat test in 1 year

≥ 200 mg/dl
(Abnormal ↑ Cholesterol)
Inform of abnormally high cholesterol, counsel & repeat test

≥ 200 mg/dl
(Abnormal ↑Cholesterol)
Plus 1 of these risks:
- 1 parent/grandparent had heart/vascular disease, attack, stroke at ≤55 yrs.
- 1 parent has a cholesterol level ≥ 240 mg/dl

Contra Costa County CCS
(925) 313-6100
Fax: (925) 313-6115

Refer to CCS for Diagnostic Evaluation

Contra Costa County
Child Health & Disability Prevention
925-313-6150
ACadiz 12/21/09

Encouraging Physical Activity in Children

Diane Dooley MD

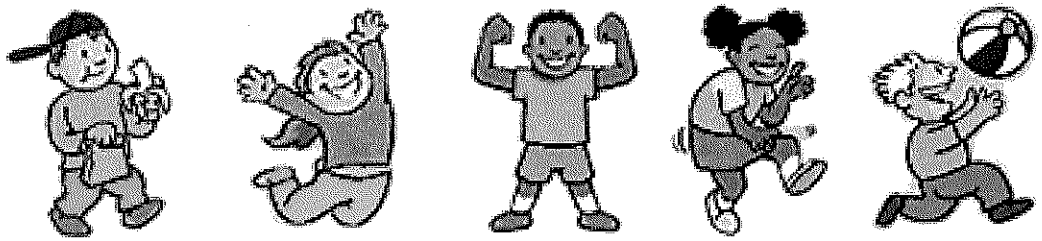
February 26, 2010

Finding Quality Programs

Child Care and Preschool programs

Questions to ask about Child Care/ Preschools:

- Amount of teacher-led and child-initiated play per day
- Presence of TV in classroom
- Staff training re: physical activity
- Presence of a written policy regarding play
- Availability of large, open outdoor spaces, play equipment and portable equipment (balls, jump ropes, etc.)

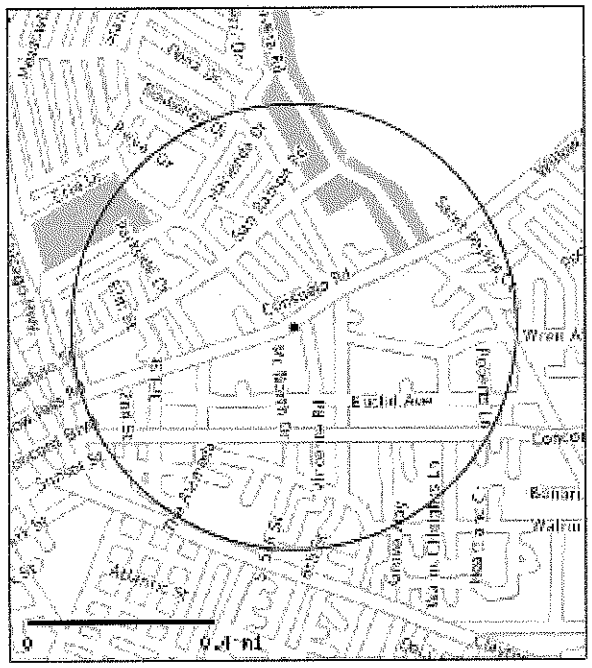


Access to Parks

California State Parks
Community FactFinder Report

This is your Community FactFinder report for the project you have defined. Please refer to your Project ID in any future communications about this project.

Project ID:	**6237**
Date created:	**February 13, 2010**
County:	**Contra Costa**
City:	**Concord**
Coordinates:	**37.980489, -122.021188**
Total Population:	**4,888**
Median Household Income:	**$65,835**
Number of people below poverty line:	**241**
Park acreage:	**31.46**
Park acres per 1,000 population:	**6.44**



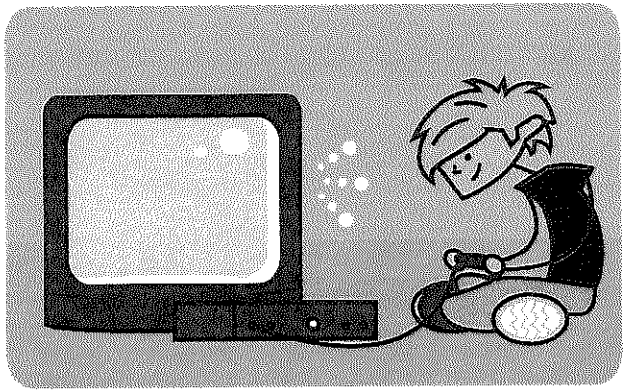
Project Site

A significant association exists between race, ethnicity, socioeconomic status and access to physical activity settings

Where do kids play?

Home

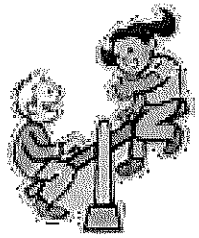
- Influences on amount of play in home:
  - Gender and ethnicity
  - Indoor rules for household
  - Outdoor rules
  - Convenience of play spaces
  - Time and frequency in play spaces
  - Prompts by siblings

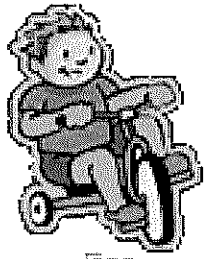


Where do kids play?

Parks

- Access to open spaces, parks and play spaces correlates with levels of physical activity
- Programming, staffing and outreach most important determinants of park use
- Other considerations: safety, availability of toilets and water, lighting, playground space and equipment

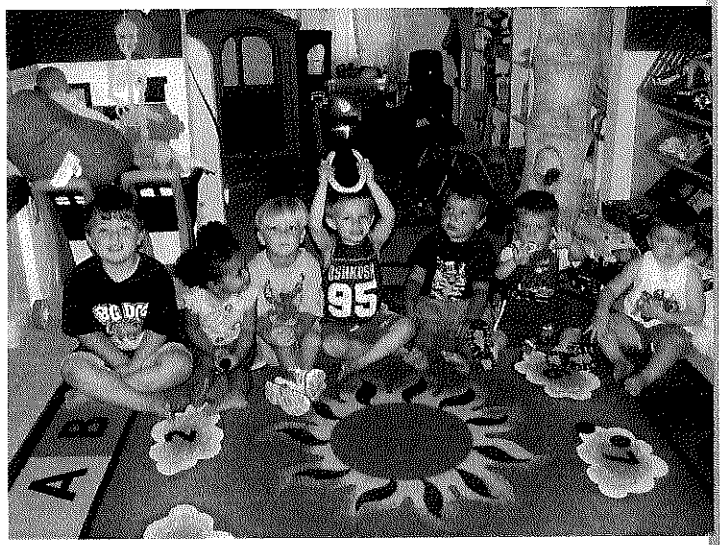




Where do kids play?

Child Care and Preschool programs

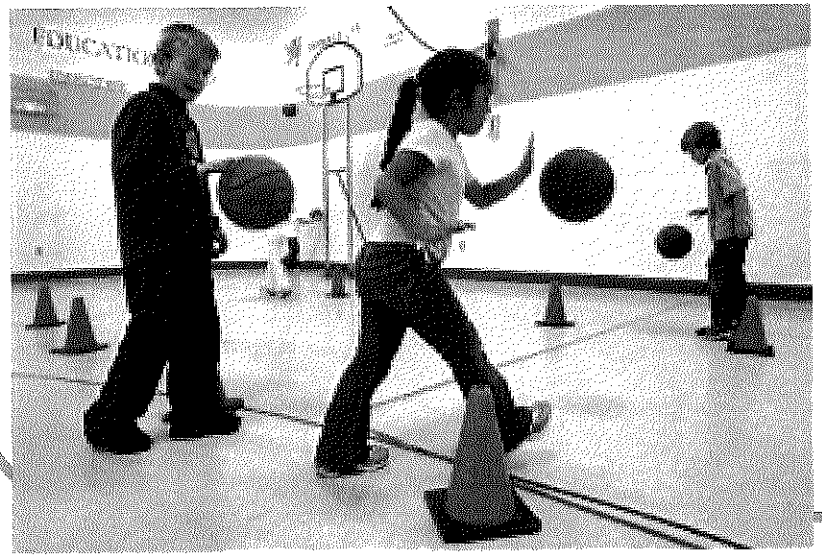
- More than ½ of all 3-6 year olds are enrolled in center-based child care
- Space, programs and outdoor time at child care centers and preschools very predictive of physical activity levels
- Specific preschool attended correlates with physical activity



Where do kids play?

Schools and Afterschool programs

Value of PE depends upon level of activity

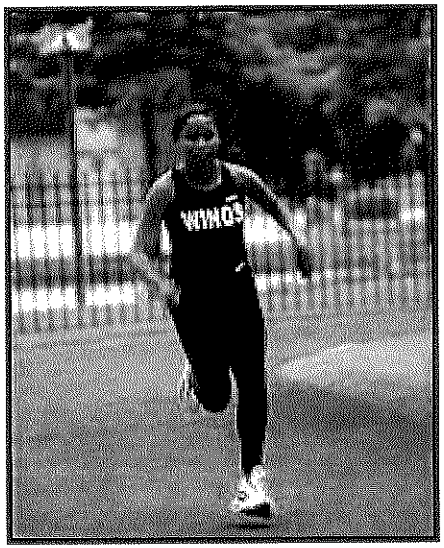


- California Ed Code requires:
  - Elementary: 200 minutes of physical education every ten school days
  - Grades 7-12: 400 minutes of physical education every ten school days

Where do kids play?

Schools and Afterschool programs

- Many school yards closed off hours
- NPLAN: Increased joint use agreements
- After School Education and Safety program/21st Century programs exist at most low income schools



Determining Physical Activity Levels in the Provider Visit

What does your child like to do?

How often do you play with her?

Where does she like to play?

How often does she get a chance to run?

Is your child attending a child care or preschool program?

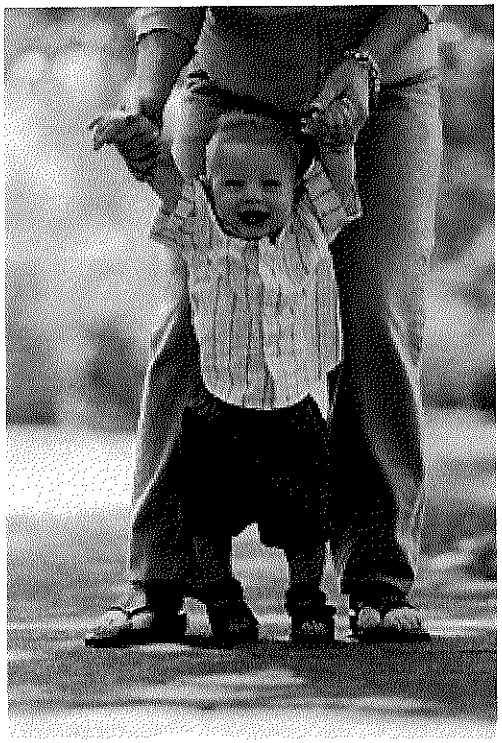
How many minutes a day does your child spend outside?

Do you have a park or a place nearby for to play?

Do you have a bike or a scooter?

Do you like to do any sports or after school activities?

Do you walk to or from school?

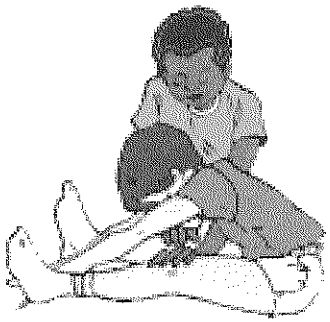


Determining Physical Activity Levels at School

Fitnessgram

Testing by all schools at grades 5,7,9

- Aerobic Capacity
- Abdominal Strength and Endurance
- Upper Body strength and endurance
- Body Composition
- Trunk Extensor Strength and Endurance



Results for Contra Costa 2008-09:

- 5/6 Fitness criteria:
  - Grade 5 – 59%,
  - 7 -63%, 9 – 70%

Benefits of Physical Activity

- Improved motor skill development
- Improved bone health
- Decreased risk for obesity, cardiovascular disease
- Socialization
- Mental health benefits
- Improved learning

Guidelines for Physical Activity

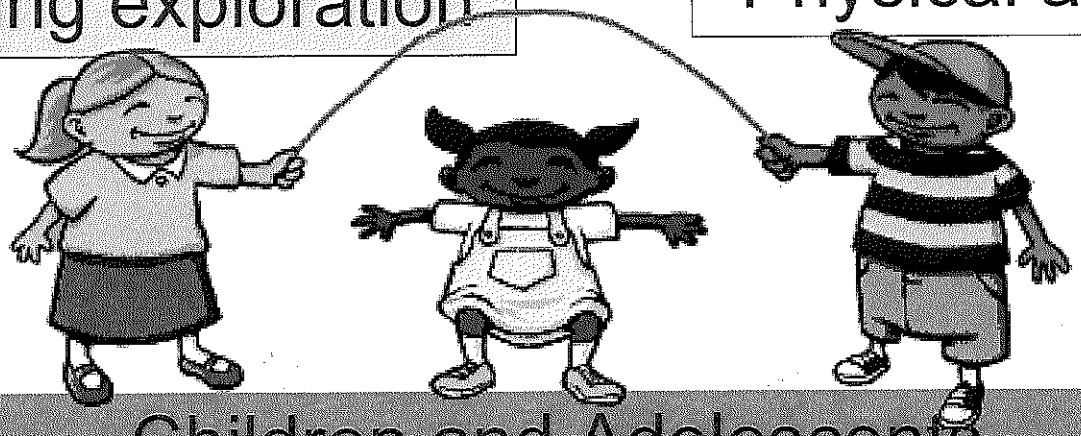
Infants

Should interact with parents in daily activities dedicated to promoting exploration

Toddlers

60 minutes daily play +structured

Physical activity

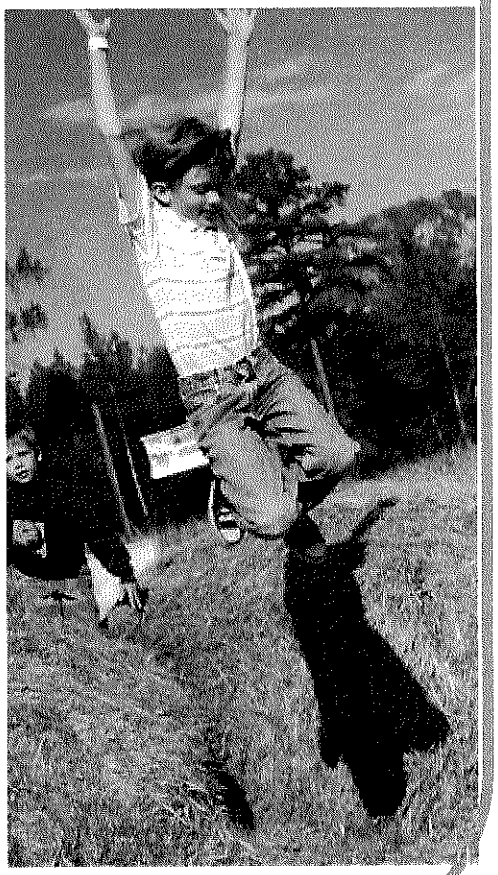


Children and Adolescents

Physically active at least 60 minutes daily

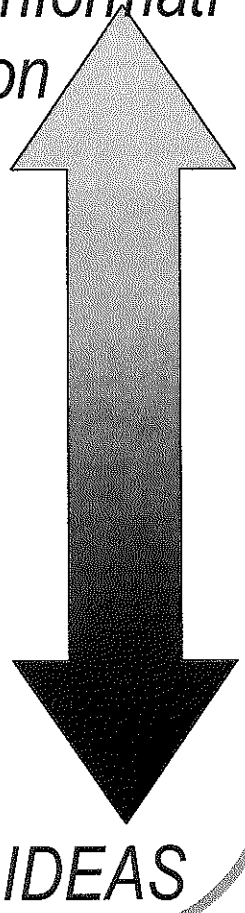
Who gets enough physical activity?

- Boys are more active than girls
- 42% of children aged 6-11 obtain recommended 60 minutes PA per day
- Physical activity declines with age
- 7.6% of teens 16-19 met standards
- No relationship to obesity, TV watching in young children
- Kids with asthma less active



Stages of Change

- **Precontemplation** - Not thinking about change
  May be resigned, believes consequences are not serious
- **Contemplation** - Weighing benefits and costs of behavior
- **Preparation** - Experimenting with small changes
- **Action** - Taking a definitive action to change
- **Maintenance** - Maintaining new behavior over time



Creating Change
Contemplation

Motivational Interviewing

- Explore the risks and benefits of making changes
- Encourage change talk
- Point out contradictions
- Encourage incremental changes

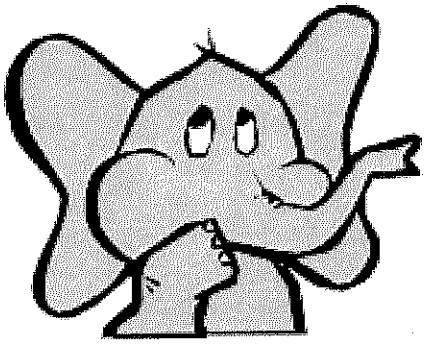
Negotiate!

Creating Change - Precontemplation

- Unaware of problem behavior or unwilling to consider changing it

Reluctance

Rationalization



Resignation

Rebellion

- Describe risk and concerns
- Educate family

Creating Change
Action

5 As

Ask

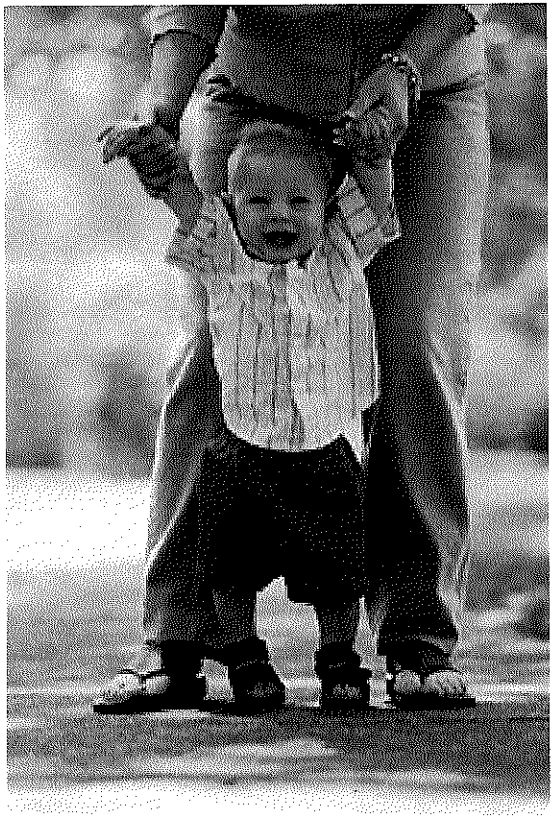
Advise

Assess

Assist

Arrange

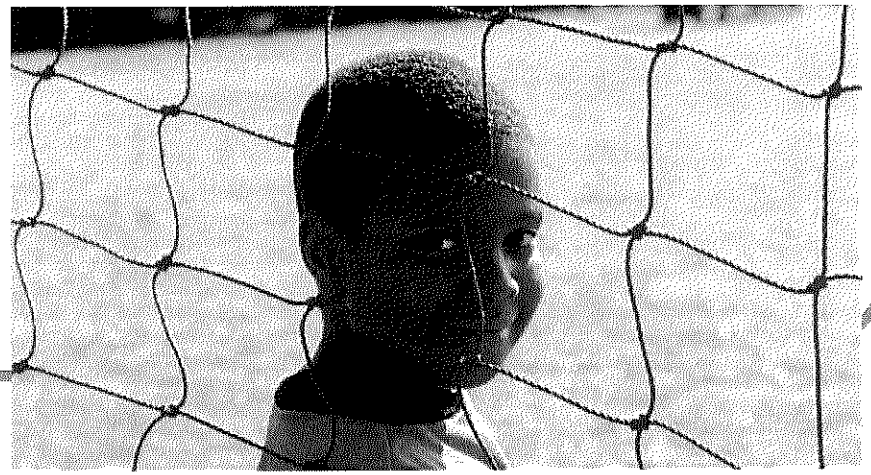
Set reasonable SMART goals



Resources

Make referrals, educate, offer community resources

- Contra Costa Child Care Council– www.cocokids.org
- Headstart, State Preschool, First 5 Centers – 211ContraCosta.org
- City Parks and Recreation Departments
- Local School Districts
- NEW Kids



State of California-Health and Human Services Agency
Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

August 22, 2006

CHDP Provider Information Notice No.: 06-08

TO: ALL CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM PROVIDERS

SUBJECT: FLUORIDE VARNISH IS A NEW MEDI-CAL BENEFIT FOR CHILDREN UNDER SIX YEARS OF AGE

The purpose of this notice is to inform CHDP providers that, effective June 1, 2006, fluoride varnish applications to the teeth became a new benefit available to all Medi-Cal enrolled children under age six, including children pre-enrolled through the CHDP Gateway. This information can be found in the Medi-cal Bulletin at http://files.medi-cal.ca.gov/pubsdoco/publications/bulletins/gm/archive/word/gm20060501.doc.

Although fluoride varnish applications are not a benefit of the CHDP program, fluoride varnish may be applied at the CHDP health assessment visit to children pre-enrolled in CHDP Gateway or already Medi-Cal beneficiaries. In either case, the procedure must be billed separately to Medi-Cal. Currently, claiming for fluoride varnish applications is limited to fee-for-service Medi-Cal providers. Procedures for claiming in Medi-Cal managed care plans have not yet been identified.

Fluoride varnish is a form of topical fluoride that is more effective in preventing tooth decay in very young children than other topical fluorides, and is 1) more easily tolerated by young children and developmentally disabled persons; 2) less toxic; and 3) easier to use and faster to apply than other topical fluorides. It requires no special dental equipment and minimal training to apply, e.g. a non-dental health care provider can easily apply it. Although Medi-Cal will only allow this procedure up to three times in a 12-month period, the effectiveness of fluoride varnish has been found to be greater with more applications.

Since medical providers routinely see infants and toddlers before they are seen by a dentist, medical providers are strategically positioned to implement a simple intervention for the primary prevention and control of tooth decay through the application of fluoride varnish. Physicians are legally permitted to apply fluoride varnish, as are nurses and other medical personnel when the procedure is delegated to them with a protocol established by the attending physician.

All young children who are at moderate to high risk of caries should receive fluoride varnish treatments. Caries risk assessment tools are available through the First Five website listed below. Most CHDP children fall into the high risk category for caries. As a reminder, when caries are found during the CHDP health assessment and recorded on the PM 160, a referral to a dentist must be made.

Medi-Cal is reimbursing for fluoride varnish using Health Care Procedure Coding System code D1203 (topical application of fluoride [prophylaxis not included], child). The rate is $18.00. The rate is inclusive of all materials and supplies needed for application. The procedure is payable to the medical provider up to three times in a 12-month period. If a fluoride varnish application is provided in conjunction with a CHDP health assessment visit, no additional charge for an office visit will be covered. Fluoride varnish is not a benefit of the CHDP program and must be billed separately to Medi-Cal. Medical providers can, however, bill for an office visit if the procedure is provided at a visit separate than the CHDP health assessment.

A video on conducting an infant oral health assessment and fluoride varnish application can be found online at http://www.first5oralhealth.org/page.asp?page_id=286. Additional information on fluoride varnish can be found at www.first5oralhealth.org. Further information, including the ordering of fluoride varnish materials and another video on fluoride varnish application can be found at http://www.kdheks.gov/ohi/fluoride_varnish_info.html.

Original Signed by Marian Dalsey, M.D., M.P.H.

Marian Dalsey, M.D., M.P.H., Chief
Children's Medical Services Branch

Enclosure

MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Medical Services • General Medicine

May 2006 • Bulletin 382

Contents

Fluoride Varnish is a New Medi-Cal Benefit

Effective for dates of service on or after June 1, 2006, HCPCS code D1203 (topical application of fluoride [prophylaxis not included], child) is a Medi-Cal benefit for children younger than 6 years of age, up to three times in a 12-month period.

Because many dentists are not willing to see children this young, medical providers who routinely see pregnant women and young children offer the best hope for preventing and controlling tooth decay through the application of fluoride varnish. Physicians, nurses and medical personnel are legally permitted to apply fluoride varnish when the attending physician delegates the procedure and establishes protocol.

Reimbursement for code D1203 is $18, and includes materials and supplies needed for application.

This information is reflected in new manual section dental 1 (Part 2) and manual page hcpcsii 1 (Part 2).

Dental Benefits

This section describes the procedures and codes used to bill dental benefits for children.

Fluoride Varnish

HCPCS code D1203 (topical application of fluoride [prophylaxis not included], child) is a Medi-Cal benefit for children younger than 6 years of age, up to three times in a 12-month period.

When the procedure is delegated to them and follows a protocol established by the attending physician, nurses, physicians and other medical personnel are legally permitted to apply fluoride varnish.

Dentists Providing Denti-Cal Services for Children

WEST CONTRA COSTA – By City									
Name	**Address**	**City**	**Zip**	**Phone**	**Min. Age**	**Practice**	**Denti-Cal Pregnant Women**	**Office Hours**	**Other Languages**
Western Dental	11299 San Pablo Avenue, Suite A	El Cerrito	94806	(510) 231-0147	5 yrs	General	Yes, with doctor's note	MTh 9-8 Fridays 9-7 Saturdays 8-4:30	Korean Spanish
Dr. Firoozeh Lavassani	411 Kearney St.	El Cerrito	94530	(510) 527-1742	1 yr	General Nitrous Simple Ext. Oral Sedation	Yes, with doctor's note	MWF 9-5 T-Th 10-6	Arabic Tagalog Persian Spanish
Dr. Micheal Ajayi	3980 San Pablo Dam Road, Suite 102	El Sobrante	94803	(510) 222-2163	6 yrs and over 60 lbs	Oral surgery – WISDOM TEETH ONLY		MTWF 9-5	Spanish
Dr. Dani Laksana	4426 Appian Way	El Sobrante	94803	(510) 222-1621	3 yrs	General	Yes, with doctor's note	M-W 9-5 F 8:30-4:30	Indonesian Spanish Tagalog
Dr. Gloria Farne-Uy	500 Alfred Nobel Drive, Suite 265	Hercules	94547	(510) 724-4678	6 yrs	General	Yes, with doctor's note (No X-Rays)	T-S 9-6	Tagalog
Dr. Benjamin Rosales	1989 San Pablo Ave., Ste. 105	Pinole	94564	(510) 741-0770	2 yrs	General Endo Extractions	Yes, with doctor's note	T-S 9-6, and Every Other Monday	Spanish Tagalog

Dentists Providing Denti-Cal Services for Children

WEST CONTRA COSTA – By City									
Name	**Address**	**City**	**Zip**	**Phone**	**Min. Age**	**Practice**	**Denti-Cal Pregnant Women**	**Office Hours**	**Other Languages**
Dr. Mojdeh Oshagh	2000 Appian Way, Suite 204	Pinole	94564	(510) 724-5700	3 yrs	General Nitrous	Yes – Exam and cleaning only! Tx = 60 days Post-partum	MTTH 9-5 W – On Call	Spanish Farsi Romanian
Youthful Tooth Dr. Mary Jane Salazar Dr. Jeffrey Alexander	2830-A Pinole Valley Road.	Pinole	94564	(510) 758-6684	2 yrs	General Endo Simple Ext. Oral Sedation	Yes, with doctor's note – exam and cleaning only!	M W 9-6 TThFS 7:30-4	Tagalog Spanish
Dr. Andres Abusleme	243 Civic Center St.	Richmond	94804	(510) 215-7944	2 yrs – If Cooperative	General Nitrous	Yes, with doctor's note	M-Th 9-5	Spanish Portuguese
Dr. Chester Low	265 16th Street	Richmond	94801	(510) 233-6515	4 yrs or early if cooperative	General Nitrous Simple Ext. Endo	Yes, with doctor's note	M-F 8:45-4:30	Spanish Cantonese
Richmond Health Center - Dental Clinic	100 38th Street	Richmond	94801	(510) 231-1240 **Emergencies: Call @ 7am (510) 231-1242**	5 yrs	General Endo Simple Ext. Nitrous	Yes – Emergency Only Exam and Cleaning OK	M-F 8-3	Spanish Interpreters available

Dentists Providing Denti-Cal Services for Children

WEST CONTRA COSTA – By City									
Name	**Address**	**City**	**Zip**	**Phone**	**Min. Age**	**Practice**	**Denti-Cal Pregnant Women**	**Office Hours**	**Other Languages**
Dr. Pai-Cheng Shen	194 Broadway Ave.	Richmond	94804	(510) 234-4961	3 yrs	General Endo Simple Ext.	Yes, with doctor's note – Emergency only	TTh 9-5 WF 9-12	Mandarin
Dr. Shig Shinhira	3731 Bissell Avenue, Suite B	Richmond	94805	(510) 235-5123	3 yrs	General Simple Ext. Endo	Yes, with doctor's note	TWF 9-5 Sat 9-1	Japanese
Brookside Community Health Center	2023 Vale Road, Suite 111	San Pablo	94806	(510) 231-9814	3 yrs	General	Yes	M-F 9-5	Spanish

Dentists Providing Denti-Cal Services for Children

CENTRAL CONTRA COSTA – By City									
Name	**Address**	**City**	**Zip**	**Phone**	**Min. Age**	**Practice**	**Denti-cal Preg Women**	**Office Hours**	**Other Languages**
Dr. Rose Joy Endonila Dr. C Balancio	1803 Monument Blvd., Suite 3F	Concord	94520	(925) 671-9177	4 yrs	General	Yes, with doctor's note – extractions only	M-F 8:30-4:30	Spanish Tagalog
Dr. Abbas Nouri	3301 Clayton Road	Concord	94519	(925) 676-0343	9 yrs	General	Yes, with doctor's note	M-Th 9-5	Farsi
Dr. Hait Phan	1941 Parkside Dr.	Concord	94519	(925) 689-0811	5 yrs	General Endo for Adults Only	Yes, Exams Only	M-TH 8-3:30 F 9-1 S 9-4	Vietnamese
Western Dental Services – John Steven Ma	1821 Concord Ave.	Concord	94520	(925) 825-8900	5 yrs	General Extractions Endo Nitrous	Yes, with doctor's note	M 9-8 T-F 9-7 S 8-4:00	Spanish, Tagalog
Dr. Farahnaz Nasseri	3355 Clayton Rd.	Concord	94519	(925) 356-5676	5 yrs – If Cooperative	General Simple Ext. Surgical – Root Canal Ext	Yes, with doctor's note	Mondays 9-4 Sat. by Appt. Only	Spanish Persian
Dr. George Koerber	1001 Sun Valley Blvd.	Concord	94520	(925) 682-3929	4 yrs	General	Yes, with doctor's note	M-F 10-6:30 Sat 9-4:30	Spanish Tagalog Hindu

Dentists Providing Denti-Cal Services for Children

CENTRAL CONTRA COSTA – By City									
Name	**Address**	**City**	**Zip**	**Phone**	**Min. Age**	**Practice**	**Denti-cal Preg Women**	**Office Hours**	**Other Languages**
Dr. Marjan Norroozi	3142 Clayton Road	Concord	94521	(925) 330-0013	2 yrs	General Extractions	Yes, with doctor's note	MWF 9:30-6:00	Spanish Farsi
Dr. Lester Yamashita	2969 Salvio Street	Concord	94519	(925) 685-5296	6 yrs	General Simple Ext.	Yes, with doctor's note	MTW 8-5	Spanish Japanese
Dr. Donald C Schmitt Dr. Ra Wiley	2879 Willow Pass Road	Concord	94519	(925) 685-0513	FOSTER FAMILIES ONLY	General SPECIAL NEEDS	NO	M-S Children w/Special Needs are seen in AM only	English Only
Martinez Dental Clinic	2500 Alhambra Avenue	Martinez	94553	(925) 370-5300 **Emergencies: Call @ 7am Press Option #1**	5 yrs	General	Yes, Exam and cleaning	M-F 8-3	Interpreters available
Western Dental	4040 Alhambra Avenue	Martinez	94553	1-888-811-5111 OR (925) 313-9700	3-4 yrs., if cooperative	General --- **Pedo DDS twice a month**	YES, with doctor's note	MTW 9-7pm Th-closed F 9-7pm Sat 8-4:30	Spanish
Dr. Fung, Edmond	1500 Tara Hills	Pinole		(510) 724-2360	5 yrs, If Cooperative	General	YES	T-F 9-3:30	Spanish

Dentists Providing Denti-Cal Services for Children

CENTRAL CONTRA COSTA – By City

Name	Address	City	Zip	Phone	Min. Age	Practice	Denti-cal Preg Women	Office Hours	Other Languages
Diablo Valley College Dental Hygiene Clinic	321 Golf Club Road	Pleasant Hill	94523	(925) 685-1230 ext.356	5 yrs	Dental Hygiene Services ONLY	NO	Varies	Spanish
La Clinica Monument	2100 Monument Blvd., #A	Pleasant Hill	94523	(925) 363-1256	1 yr	Pedo DDS Extractions Nitrous	Yes, with doctor's note	M-F 8:30-5:30 Sat 8-4:30	Spanish
Nawabi, Farida, RDHAP	9844 Alcosta Blvd	San Ramon	94583	(925) 768-5337	3 yrs	Cleaning and Prophy	Yes, under the direct supervision of a Dentist	F-S	Farsi
Dr. Haritha Tirupathi	9260 Alcosta Blvd., Suite 84	San Ramon	94583	(925) 828-9422	3 yrs	General	YES	MW 8-5 TTh 9-6	Farsi Hindi Tagalog

Dentists Providing Denti-Cal Services for Children

EAST CONTRA COSTA – By City									
Name	**Address**	**City**	**Zip**	**Phone**	**Min. Age**	**Practice**	**Denti-cal Preg Women**	**Office Hours**	**Other Languages**
Western Dental Services, Inc.	2590 Sycamore Dr.	Antioch	94509	(925) 776-1140	5 yrs (4yrs – if need school forms & coop)	General Simple Extractions Endo	Yes, with doctor's note	M - F 9-7 S 8-4:30	Spanish Vietnamese Tagalog Indian
Bay Point Family Health Center – Dental Clinic	215 Pacifica Ave.	Bay Point	94565	(925) 427-8302	2 yrs	General Extractions	NO	M-F 8-3	Spanish
Dr. Manuel Alvear	3840 Railroad Ave.	Pittsburg	94565	(925) 427-5032	3 yrs	General Simple Extractions Endo –Not on Perm Molars	NO	M-F 9-6	Tagalog
La Clinica de la Raza	335 E. Leland Road	Pittsburg	94565	(925) 432-1250	1 yr	General Simple Ext Nitrous	Yes, with doctor's note	M-F 8:30-5:30	Spanish
Pittsburg Health Center - Dental Clinic	2311 Loveridge Road	Pittsburg	94565	(925) 431-2501 **Emergencies: Call @ 7am (925) 431-2502**	1 yrs	General Simple Ext.	YES	M-F 7:45-3:30	Interpreters Available for a Variety of Languages

Dentists Providing Denti-Cal Services for Children

EAST CONTRA COSTA – By City									
Name	**Address**	**City**	**Zip**	**Phone**	**Min. Age**	**Practice**	**Denti-cal** Preg Women	**Office Hours**	**Other Languages**
Dr. Jerome Savel	3715 Railroad Ave, Ste. A	Pittsburg	94565	(925) 439-2588	3 yr s	General Simple Ext.	Yes, with doctor's note	TWTh 7:30-5 F 7:30-4:30	Spanish
Western Dental	2120 Railroad, Suite 105	Pittsburg	94565	(925) 439-4773	4 yrs.	General & --- **Pedo DDS every other Thursday Ages 2yrs+**	Yes, with doctor's note	M-F 9-7 S 8-4:30	Spanish

California Medi-Cal Dental Program

Denti-Cal Bulletin

Volume 26, Number 7, March 2010
www.denti-cal.ca.gov

PO Box 15609 Sacramento, CA 95852-0609
(800) 423-0507

Dental Periodicity Schedule for Children

Federal law governing the provision of dental services to children under Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requires that dental services be provided in accordance with a dental periodicity schedule. This schedule must recommend treatment intervals that meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and at such other intervals that are medically necessary to determine the existence of a suspected illness or condition. The dental periodicity schedule reflects the ages and intervals at which a child should receive specified dental services, not when a referral should take place.

Following consultation with the California Dental Association (CDA), California Society of Pediatric Dentistry (CSPD) and American Academy of Pediatric Dentistry (AAPD), Denti-Cal has elected to use the attached periodicity schedule recommended by AAPD (reproduced with permission). The rationale supporting the procedures recommended in the periodicity schedule can be found on the AAPD Web site at http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf. Although Denti-Cal supports the intervals recommended in the AAPD Periodicity Schedule, please be aware that the Manual of Criteria contained in the Provider Handbook governs Denti-Cal policy with respect to which procedures are benefits and the frequency at which they are allowable.

For questions, please contact the Denti-Cal Telephone Service Center at (800) 423-0507.

RECOMMENDATIONS FOR PREVENTIVE PEDIATRIC ORAL HEALTH CARE

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references.

AGE	6–12 MONTHS	12–24 MONTHS	2–6 YEARS	6–12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1,2]	•	•	•	•	•
Assess oral growth and development [3]	•	•	•	•	•
Caries-risk assessment [4]	•	•	•	•	•
Radiographic assessment [5]	•	•	•	•	•
Prophylaxis and topical fluoride [4,5]	•	•	•	•	•
Fluoride supplementation [6,7]	•	•	•	•	•
Anticipatory guidance/ counseling [8]	•	•	•	•	•
Oral hygiene counseling [9]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [10]	•	•	•	•	•
Injury prevention counseling [11]	•	•	•	•	•
Counseling for nonnutritive habits [12]	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Assessment and treatment of developing malocclusion			•	•	•
Assessment for pit and fissure sealants [13]			•	•	•
Assessment and/or removal of third molars					•
Transition to adult dental care					•

[1] First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/ susceptibility to disease.

[2] Includes assessment of pathology and injuries.

[3] By clinical examination.

[4] Must be repeated regularly and frequently to maximize effectiveness.

[5] Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

[6] Consider when systemic fluoride exposure is suboptimal.

[7] Up to at least 16 years.

[8] Appropriate discussion and counseling should be an integral part of each visit for care.

[9] Initially, responsibility of parent; as child develops, jointly with parent; then, when indicated, only child.

[10] At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

[11] Initially play objects, pacifiers, car seats; then when learning to walk, sports and routine playing, including the importance of mouthguards.

[12] At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

[13] For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

California Medi-Cal Dental Program

Denti-Cal Bulletin

Volume 25, Number 22, May 2009
www.denti-cal.ca.gov

PO Box 15609 Sacramento, CA 95852-0609
(800) 423-0507

Elimination of Most Adult Dental Services

Assembly Bill X3 5 (Evans, Chapter 20, Statutes of 2009-10), the budget trailer bill for the recently signed budget bill, contained a provision for elimination of selected optional benefits under the Medi-Cal program, including most adult dental services, effective July 1, 2009. This state law change will not affect services provided to beneficiaries under age 21.

Dental services for adults ages 21 and older will no longer be payable under the Denti-Cal program, with the following exceptions:

Exemptions to Eliminated Adult Dental Benefits

- Medical and surgical services provided by a doctor of dental medicine or dental surgery, which, if provided by a physician, would be considered physician services, and which services may be provided by either a physician or a dentist in this state
  - Federal law requires the provision of these services. The services that are allowable as Federally Required Adult Dental Services (FRADS) under this definition have been listed. (Please refer to Table 1 for a list of allowable procedure codes).
- Pregnancy-related services and services for the treatment of other conditions that might complicate the pregnancy
  - This includes 60 days of postpartum care. Services for pregnant beneficiaries who are 21 years of age or older are payable if the procedure is listed under either Table 1 (Federally Required Adult Dental Services) or Table 2 (Allowable Procedure Codes for Pregnant Women).
- Beneficiaries under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program
  - There will be no change in dental benefits for beneficiaries who are under age 21.
- Beneficiaries who are under 21 years of age and whose course of treatment is scheduled to continue after he/she turns 21 years of age (continuing services for EPSDT recipients) [***Note:*** *With the exception of orthodontic services which must be completed by the beneficiary's 21st birthday.]*
  - If the service requires a Treatment Authorization Request (TAR), **all** of the following requirements must be met:
    - TARs must be received by Denti-Cal prior to the beneficiary's 21st birthday for consideration.
    - The treatment must require prior authorization.
    - The treatment must be authorized on a Notice of Authorization (NOA).
    - The treatment must be completed within the approved authorization period on the NOA.

- If the service does not require a TAR:
  - For treatment that does not require prior authorization, the treatment must be completed prior to the beneficiary's 21st birthday.

- Adult beneficiaries (age 21 and older) whose course of treatment began prior to July 1, 2009, and is scheduled to continue on or after July 1, 2009, treatment may be completed under the following conditions:
  - If the service requires a Treatment Authorization Request (TAR), **all** of the following requirements must be met:
    - TARs must be received by Denti-Cal by June 30, 2009 for consideration.
    - The treatment must require prior authorization.
    - The treatment must be authorized on a Notice of Authorization (NOA).
    - The treatment must be completed within the approved authorization period on the NOA.
    - There will not be any extensions or re-evaluations after June 30, 2009.
  - If the service does not require a TAR:
    - For treatment that does not require prior authorization, the claim will only be paid with a Date of Service (DOS) prior to July 1, 2009.

- Beneficiaries receiving long-term care in an intermediate care facility (ICF) or a skilled nursing facility (SNF), as defined in the *Health and Safety Code* (H&S Code), Section 1250, subdivisions (c) and (d), and licensed pursuant to H&S Code Section 1250, subdivision (k). Dental services do not have to be provided in the facility to be payable.
  - This exception only applies for beneficiaries who reside in a SNF or ICF as defined above. This does not apply to beneficiaries residing in facilities defined under separate sections of the Heath and Safety Code such as ICF-Developmentally Disabled (DD), ICF-Developmentally Disabled Habilitative (DDH) or ICF-Developmentally Disabled Nursing (DDN).
  - The following definitions of SNF and ICF are available on the California Department of Public Health website at http://hfcis.cdph.ca.gov/servicesAndFacilities.aspx. Providers may confirm the licensing of a facility from this web page.

    Skilled Nursing Facility (SNF): A skilled nursing facility is a health facility or a distinct part of a hospital which provides continuous skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. A skilled nursing facility provides 24-hours inpatient care and, as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program.

    Intermediate Care Facility (ICF): An intermediate care facility is a health facility, or a distinct part of a hospital or skilled nursing facility which provides inpatient care to patients who have need for skilled nursing supervision and need supportive care, but who do not require continuous nursing care.

- Dental Service Precedent to a Covered Medical Service
  - Beneficiaries may receive dental services that are necessary (precedent) in order to undergo a covered medical service. The majority of these dental services are covered under the FRADS listed in Table 1. A precedent dental service that is not on the list of FRADS will be evaluated and adjudicated on a case by case basis.

An adult dental service may be reimbursable if any one of the above exceptions is met.

All criteria in the Manual of Criteria (MOC) will remain in effect and unless otherwise stated in this bulletin, all policies remain the same for payable dental services.

Future Denti-Cal bulletins will provide additional information to providers regarding this change. In addition, the Denti-Cal and Medi-Cal websites will contain updated information. (www.denti-cal.ca.gov and www.medi-cal.ca.gov)

Medi-Cal beneficiaries will receive a notification regarding these changes.

For questions, please contact the Denti-Cal Telephone Service Center at (800) 423-0507.

Table 1: Federally Required Adult Dental Services (FRADS)

The following procedure codes will continue as reimbursable procedures for Medi-Cal beneficiaries 21 years of age and older beginning July 1, 2009.

*Please note: The CDT-4 procedure codes marked with an asterisk (D0220, D0230, D0250, D0260, D0290, D0310, D0322 and D0330) are only payable for Medi-Cal beneficiaries age 21 and older who are not otherwise exempt when the procedure is appropriately rendered in conjunction with another FRADS.

CDT-4 Code	CDT-4 Code Description
D0220*	Intraoral - periapical first film
D0230*	Intraoral - periapical each additional film
D0250*	Extraoral - first film
D0260*	Extraoral - each additional film
D0290*	Posterior - anterior or lateral skull and facial bone survey film
D0310*	Sialography
D0320	Temporomandibular joint arthrogram, including injection
D0322*	Tomographic survey
D0330*	Panoramic film
D0502	Other oral pathology procedures, by report
D0999	Unspecified diagnostic procedure, by report
D2910	Recement inlay
D2920	Recement crown
D2940	Sedative filling
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement

CDT-4 Code	CDT-4 Code Description
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification
D5960	Speech aid prosthesis, modification
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5999	Unspecified maxillofacial prosthesis, by report
D6100	Implant removal, by report
D6930	Recement fixed partial denture
D6999	Unspecified fixed prosthodontic procedure, by report
D7111	Coronal remnants - deciduous tooth

Table 1: Federally Required Adult Dental Services (FRADS) - Continued

CDT-4 Code	CDT-4 Code Description
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth - soft tissue
D7230	Removal of impacted tooth - partially bony
D7240	Removal of impacted tooth - completely bony
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7285	Biopsy of oral tissue - hard (bone, tooth)
D7286	Biopsy of oral tissue - soft (all others)
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25cm
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
D7490	Radical resection of mandible with bone graft
D7510	Incision and drainage of abscess - intraoral soft tissue
D7520	Incision and drainage of abscess - extraoral soft tissue
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction producing foreign bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla - open reduction (teeth immobilized, if present)
D7620	Maxilla - closed reduction (teeth immobilized, if present)
D7630	Mandible - open reduction (teeth immobilized, if present)
D7640	Mandible - closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch - open reduction
D7660	Malar and/or zygomatic arch - closed reduction
D7670	Alveolus - closed reduction, may include stabilization of teeth
D7671	Alveolus - open reduction, may include stabilization of teeth
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7710	Maxilla - open reduction
D7720	Maxilla - closed reduction
D7730	Mandible - open reduction
D7740	Mandible - closed reduction
D7750	Malar and/or zygomatic arch - open reduction
D7760	Malar and/or zygomatic arch - closed reduction

Table 1: Federally Required Adult Dental Services (FRADS) - Continued

CDT-4 Code	CDT-4 Code Description
D7770	Alveolus - open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy - surgical: lavage and lysis of adhesions
D7874	Arthroscopy - surgical: disc repositioning and stabilization
D7875	Arthroscopy - surgical: synovectomy
D7876	Arthroscopy - surgical: debridement
D7877	Arthroscopy - surgical: debridement
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
D7920	Skin graft (identify defect covered, location and type of graft)
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical - per sextant or quadrant

CDT-4 Code	CDT-4 Code Description
D7945	Osteotomy - body of mandible
D7946	LeFort I (maxilla - total)
D7947	LeFort I (maxilla - segmented)
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949	LeFort II or LeFort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones - autogenous or nonautogenous, by report
D7955	Repair of maxillofacial soft and hard tissue defect
D7971	Excision of pericoronal gingiva
D7980	Sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	Unspecified oral surgery procedure, by report
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9210	Local anesthesia not in conjunction with operative or surgical procedures
D9220	Deep sedation/general anesthesia - first 30 minutes
D9221	Deep sedation/general anesthesia - each additional 15 minutes
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide
D9241	Intravenous conscious sedation/analgesia - first 30 minutes
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes
D9248	Non-intravenous conscious sedation
D9410	House/extended care facility call

Table 1: Federally Required Adult Dental Services (FRADS) - Continued

CDT-4 Code	CDT-4 Code Description
D9420	Hospital call
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours
D9610	Therapeutic drug injection, by report
D9910	Application of desensitizing medicament
D9930	Treatment of complications (post - surgical) - unusual circumstances, by report
D9999	Unspecified adjunctive procedure, by report

Table 2: Allowable Procedure Codes for Pregnant Women

CDT-4 Code	CDT-4 Code Description
D0120	Periodic oral evaluation
D0150	Comprehensive oral evaluation - new or established patient
D1110	Prophylaxis - adult
D1204	Topical application of fluoride (prophylaxis not included) - adult
D1205	Topical application of fluoride (including prophylaxis) - adult
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant

CDT-4 Code	CDT-4 Code Description
D4260	Osseous surgery (including flap entry and closure) -four or more contiguous teeth or bounded teeth spaces per quadrant
D4261	Osseous surgery (including flap entry and closure) -one to three teeth, per quadrant
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces per quadrant
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant
D4920	Unscheduled dressing change (by someone other than treating dentist
D9951	Occlusal adjustment - limited

Erika Jenssen/PH/HSD/US
04/16/2010 11:33 AM

To Guy Buechler/MedSrv/HSD/US@HSD, Ken Nguyen/MedSrv/HSD/US@HSD, Liza Arrivas/MedSrv/HSD/US@HSD, Henry
cc
bcc
Subject Pneumococcal 13-valent conjugate vaccine

Hi all,

I wanted to let you know that a new vaccine is coming soon - a 13-valent pneumococcal conjugate vaccine with the brand name of Prevnar. This vaccine will replace the 7-valent pneumococcal conjugate vaccine, also brand name Prevnar, that you all have been using for children under 5 years of age.

Here are the details:

New vaccine code in the Immunization Registry
PCV13 - please enter this vaccine code when you are giving the new 13-valent pneumococcal conjugate vaccine. This way we will be able to tell which vaccine a child received - the 7-valent or the 13-valent pneumococcal conjugate vaccine.

Here are the old vaccine codes in the Immunization Registry
PNUcon - this is the vaccine code for the 7-valent conjugate vaccine, brand name Prevnar (the one you have been using for years now for CHILDREN)
PNUps - this is the ADULT vaccine, brand name Pneumovax; this is still recommended for adults

Schedule change
Here is a summary of the details about the new 13-valent pneumococcal conjugate vaccine from the VFC Program.
http://eziz.org/PDF/13ValentPneumococcalConjugateVac.pdf

The schedule is basically the same as the current schedule for healthy children, with the addition that if children under 5 years of age got all four doses of the old PNUcon 7-valent vaccine, they need one booster dose of the new PCV13 13-valent vaccine. This is also covered in the Public Health Immunization Policies and Procedures Manual which can be found on iSite on the Public Health site:
http://cchs/Yips/SiteViewerHTML.aspx?SiteName=PH

We will NOT be making this schedule change in the Contra Costa Immunization Registry at this time because we are moving to the web-based Immunization Registry in June 2010.

Vaccine arrival
The new 13-valent pneumococcal vaccine may arrive with the next VFC shipment. If it does, please mark this vaccine with "PCV13" on the boxes so that everyone knows it is the new one. If you still have remaining doses of the old 7-valent vaccine, please follow the instructions below to return that vaccine to VFC.
http://eziz.org/PDF/PCV13AvailabilityFAX_Final.pdf

Please let me know if you have any questions about this vaccine and its arrival.
Thanks
Erika

Erika Jenssen, MPH
Immunization Coordinator
Contra Costa Public Health
597 Center Avenue, #200A

IMPORTANT MESSAGE

California Department of Public Health
Immunization Branch
Vaccines for Children (VFC) Program
850 Marina Bay Parkway
Richmond, CA 94804

Toll Free Phone:
877-2GET-VFC (877-243-8832)

Toll Free Fax:
877-FAXX-VFC (877-329-9832)

April 1, 2010

Recent Provider Communications and Updated Forms

Dear VFC Provider,

The following letters have been recently e-mailed to participating VFC providers and posted on VFC's website, www.eziz.org. Please ensure that this information is shared with your practice's immunization coordinator and staff administering vaccines.

- Temporary Suspension of GSK's Rotavirus Vaccine, Rotarix™
- Notice of Availability of the new Pneumocccal Conjugate Vaccine (PCV13)
- Notice of availability of Merck's PedVax® Hib vaccine through VFC

Updated VFC Forms

- VFC's Vaccine Order Form (CDPH 8501, 3/10) has been revised to reflect product availability changes.
- VFC's Return and Transfer Form (IMM-986, 3/10) instructions for the return of non-viable vaccines have been updated. Providers may contact VFC to request a postage-paid shipping label for the return of non-viable vaccines back to McKesson.

Important Reminders

- Please return any unused doses of PCV7 to McKesson after the receipt of PCV13 doses. Doses must be returned by April 30th, 2010 and do not have to be returned in cold packaging.
- Due to Rotarix's temporary suspension, VFC is currently substituting Merck's Rotateq on all Rotavirus orders. Orders may be adjusted to ensure adequate supplies. Please be sure to keep your Rotarix in your refrigerator marked "Do Not Use" until notified by VFC.

If you have any questions about this process, please call VFC's Customer Service at 1-877-243-8832.

Would you like to receive VFC communications via e-mail?
Visit our website at www.eziz.org and register to receive electronic updates.

Erika Jenssen/PH/HSD/US
04/16/2010 11:33 AM

To Guy Buechler/MedSrv/HSD/US@HSD, Ken Nguyen/MedSrv/HSD/US@HSD, Liza Arrivas/MedSrv/HSD/US@HSD, Henry
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