

**COUNTY OF LOS ANGELES
CHILDREN'S MEDICAL SERVICES
HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE (HCPCFC)**

CMS
HCPCFC

Policy/Procedure (Revised 04-11-12)

Subject: Public Health Nurse Documentation Policy
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PURPOSE

To standardize the documentation for HCPCFC Public Health Nurses.

SCOPE

Responsibilities of the Public Health Nurse (PHN) when documenting foster children's health information into the Child Welfare System/Case Management Services (CWS/CMS) database.

DEFINITION

Documentation is the process of inputting health information electronically into the CWS/CMS database.

POLICY

The PHN will adhere to documentation guidelines established in this policy when inputting health information into CWS/CMS.

PROCEDURE

1. The PHN will document the contact note in PIE format(Delivered Service Log) PIE Charting: A written method used to communicate a case consultation as follows:
 - i. Problem/Purpose- State the problem or purpose subjective and/or objective data supporting the stated focus.
 - ii. Intervention- Nursing actions taken (record in contact not Health and Education Passport (HEP).
 - iii. Evaluation- Evaluation of interventions and outcomes.

- 2. The PHN will create a contact note (Delivered Service Log) for every entry.**

- 3. The PHN will complete each contact note with the initial of their first name, full last name, and title at the end of the contact note (Delivered Service Log). Example: T. Works, PHN.**

- 4. The PHN will write their initials and title in capital letters, and the date of entry in parenthesis after every entry into CWS/CMS Health Notebook. Example: (TW, PHN, 8/01/10).**

- 5. The PHN will provide Children Social Worker (CSW) a Delivered Service Log for each consultation.**

- 6. The PHN will save the consultation form and the Delivered Service Log for 2 years when health problems have been identified.**

- 7. The PHN will document the source of health information into CWS/CMS, i.e. PM160, PMA.**

- 8. The PHN will adhere to the PM160, F-Rate, Home Visit, PMA and any other policies pertaining to documentation.**

- 9. The PHN will document all pertinent health information into CWS/CMS Health Notebook**

- 10. The PHN will check for correct spelling and grammar before saving all documentation.**

- 11. Do not use abbreviations of medical terminology or words that are not approved.**

- 12. The PHN will record all interventions into the Children Medical Services Portal (CMS Portal) daily.**

- 13. The PHN or PHNS will complete a contact if they are asked to review a case in CWS/CMS that is not part of their caseload.**

PROCEDURAL GUIDELINES FOR DOCUMENTATION IN THE HEALTH NOTEBOOK

CONTACT: A written entry into CWS/CMS using the PIE format about a nursing intervention (s).

Problem/Purpose: A statement of how the PHN received the case consultation and a problem if known.

Intervention: The PHN assessment, observation, findings, and action taken.

Evaluation: Plan and or recommendation for follow up or completion of the consultation

Contact Example:

The screenshot shows a software window with a menu bar (File, Edit, Search, Action, Associated, Attach/Detach, Window, Help, Toolz) and a toolbar. The main area is divided into several sections:

- Contact Information:** Includes fields for Staff Person (1), Start Date (2), End Date, End Time, Contact Purpose (3), Method (5), Location, and Status (6).
- Participants:** A table with one entry: 1 Harbor UCLA (4).
- On Behalf of Child:** A table with one entry: 1 Guthrie, Nancy L.
- Contact Party Type:** A table with one entry: 1 Staff Person/Service Provider.
- Case Management Services/Referrals:** A table with one entry: 1 Management Services/Referrals (7).
- Narrative:** A text area containing:
 - Problem: PHN received PM 160 from T. Smith, CSW.
 - Intervention: PHN reviewed, entered medical and immunization information and updated HEP.
 - Evaluation: Follow up as necessary. Returned PM 160 to CSW to file. T.Works,PHN.
 (8)

The Windows taskbar at the bottom shows the Start button, several open applications (Doc..., CWS..., Inbo..., Clie..., CAI...), and the system clock showing 8:36 AM.

ASSOCIATE SERVICE SECTION:

- 1. Associate Services:** Check the history of date of services first to avoid multiple dates of health services.
- 2. Associate Narrative box, Sick Visit:** Document “See diagnosed condition of the Health Notebook.”

Associated Narrative box, Sick Visit Example:

The screenshot shows a software application window with the following components:

- Menu Bar:** File, Edit, Search, Action, Associated, Attach/Detach, Window, Help, Toolz.
- Toolbar:** Contains icons for file operations and a user profile icon.
- Associated Services Table:**

	Start Date	End Date	Service Category	Service Type	Wraparound
1	02/23/2012	02/23/2012	Health/CHDP Services	Medical Visit	
- Service Details Form:**
 - Offered but not delivered
 - Hard Copy On File
 - Well Child Exam
 - Start Date: 02/23/2012, Start Time: : am
 - End Date: 02/23/2012, End Time: : am
 - Service Category: Health/CHDP Services
 - Service Type: Medical Visit
 - Wraparound
 - Staff Person, Service Provider, Collateral, Substitute Care Provider (radio buttons)
 - Provider Name: Harbor UCLA
- Participants Table:**

	On Behalf of Child	Service Recipient
1	Guthrie, Nancy L	Guthrie, Nancy L
- Narrative Text Area:** See diagnosed condition. (T.W, PHN, 2/29/12).

- 3. Associate Narrative box, Well Child Visit:** Do not document any information in this box because when you print out the HEP, it will populate 2 entries in the well child section of the HEP.

Associate Narrative box, Well Child Visit Exam:

The screenshot displays a medical software interface with a 'Well Child Exam' service record and a data entry dialog box. The interface includes a tab bar at the top, a table of associated services, and a detailed service record. A dialog box titled 'Well Child Exam' is open, showing patient demographics and a narrative text area. Numbered callouts (1-8) highlight specific UI elements:

- 1: Tab bar (Contact, Associated Services, Associated Visits)
- 2: Service details (Offered but not delivered, Hard Copy On File, Start Date, End Date, Service Category, Service Type, Wraparound)
- 3: Service Category dropdown menu
- 4: Service Type dropdown menu
- 5: Add button (+)
- 6: Provider Name dropdown menu
- 7: Narrative text area
- 8: OK button in the dialog box

	Start Date	End Date	Service Category	Service Type	Wraparound
1	09/14/2011	09/14/2011	Health/CHDP Services	HEP - CHDP Equivalent Physical Exam	
2	08/29/2011	08/29/2011	Health/CHDP Services	Medical Visit	
3	08/22/2011	08/22/2011	Health/CHDP Services	HEP - CHDP Equivalent Physical Exam	

Well Child Exam

Age	Age Unit	Height	Height %	Weight	Weight %	Head Circumference
2	Months	20.5 inch	4%	8 lbs 5oz	10%	16 in

Age Estimated
 Does this client have any health conditions diagnosed by a certified medical professional?
 No Yes

Medical/Dental Referral

Per PM 160, head circumference 25%. (TW, PHN, 11/30/11).

OK Cancel

Associate Narrative box, Well Child Visit Example 2: populated to the HEP, showing 2 entries:

The screenshot shows a Microsoft Word document titled 'cpohc000.doc'. The document contains a table with two entries for Well Child Visits. The first entry is dated 11/16/2011 and the second is dated 09/14/2011. The second entry's comment is highlighted with a blue arrow.

DATE	EXAM TYPE	SERVICE PROVIDER			
11/16/2011	HEP - CHDP Equivalent Physical Exam	Nasir Tejani M.D			
AGE AT TIME OF EXAM	HEIGHT	HEIGHT %	WEIGHT	WEIGHT %	HEAD CIRCUMFERENCE
4 Month(s)	22.28 inch	3-5%	11 lbs	5%	15.75
COMMENTS / OUTCOMES / REFERRALS					
PM 160, head circumference 10%. (DT/PHN 1/19/12).					
DATE	EXAM TYPE	SERVICE PROVIDER			
09/14/2011	HEP - CHDP Equivalent Physical Exam	Nasir Tejani M.D			
AGE AT TIME OF EXAM	HEIGHT	HEIGHT %	WEIGHT	WEIGHT %	HEAD CIRCUMFERENCE
2 Month(s)	20.5 inch	4%	8 lbs 5oz	10%	16 in
COMMENTS / OUTCOMES / REFERRALS					
Per PM 160, head circumference 25%. (TW, PHN, 11/30/11).					
Per PM 160, head circumference 25%. (TW, PHN, 11/30/11).					
DATE	EXAM TYPE	SERVICE PROVIDER			
08/22/2011	HEP - CHDP Equivalent Physical Exam	Nasir Tejani M.D			
AGE AT TIME OF EXAM	HEIGHT	HEIGHT %	WEIGHT	WEIGHT %	HEAD CIRCUMFERENCE

In the Health Notebook Sections (Blue Button in CWS/CMS): Summary, Diagnosed Condition, Observed Condition, Hospitalization, Medication, Medical Test, Referral, Immunization, Well Child, and Birth Record. The PHN is required to document as follow:

I. SUMMARY PAGE SECTION:

Use this section to summarize a foster child's *current major health* condition & information such as:

1. CCS, case manager, hospital medical record numbers.
2. List only major/chronic health conditions: Heart, Cancer, Asthma, CP, DM, Autism, Heart Surgery, Intracranial Shunt, G-Tube, etc. **NOTE:** These are not substitute diagnoses. The PHN must initiate the diagnoses in the diagnosed condition section.
3. If the medical condition is resolved, the PHN may document it as resolved, include date if known. Example: GERD: resolved per 561(a) dated 3/17/11.
4. Check small boxes: Sensitive Health, Regional Center, and/or Developmental Disability if applicable. (see example below): * **Note:** Sensitive Health box is only checked for HIV/AIDS. All the developmental disabilities must be diagnosed by Regional Center before the regional center and disability boxes can be checked.
5. Document F-rate and date of completion *but not the F-rate level*.
6. Document the current specialist name and phone number, i.e. cardiologist, neurologist, and urologist.
7. Do not document PHN telephone calls, actions, unnecessary and lengthy information in this section.
8. Do not document treatment/medication (s) in this section.

Summary Example:

Summary | Diagnosed Condition | Observed Condition | Medications | Hospitalizations | Medical Tests | Referrals | Immunization | Well Child | Birth History

Summary

Sensitive Health & Medical Information is on file for this person Individual Health Care Plan on File for Special Needs Child

Limitation Put on Substitute Care Provider's Ability to Make Health Decisions

Summary of Current Health Condition

GERD resolved on 3/17/11. (TW, PHN, 5/10/11).

CCS # 12345. (TW, PHN, 5/10/11).

USC MR # 2354. (TW, PHN, 10/10/11).

South Central Regional Center Coordinator name, phone, UCI # 20613. (TW, PHN, 10/10/11).

F-rate completed. (TW, PHN, 1/10/12).

Currently Receives Services From

CA Children's Services

Regional Center

Other

Previously Received Services From

CA Children's Services

Regional Center

Other

Has this child been clinically diagnosed as having a disability(ies)?

Yes No Not Yet Determined

II. DIAGNOSED CONDITION SECTION:

Use this section to record any condition diagnosed by a clinician/specialist. Record as much information about the condition as possible. A diagnosis is required in order to enter additional health information in the Medication, Hospitalization, Medical Test, and Referral sections of the HEP. Use start and end dates to document child's health history.

Before entering a diagnosed condition follow the steps and example below:

1. Review all diagnosed conditions to avoid duplication.
2. Separate each diagnoses and treatments when diagnosed on the same date. List a diagnosed condition once.
3. **Alert box:** check it if applicable. See PM160 policy for details.
4. **The Health Problem Description Box:** Enter all subsequent visits related to the same diagnosis in a descending chronological order.
 - a. It is required to document the sources of services: i.e.: 561(a), (b), (c), PMA, PM 160, medical records, or clinician/specialist's notes.

5. **Treatment/Instruction Box:** List all treatments as prescribed by the provider. Enter all subsequent treatments/instructions in a descending chronological order.

a. The PHN may go to medication, hospitalization, medical test or referral sections if applicable.

b. The PHN may document short term medications prescribed for 10 days or less.

6. End Date the diagnosed condition if supported by medical documentation.

Health Problem Description and Treatment Example 1: PM160, 561(a)

Summary | Diagnosed Condition | Observed Condition | Medications | Hospitalizations | Medical Tests | Referrals | Immunization | Well Child | Birth History

Alert Onset Date/First Visit: 05/20/2010 Diagnosed By: Dr. Gold Phone: () -

End Date: Next Scheduled Visit Date:

Condition

Category: Physical Health

Health Problem: Fracture - Bone

Communicable Disease

Unknown No Yes

For This Diagnosed Condition

Medications Prescribed

Unknown No Yes

Medical Tests Ordered

Unknown No Yes

Hospitalizations Occurred

Unknown No Yes

Referrals Made

Unknown No Yes

Health Problem Description

05/20/10, per PM 160, Fracture of the right elbow. (TW, PHN, 6/3/10).
05/26/10, per 561(a), by CHLA orthopedist, Fracture of the right elbow. (TW, PHN, 06/03/10).

Treatment Plan / Instructions

05/20/10, per PM 160, splint of the right elbow. Instructed neuro-circulation check and precaution. Tylenol # 3 for pain. Refer to CHLA orthopedist. (TW, PHN, 06/03/10).
05/26/10, per 561(a), right elbow cast. Follow up in 2 week. (TW, PHN, 06/03/10).
06/10/10, per 561(a), CHLA orthopedist follow up. Still keeping the cast. Right arm elevated. (TW, PHN, 06/03/10).

Start | Docum... | Deleted... | CWSTr... | CWS/C... | Client ... | 11:47 AM

Health Problem Description and Treatment Example 2: PM160, 561(a)

The screenshot displays a medical software window with the following sections and callouts:

- 1**: Onset Date/First Visit: 05/20/2010
- 2**: Diagnosed By Name: Dr. Gold
- 3**: Alert:
- 4**: Condition Category: Physical Health
- 5**: Health Problem: Fracture - Bone
- 6**: Health Problem Description:
05/20/10, per PM 160, Fracture of the right elbow. (TW, PHN, 6/3/10).
05/26/10, per 561(a), CHLA orthopedist, Fracture of the right elbow. (TW, PHN, 06/03/10).
06/10/10, per 561(a), CHLA orthopedist follow up for the Fracture of the right elbow. (TW, PHN, 6/12/10)
- 7**: Treatment Plan / Instructions:
05/20/10, per PM 160, splint of the right elbow. Instructed neuro-circulation check and precaution.
Tylenol # 3 for pain. Refer to CHLA orthopedist. (TW, PHN, 06/03/10).
05/26/10, per 561(a), right elbow cast. Follow up in 2 week. (TW, PHN, 06/03/10).
06/10/10, per 561(a), keeping the cast. Right arm elevated. (TW, PHN, 06/12/10).

Additional form fields include: End Date, Next Scheduled Visit Date, Diagnosed By Phone, Communicable Disease (Unknown, No, Yes), Medications Prescribed (Unknown, No, Yes), Medical Tests Ordered (Unknown, No, Yes), Hospitalizations Occurred (Unknown, No, Yes), and Referrals Made (Unknown, No, Yes).

Health Problem and Description Treatment Example 3: PMA example:

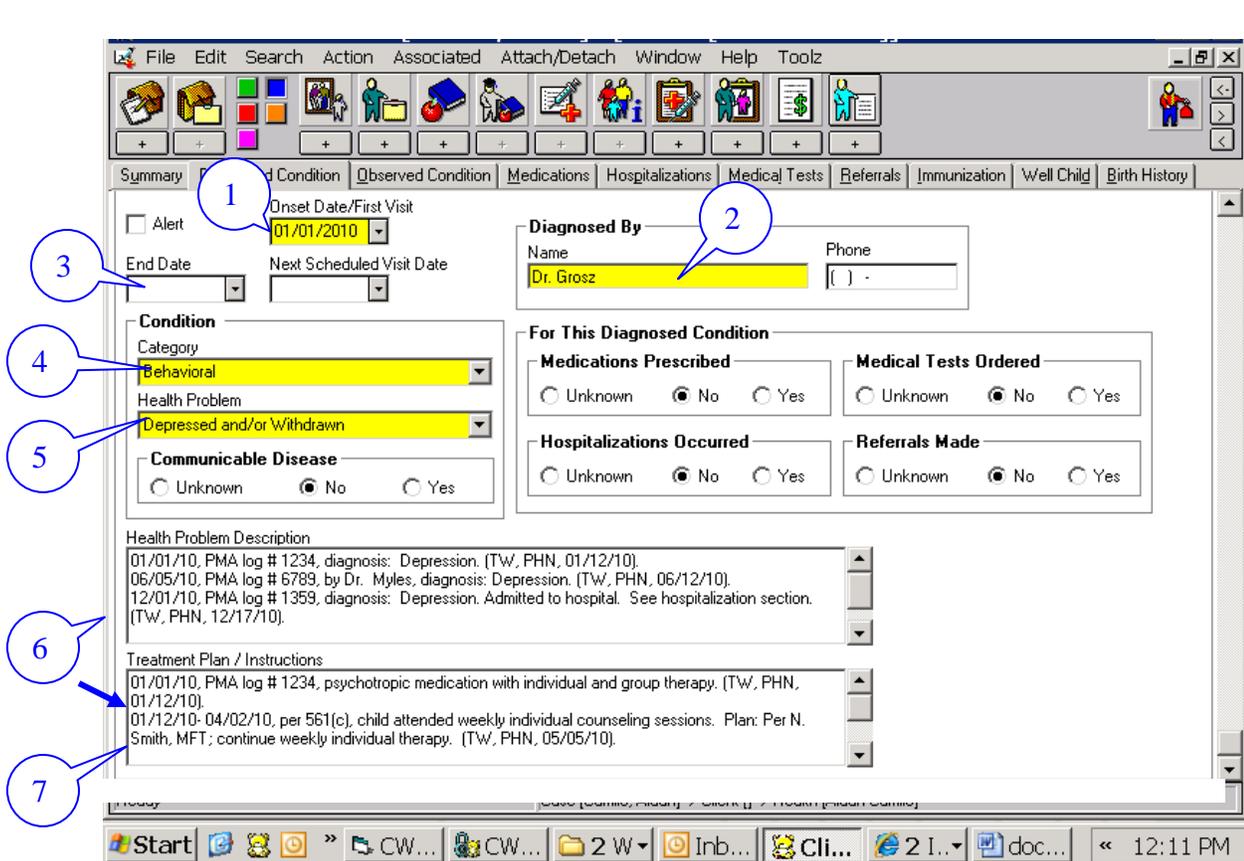
The screenshot shows a medical software window with the following elements:

- 1:** Onset Date/First Visit: 03/24/2011
- 2:** Diagnosed By: Dr. Gessesse, Hiruy
- 3:** Alert checkbox (unchecked)
- 4:** Condition Category: Emotional
- 5:** Health Problem: Mood Swings (Frequent and/or Persistent)
- 6:** Health Problem Description: Per PMA # 1259, diagnosis Mood Disorder, Not Otherwise Specified (NOS). (TW, PHN, 4/25/11). 6/27/11, PMA # 11-01211 by Dr. Askins, Mood Disorder (NOS). (TW, PHN, 8/2/11). 8/24/11, PMA # 11-01881, by Dr. Gulimo, Joseph, Rule Out Mood Disorder NOS (TW, PHN, 9/12/11). 12/5/11, per medical record by Gateways Hospital, Mood Disorder. See hospitalization section. (TW,
- 7:** Treatment Plan / Instructions: Per PMA # 1259, psychotropic medication with individual and group therapy. (TW, PHN, 4/25/11). 6/27/11, PMA # 11-01211 by Dr. Askins, psychotropic medication with daily individual and group therapy. (TW, PHN, 8/2/11). 8/24/11, PMA # 11-01881, psychotropic medication with individual therapy. (TW, PHN, 9/12/11).

Two red callout boxes contain the following text:

- Do not use psychotropic medications as a diagnosis**
- Avoid labeling child i.e. Anxiety, Crazy.**

Health Problem and Description Treatment Example 4: PMA example, how to enter multiple 561(c):



III. OBSERVED CONDITION SECTION:

Use this section to record any conditions observed by a PHN. Record as much information about the condition as possible. Use start and end dates to document child's health history. Observed conditions will only print to passport if the alert box is checked.

IV. MEDICATION SECTION:

Use this section to document prescribed medications. These medications must be tied to a “Diagnosed Condition.”

1. **In the Prescribed Medication Section:** Enter the name of the medication only.
2. **In the Comment Section:** Enter the date of services in a descending chronological order, the source of information, dosage, route, and frequency ordered by a clinician/specialist.
3. End Date the medication/s when appropriate.
4. Use this section for long term medication(s).
5. Do not document medications prescribed for 10 days or less in this section.

Medication Example from the PM160 and 561 (a): How to enter in the Comment/Instructions box:

The screenshot displays the 'Medications' section of a medical software interface. At the top, there is a toolbar with various icons and a menu bar with options like 'Summary', 'Diagnosed Condition', 'Observed Condition', 'Medications', 'Hospitalizations', 'Medical Tests', 'Referrals', 'Immunization', 'Well Child', and 'Birth History'. The main window shows a table of medications with columns for '+', 'Alert', 'Prescribed Medication', 'Start Date', and 'End Date'. Below the table, there is a form for a selected medication. The form includes fields for 'Client Condition' (Asthma), 'Onset Date / First Visit' (03/29/2011), 'End Date', 'Prescribed Medication' (Proventil HFA (Albuterol)), 'Alert' (unchecked), 'Prescribed By' (Dr. De Leaver), 'Start Date' (03/29/2011), 'Projected End Date', and 'End Date'. A 'Comment / Instructions' text area contains detailed notes about the medication's use. At the bottom, there are two questions: 'Is this a psychotropic medication?' and 'Is this medication administered for psychiatric reasons?'. A 'Parental Consent/Court Order' table is also visible at the bottom right. Red callout boxes with numbers 1 through 7 point to specific elements in the interface.

	Alert	Prescribed Medication	Start Date	End Date
3	No	Singulair	10/19/2011	
4	No	Proventil HFA (Albuterol)	03/29/2011	
5	No	Proventil HFA (Albuterol)	03/29/2011	
6	No	Amoxil	09/16/2011	09/26/2011

Client Condition: Asthma
Onset Date / First Visit: 03/29/2011
End Date: []
Prescribed Medication: Proventil HFA (Albuterol)
Alert: []
Prescribed By: Dr. De Leaver
Start Date: 03/29/2011
Projected End Date: []
End Date: []
Comment / Instructions: 9/16/11, per 561(a), by Reliant Immediate Care, give medication. (TW, PHN, 9/16/11). 10/19/11, per 561(a), by Harbor UCLA, 0.083%, 1 vial via nebulizer every 6 hours as needed. (TW, PHN, 10/24/11). 11/16/11, per 561(a), as above. (TW, PHN, 12/10/11).

Is this a psychotropic medication?
 Yes No

Is this medication administered for psychiatric reasons?
 Yes No

Consent Type	Date
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Medication Example from the PMA: Non-Emergency Medications. How to enter medications in the Comment/Instructions box:

The screenshot shows a medical software interface with the following components and callouts:

- 1:** Points to the 'Medications' table header.
- 2:** Points to the 'Start Date' field (07/10/2011).
- 3:** Points to the 'Client Condition' field (Mood Swings (Frequent and/or Persistent)).
- 4:** Points to the 'End Date' field (08/30/2011).
- 5:** Points to the 'Parental Consent/Court Order' table.
- 6:** Points to the 'Comment/Instructions' box.
- 7:** Points to the 'Projected End Date' field.
- 8:** Points to the 'End Date' field.
- 9:** Points to the 'Is this a psychotropic medication?' checkbox.

The 'Medications' table contains the following data:

	Alert	Prescribed Medication	Start Date	End Date
2	No	Depakote	08/24/2011	
3	No	Neurontin	08/24/2011	12/06/2011
4	No	Trazadone	07/10/2011	08/30/2011
5	No	Zyprexa	06/27/2011	06/27/2011

The 'Parental Consent/Court Order' table contains the following data:

	Consent Type	Date
1	Court Ordered	08/30/2011
2	Court Ordered	07/20/2011

The 'Comment/Instructions' box contains the following text:

7/20/11, PMA # 11-01211, start 100 mg at bedtime. (TW, PHN, 8/10/11).
 8/30/11, PMA 3 11-01881, by Dr. Gulimo, discontinue. (TW, PHN, 9/10/11).

* In the Comment /Instruction box: Non-emergency case: enter the current court date (current PMA).

* Projected End Date Medication: 180 days or 6 months from the date of the current court approval date (current PMA).

* Note: End Date medication using the current court approval date (current PMA) or when child no longer takes medication.

Medication Example from the PMA: Emergency Medication. How to enter the PMA in the Comment/Instructions box:

The screenshot shows a software interface for managing medications. At the top, there is a navigation bar with tabs for Summary, Diagnosed Condition, Observed Condition, Medications, Hospitalizations, Medical Tests, Referrals, Immunization, Well Child, and Birth History. The 'Medications' tab is active, displaying a table of prescribed medications:

	Alert	Prescribed Medication	Start Date	End Date
1	No	Neurontin	12/06/2011	
2	No	Depakote	08/24/2011	
3	No	Neurontin	08/24/2011	12/06/2011
4	No	Trazadone	07/10/2011	08/30/2011

Below the table, the 'Client Condition' is 'Mood Swings (Frequent and/or Persistent)'. The 'Prescribed Medication' is 'Depakote', prescribed by 'Dr. Gulimo'. The 'Start Date' is '08/24/2011', the 'Projected End Date' is '06/09/2012', and the 'End Date' is blank. The 'Comment/Instructions' field contains: '8/24/11, PMA # 3 11-01881, continue 750 mg at bed time. (TW, PHN, 9/1/11). 12/6/11, PMA log#03372, change to 500 mg at bedtime. (TW, PHN, 1/2/12)'. A 'Parental Consent/Court Order' table is also visible:

	Consent Type	Date
1	Court Ordered	12/09/2011
2	Court Ordered	08/30/2011

Callout 1 points to the Medications table. Callout 2 points to the Start Date field. Callout 3 points to the Prescribed Medication field. Callout 4 points to the Prescribed By field. Callout 5 points to the Comment/Instructions field. Callout 6 points to the Parental Consent/Court Order table. Callout 7 points to the Projected End Date field. An orange callout box contains the text: 'Emergency medication: use the date the Psychiatrist saw the child.'

* In the Comment/Instruction box: Emergency case: enter the date the psychiatrist saw the child (JV 220A #5 or after # 17 where the doctor signed).

* Project End Date Medication: 180 days or 6 months from the date of the current court approval date (current PMA).

Medication Example from the PMA: How to End Date psychiatric medications when the Comment/Instructions box runs out of space:

Medications

	Alert	Prescribed Medication	Start Date	End Date
2	No	Depakote (continue)	08/24/2011	
3	No	Depakote	08/24/2011	
4	No	Neurontin	08/24/2011	12/06/2011
5	No	Tramazone	07/10/2011	08/30/2011

Client Condition: Mood Swings [Frequent and/or Persistent]

Onset Date / First Visit: 03/24/2011

End Date: [Empty]

Prescribed Medication: Depakote (continue)

Prescribed By: Dr. Gulimo

Start Date: 08/24/2011

Projected End Date: [Empty]

End Date: [Empty]

Comment / Instructions: 8/24/11, PMA # 3 11-01881, continue 750 mg at bed time. (TW, PHN, 9/1/11). 10/3/11, PMA # 3 11-01991, continue as above (TW, PHN, 9/1/11). 12/6/11, PMA log#03372, change to 500 mg at bedtime. (TW, PHN, 1/2/12).

Is this a psychotropic medication?
 Yes No

Is this medication administered for psychiatric reasons?
 Yes No

Parental Consent/Court Order

	Consent Type	Date
1	Court Ordered	12/09/2011
2	Court Ordered	10/30/2011
3	Court Ordered	08/30/2011

Medication Example from the PMA: The HEP appears in a chronological order when you print it out.

The screenshot shows a Microsoft Word document titled "cpohc000.doc" with a medication list. The list is organized into rows, each containing medication details and dates. The rows are as follows:

Medication	START DATE	PROJECTED END DATE	END DATE
Neurontin	12/06/2011	06/09/2012	
MEDICATION COMMENTS / INSTRUCTIONS: 12/6/11, PMA log#03372, continue 100 mg daily at bedtime. (TW, PHN, 1/10/12).			
Depakote	08/24/2011	07/10/2012	
MEDICATION COMMENTS / INSTRUCTIONS: Psychotropic medication for psychiatric reasons. 1/10/12, PMA # 0111-01881, continue 550 mg at bed time. (TW, PHN, 2/10/12).			
Depakote (continue)	08/24/2011		
MEDICATION COMMENTS / INSTRUCTIONS: Psychotropic medication for psychiatric reasons. 8/24/11, PMA # 3 11-01881, continue 750 mg at bed time. (TW, PHN, 9/1/11). 10/3/11, PMA # 3 11-01991, continue as above (TW, PHN, 9/1/11). 12/6/11, PMA log#03372, change to 500 mg at bedtime. (TW, PHN, 1/2/12).			
Neurontin	08/24/2011	09/30/2011	12/06/2011
MEDICATION COMMENTS / INSTRUCTIONS: 8/30/11, PMA 3 11-01881, continue 100mg at bed time. Allow for 30 days to resubmission with additional information. The use of Neurontin for			

Annotations in the image include a blue box labeled "CORRECT" with an arrow pointing to the Depakote (continue) row, and orange arrows pointing to the first and last rows of the medication list.

Medication Example from the PMA: Do not End Date the medication when the space of the Comment/Instructions box has ran out. When you print the HEP, it will not print out in chronological order.

INCORRECT

DO NOT END DATE!!!!

CURRENT HEALTH ISSUES			
HEALTH PROBLEM Other Behavioral Condition	ONSET DATE/FIRST VISIT 07/03/2003	NEXT SCHEDULED VISIT DATE	
DIAGNOSED BY: NAME Dr. Gold	DIAGNOSED BY: PHONE	COMMUNICABLE DISEASE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN	
HEALTH PROBLEM DESCRIPTION 07/03/03, PMA # 0023, diagnosis: Depression. (MX/PHN 07/20/03).			
TREATMENT PLAN/INSTRUCTIONS 07/03/03, PMA # 0023, psychotropic medication with individual therapy. (MX/PHN 07/20/03).			
PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Concerta	01/01/2006	07/07/2006	
MEDICATION COMMENTS/INSTRUCTIONS: Psychotropic medication for psychiatric reasons. 01/01/06, continue 54 mg once at night. (MX/PHN 01/10/06)			
PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Prozac	01/01/2006	07/01/2006	
MEDICATION COMMENTS/INSTRUCTIONS: Psychotropic medication for psychiatric reasons. 01/01/06, continue 20 mg once at night. (MX/PHN 01/10/06)			
PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Concerta	07/07/2004		01/01/2006
MEDICATION COMMENTS/INSTRUCTIONS: Psychotropic medication for psychiatric reasons. 07/07/04, PMA # 1234, continue 54 mg-1 tabet twice a day. (MX/PHN 07/10/04). 01/02/05, PMA # 1235, change to 54 mg -1 tablet at night. (MX/PHN 01/10/05). 07/07/05, PMA 0012, change to 54 mg in morning & 38 mg at night. (MX/PHN 07/15/05).			
PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Prozac	07/07/2004		01/01/2006
MEDICATION COMMENTS/INSTRUCTIONS: 07/07/04, PMA # 1234, continue 20 mg-1 tabet twice a day. (MX/PHN 07/10/04). 01/02/05, PMA # 1235, change to 20 mg -1 tablet at night. (MX/PHN 01/10/05). 07/07/05, PMA 0012, change to 20 mg in morning & 10mg at night. (MX/PHN 07/15/05).			
PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Concerta	07/03/2003		07/07/2004
MEDICATION COMMENTS/INSTRUCTIONS: Psychotropic medication for psychiatric reasons. 07/10/03, PMA # 0023, start 54 mg- 2 tablets twice a day. (MX/PHN 07/20/03). 01/01/04, PMA 0211, take 1 tablet twice a day. Approved for hospital stay and 2 weeks after discharge. (MX/PHN 01/10/04).			
PRESCRIBED MEDICATIONS	START DATE	PROJECTED END DATE	END DATE
Prozac	07/03/2003		07/07/2004
MEDICATION COMMENTS/INSTRUCTIONS: Psychotropic medication for psychiatric reasons. 07/10/03, PMA # 0023, start 20 mg- 2 tablets twice a day. (MX/PHN 07/20/03). 01/01/04, PMA 0211, take 1 tablet twice a day. Approved for hospital stay			

V. HOSPITALIZATION SECTION:

Use this section to document anytime a child has been hospitalized (medical and psychiatric hospitalizations). Document the admission date, discharge date, client condition, and hospital name for every hospitalization. The hospitalization must be tied to a “Diagnosed Condition”.

1. **In the Hospital Comment Section:** Document source of information, then the child’s hospitalization information such as diagnosis (es) and discharge summary. Document treatment and follow up plan in the Diagnosed Condition Section.

2. Do not document Intravenous drip rates, Oxygen liter per minute increments, daily medications and lab results in this section.

3. Do not document weekly follow up phone call(s) which should be listed under the contact.

4. Do not transcribe the entire discharge summary into the contact or Hospitalization Comment Box. Document the admission and discharge diagnosis in the Hospitalization Comment Box. See hard copy.

Hospitalization Example:

The screenshot displays a medical software interface with a toolbar at the top and a navigation menu below it. The 'Hospitalizations' tab is selected, showing a table with one entry. Below the table, a detailed form for the selected hospitalization is visible, with several fields highlighted by numbered callouts:

Admit Date	Discharge Date	Client Condition	Hospital
07/11/2010	09/11/2010	Prematurity	CHLA

Client Condition: Prematurity (Callout 2)
Onset Date / First Visit: 07/11/2010 (Callout 5)
End Date: (Callout 5)
Admit Date: 07/11/2010 (Callout 4)
Discharge Date: 09/11/2010 (Callout 3)
Attending Physician Name: Gold (Callout 6)
Hospital Name: CHLA (Callout 6)
Hospital Location: Los Angeles (Callout 7)
Hospitalization Comments: Per admission summary: Diagnoses: Prematurity, increased bilirubin, heart murmur, VSD, anemia, and retinal hemorrhage. (TW, PHN, 11/24/10). (Callout 4)

Windows taskbar at the bottom shows the Start button, several application icons, and the system clock displaying 3:15 PM.

Prematurity Hospitalization Example: Upon discharge, for the unresolved diagnosis, go to the Diagnosed Condition section and click the (+) sign. The start date for the unresolved diagnosis will be the discharge date:

Example A

The screenshot shows a Microsoft Word document titled 'cpohc000.doc' containing a medical form. The form is divided into several sections:

- HEALTH PROBLEM:** Prematurity
- ONSET DATE/FIRST VISIT:** 07/11/2010
- NEXT SCHEDULED VISIT DATE:** (Empty)
- DIAGNOSED BY: NAME:** CHLA
- DIAGNOSED BY: PHONE:** (Empty)
- COMMUNICABLE DISEASE?:** YES (unchecked), NO (checked), UNKNOWN (unchecked)
- HEALTH PROBLEM DESCRIPTION:** Per admission record, Prematurity at 31 weeks. See hospitalization section. (TW, PHN, 11/24/12).
- TREATMENT PLAN / INSTRUCTIONS:** (Empty)
- HOSPITALIZATION ADMIT DATE:** 01/01/2010
- HOSPITALIZATION DISCHARGE DATE:** 09/11/2010 (indicated by an orange arrow)
- HOSPITAL NAME:** CHLA
- HOSPITAL LOCATION (CITY AND STATE):** Los Angeles
- ATTENDING PHYSICIAN NAME:** Dr. Gold
- HOSPITALIZATION COMMENTS:** Per admission summary: Diagnoses: Prematurity, increased billirubin, heart murmur, VSD, anemia, and retinal hemorrhage. The minor was on GT feeding, oxygen and intravenous fluid. The minor was seen by ophthalmologist and cardiologist. Per discharge summary, Final Diagnoses: Prematurity, anemia, and Premature of the Retinal. Resolved Diagnoses: Increased Billirubin, Heart Murmur, and VSD. Follow up with PMD next week. (TW, PHN, 11/24/10).

The Microsoft Word interface includes a menu bar (File, Edit, View, Insert, Format, Tools, Table, Window, Help), a toolbar with various icons, and a status bar at the bottom showing 'Page 1', 'Sec 1', '1/9', 'At 0.5"', 'Ln 1', 'Col 1', and system tray icons.

Example B.

File Edit Search Action Associated Attach/Detach Window Help Toolz

Summary **Diagnosed Condition** Observed Condition Medications Hospitalizations Medical Tests Referrals Immunization Well Child Birth History

Alert Onset Date/First Visit: 09/11/2010

End Date: Next Scheduled Visit Date:

Diagnosed By
Name: CHLA Phone: () -

Condition
Category: Physical Health
Health Problem: Anemia
Communicable Disease
 Unknown No Yes

For This Diagnosed Condition
Medications Prescribed: Unknown No Yes
Medical Tests Ordered: Unknown No Yes
Hospitalizations Occurred: Unknown No Yes
Referrals Made: Unknown No Yes

Health Problem Description: Per discharge summary, Anemia. (TW, PHN, 11/24/10).

Treatment Plan / Instructions: Per discharge summary, follow up with MD next week for hemoglobin recheck. (TW, PHN, 11/24/10).

Start Do... Del... CW... CW... 3 I... Cli... 2 M... 3:33 PM

Example C.

Summary **Diagnosed Condition** Observed Condition Medications Hospitalizations Medical Tests Referrals Immunization Well Child Birth History

+	Alert	Health Problem	Diagnosed By	Onset Date / First Visit	End Date
1	No	Other Physical Health Condition	CHLA	09/11/2010	

Alert Onset Date/First Visit: 09/11/2010

End Date: Next Scheduled Visit Date:

Diagnosed By
Name: CHLA Phone: () -

Condition
Category: Physical Health
Health Problem: Other Physical Health Condition
Communicable Disease
 Unknown No Yes

For This Diagnosed Condition
Medications Prescribed: Unknown No Yes
Medical Tests Ordered: Unknown No Yes
Hospitalizations Occurred: Unknown No Yes
Referrals Made: Unknown No Yes

Health Problem Description: Per discharge summary, Prematurity of the Retinal. (TW, PHN, 11/24/10).

Treatment Plan / Instructions: Per discharge summary, follow up with an ophthalmologist next week. (TW, PHN, 11/24/10)

VI. MEDICAL TEST SECTION:

Use this section to document any medical tests ordered for a child. The medical tests must be associated with a “Diagnosed Condition” or “Medical Procedure Required” if there is no related diagnosis.

1. **In the Test Result Section:** Document source of information, test results, hearing, vision, blood pressure, and urine analysis, etc.
2. Do not document BMI in this section.
3. Do not end date medical procedure; change date of the test accordingly.

Medical Test Example:

The screenshot displays a medical software interface with the following components:

- Toolbar:** A row of icons for various medical functions, with callout box 1 pointing to it.
- Navigation Menu:** A horizontal menu with tabs: Summary, Diagnosed Condition, Observed Condition, Medications, Hospitalizations, Medical Tests, Referrals, Immunization, Well Child, Birth History.
- Table:** A table titled "Tests for Diagnosed Condition" with columns "Test Date" and "Test Type". It contains one entry: "01/10/2012" and "Hemoglobin".
- Form Fields:**
 - Client Condition:** A dropdown menu showing "Medical Procedures Required" (callout box 2).
 - Onset Date / First Visit:** A date field set to "01/10/2012" (callout box 3).
 - End Date:** An empty date field (callout box 4).
 - Test Date:** A dropdown menu set to "01/10/2012" (callout box 2).
 - Test Type:** A dropdown menu set to "Hemoglobin" (callout box 3).
 - Test Location:** A text field containing "Dr. Uy".
- Test Results:** A text area containing "PM 160, Hemoglobin: 14.0 gm/dl normal. (Tw, PHN, 2/10/12)." (callout box 5).

The Windows taskbar at the bottom shows the Start button, several application icons, and the system clock displaying "3:37 PM".

VII. REFERRAL PAGE SECTION:

Use this section to document any medical referrals made on behalf of a child by a Clinician/Specialist, PHN or Children Social Worker (CSW). The referrals must be associated with a “Diagnosed Condition”.

1. **In the Reason Section:** Document source of information and referral information.
2. All referrals must be entered. Document follow up referral (s) as needed.
3. Enter date seen by the Specialist and check Referral Processed Box if known.

Referral Page Example:

The screenshot displays a software interface for entering medical referrals. At the top, there is a navigation bar with tabs for Summary, Diagnosed Condition, Observed Condition, Medications, Hospitalizations, Medical Tests, Referrals, Immunization, Well Child, and Birth History. The 'Referrals' tab is active.

Medical Referrals Table:

	Date Ref. By Provider	Referred To	Client Condition	Referred By
1	02/24/2012	Urologist	Undescended Testicles	Dr. Arashu

Form Fields:

- Client Condition:** Undescended Testicles
- Onset Date / First Visit:** 02/24/2012
- End Date:** (empty)
- Date Referral Made By Provider:** 02/24/2012
- Referred By:** Dr. Arashu
- Referred To:** Urologist
- Reason:** Per 561(a), Undescended Testicles. (TW, PHN, 3/2/12).
- Referral Processed:**
- Date Seen:** (empty)

The Windows taskbar at the bottom shows the Start button, several application icons, and the system clock displaying 11:26 AM.

VIII. IMMUNIZATION SECTION:

Use this section to document a child's immunization history.

1. Document the type and sources of vaccine as indicated in the medical record.
2. Record combination vaccines separately, *i.e.*: *Pediarix=DTap/HepB/IPV*
3. For positive PPD- document the millimeters of induration if known and the result of the chest x-ray, medication prescribed in the Immunization Comment Section. Document treatment and follow up in the Diagnosed Condition and Medication Section.
4. Access California Immunization Registry (CAIR) if applicable. Print CAIR record and input all immunizations.

Immunization Example 1:

The screenshot displays a medical software interface with a toolbar at the top and a main window titled "Immunization". The main window has a table with columns: "Immunization Type", "Date Given or Waived", "Waived", and "Next Due Date". A dialog box titled "Select Immunizations" is open over the table. The dialog box contains the following fields and options:

- Date Given or Waived: 01/18/2012 (dropdown menu)
- Waived
- Source of Information / Clinic / Physician: CAIR record (TW, PHN, 2/1/12) (dropdown menu)
- Next Due Date: (dropdown menu)
- Immunization Type: A list box containing "All Immunizations Waived", "IPV", "OPV", "DTaP", "Tdap", and "DTP".
- Buttons: OK, Apply, Cancel, Help.

Callout boxes are numbered 1 through 5:

- 1: Points to the "+" button in the table header.
- 2: Points to the "Date Given or Waived" field in the dialog box.
- 3: Points to the "Source of Information / Clinic / Physician" field in the dialog box.
- 4: Points to the "Immunization Type" list box in the dialog box.
- 5: Points to the "OK" button in the dialog box.

A callout box on the left side of the dialog box contains the text: "561(a). Dr. Kay (TW, PHN, 2/1/12)".

Immunization Example 2:

How to document information when the provider's name is too long and you are not able to enter it in the small box:

	Immunization Type	Date Given or Waived	Waived	Next Due Date
18	Hep B	03/11/2003	No	
19	VZV	09/11/2007	No	
20	VZV	05/07/2004	No	
21	Hep A	05/09/2005	No	

Immunization Type: Hep A
Date Given or Waived: 05/09/2005
Waived:

Source of Information / Clinic / Physician: 561(a), Dr. Karakajanuaian
Next Due Date:

Comments/Results: Hepatitis A #2. (Tw, PHN, 2/1/12).

TB Test Result:
 Positive
 Negative
 Not Read

IX. WELL CHILD SECTION:

Use this section to record information regarding a Well Child Exam: Medical/Dental.

-In Medical/Dental Referral Section:

1. Document source of information (i.e. 561(a), (b), Medical record, PM 160).
2. Document the BMI percentile for children 2 years of age and older and head circumference percentile for children less than 2 years of age.
3. Document annual dental: i.e. Exam, X-ray, and cleaning. No referral at this time. Do not leave the box blank.
4. Document any pertinent health information from the PM160 or 561(a) (b) that is not being documented elsewhere in the Health Notebook.
5. Document any diagnosis (es) under the diagnosed condition section.

6. May direct readers to other areas of the Health Notebook where additional health information related to this exam has been mentioned, i.e. Cardiology referral made.

Well child Example:

The screenshot shows a software interface for a 'Well Child' exam. At the top is a toolbar with various icons. Below it is a navigation menu with tabs: Summary, Diagnosed Condition, Observed Condition, Medications, Hospitalizations, Medical Tests, Referrals, Immunization, Well Child, and Birth History. The 'Well Child' tab is active.

The main form area is titled 'Well Child' and contains a table with the following data:

+	Date	Service Provider	Service Provider Type	Well Child Exam Type
1	02/24/2012	NEVHC Canoga Park	Medical	HEP - CHDP Equivalent Physical Exam

Below the table is a form with the following fields:

- Date: 02/24/2012
- Service Provider: NEVHC Canoga Park
- Service Provider Type: Medical
- Well Child Exam Type: HEP - CHDP Equivalent Physical
- Age: 9
- Age Unit: Years
- Height: 52.5 inch
- Height%: 50%
- Weight: 82 lbs
- Weight%: 90%
- Head Circumference: (empty)

There are two checkboxes: 'Est DOB' (unchecked) and 'No Problem Noted' (checked). Below these is a 'Medical/Dental Referral' text area containing the text: 'Per medical record, BMI: 20.9 (90-95%). Follow up in 3 months. Refer to cardiology. (TW, PHN, 3/1/12).'

Numbered callouts (1-7) point to the following elements:

- 1: The '+' icon in the table header.
- 2: The Date field.
- 3: The Service Provider field.
- 4: The Service Provider Type field.
- 5: The Well Child Exam Type field.
- 6: The 'No Problem Noted' checkbox.
- 7: The Medical/Dental Referral text area.

The Windows taskbar at the bottom shows the Start button, several application icons, and the system clock at 3:35 PM.

X. BIRTH HISTORY SECTION:

Use this section to enter birth history information and toxicology screening. Document information regarding the parent's health problems *that are significant to the child's health*, i.e.: drug use during pregnancy, history of mental illness, and Diabetes.

1. Newborn Screening Results: Document newborn screening and hearing screening results.
2. Prenatal/Perinatal Comments: Document Prenatal care; APGAR scores at 1 minute and 5 minutes post delivery; and method of delivery.
3. Maternal Significant Health Problem: Document: maternal prenatal history, chronic medical history, i.e. asthma, HTN, "Life Threatening Illness"; or Unknown if no information (do not leave blank).
4. Paternal significant Health Problem: Unknown if no information is available.

Birth History Example:

The screenshot shows a medical software interface with the following fields and sections:

- Birth History:**
 - Birth Place / Hospital Name: Olive View (1)
 - Birth City: Sylma (2)
 - Birth County: Los Angeles (3)
 - Birth State: California (4)
 - Birth Country: United States (5)
 - Weight: 3395 gm (6)
 - Length: 51cm (7)
 - Head Circumference: 34cm (8)
 - APGAR: 9 (9)
 - Gestation Age: 37 weeks (10)
- Toxicology Screening:**
 - Radio buttons: Unknown, Not Tested, Negative, Positive (11)
 - Results list: 1 Prenatal Drug Exposure - Heroin (12)
- Newborn Screening Results:** New born screen: negative. Hearing screen: negative. (TW, PH) (13)
- Prenatal/Perinatal Comments:** Limited prenatal care. C-section delivery. APGAR score: 8 at 1 minutes and 9 at 5 minutes. (TW, PHN, 3/1/12). (14)
- Maternal Significant Health Problems:** Diabetes. "Life Threatening Illness." (TW, PHN, 3/1/12). (15)
- Paternal Significant Health Problems:** Unknown. (TW, PHN 3/1/12).

XI. SERVICE PROVIDER SECTION:

Use this section to record any healthcare provider who renders services to the child.

1. The child service provider's information should include the initial and last date of services address and phone numbers.
2. Update the current service providers according to the current medical documentation.
3. Delete all duplicate service providers.
4. End date service providers who no longer provide services to the child.

Service Provider example 1:

The screenshot shows a software application window with a menu bar (File, Edit, Search, Action, Associated, Attach/Detach, Window, Help, Tool) and a toolbar. Below the toolbar is a tabbed interface with tabs for Summary, ID, Demog., Address, Names, Related Clients, ID Num, Juv. Cr. #, Search Log, AFDC-FC, Attorneys, Service Providers, and I.C.W.A. The 'Service Providers' tab is active, displaying a table with the following data:

	Service Provider Name	Service Provider Type	Start Date	End Date
1	Field MD, Marshall	Medical Specialist	08/10/2011	
2	Sosa-Turcios DDS, Luis	Dental	08/30/2010	
3	Gonzalez-Diaz MD, Jose Manuel	Medical		
4	Olive View HUB	Medical Specialist	09/30/2010	10/21/2011

Below the table are several form fields:

- Service Provider Name:** Gonzalez-Diaz MD, Jose Manu
- Service Provider Type:** Medical
- Date Last Seen:** (dropdown menu)
- Retrieve Date Last Seen:** (button)
- Service Provider Address:** 20440 Sherman Way, Canoga Park, CA 91306
- Service Provider Phone Number:** Phone Number: (818) 346-2395, Ext: (empty)
- Start Date:** 10/21/11
- End Date:** (dropdown menu)
- Description:** (text area)

Numbered callouts (1-6) point to specific elements: 1 points to the 'Search' menu item; 2 points to the 'Action' menu item; 3 points to the 'Service Providers' tab; 4 points to the table header; 5 points to the 'Start Date' dropdown; 6 points to the 'End Date' dropdown.

Service Provider Example 2:

When you cannot find the provider you should use the search type:

The screenshot displays a software application window with the following components:

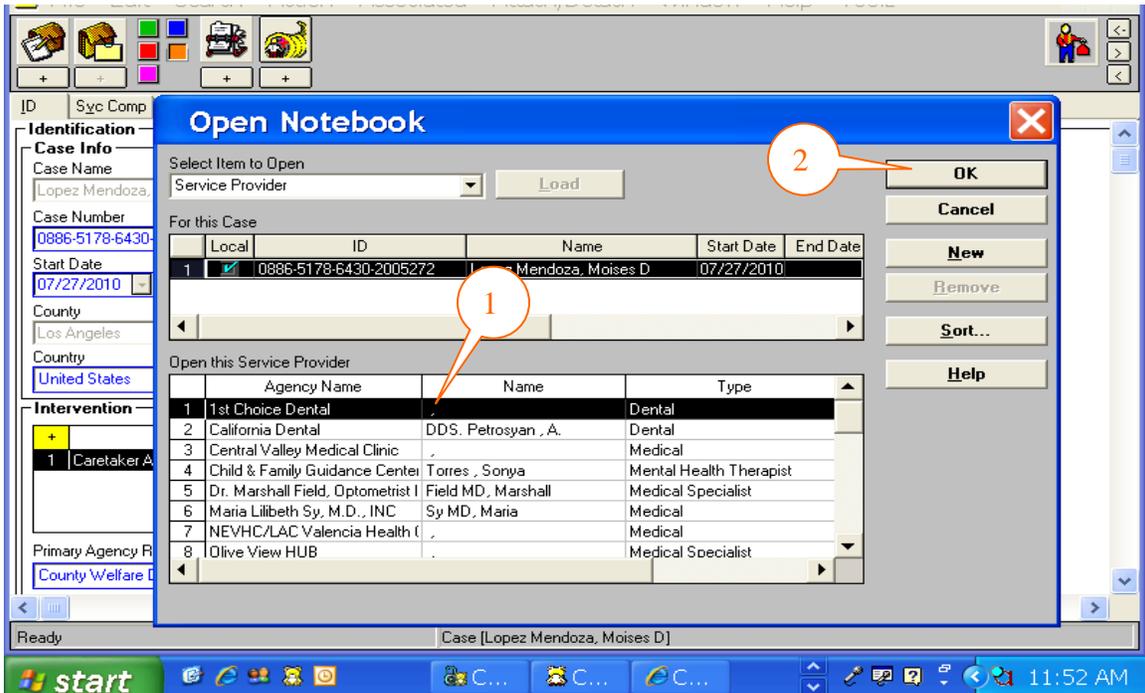
- Associated Services Table:**

	Start Date	End Date	Service Category	Service Type	Wraparound
1	11/30/2011	11/30/2011	Health/CHDP Services	HEP - Periodic Dental Exam	
- Service Details Form:**
 - Service: Well Child Exam
 - Start Date: 11/30/2011
 - End Date: 11/30/2011
 - Service Category: Health/CHDP Services
 - Service Type: HEP - Periodic Dental Exam
 - Provider: [Dropdown]
- Search Dialog:**
 - Search Type: Service Provider
 - Service Provider Category: Dental
 - Agency Name: 1st Choice Dental

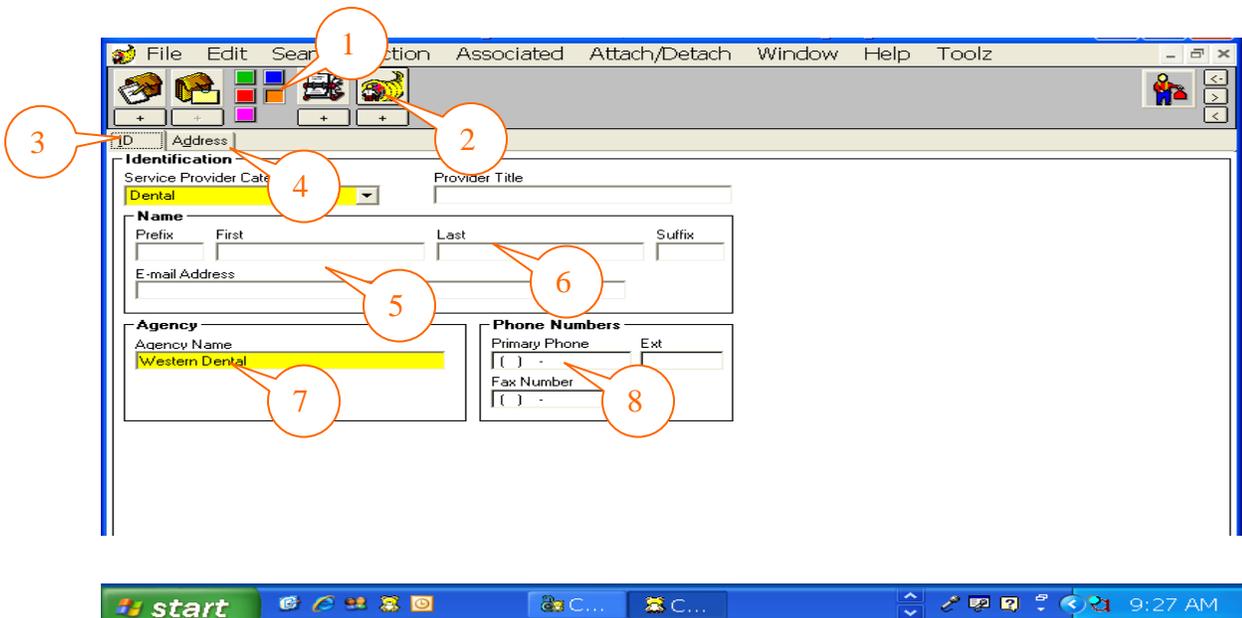
Numbered callouts indicate the following elements:

- 1: Points to the 'Provider' dropdown menu.
- 2: Points to the 'Service Category' dropdown menu.
- 3: Points to the 'Search Type' dropdown menu.
- 4: Points to the 'OK' button.

After you find the provider click OK, the open notebook will appear.



Service Provider Example 3: How to add the address and phone number of the provider:



XII. F-RATE SECTION:

A DCFS specialized care rate given to caregivers who care for children with special health care needs (medically fragile children).

1. Adhere to DCFS F-rate policy 0600-505.10 and 0900-522.11.
2. Use the approved F-rate template.
3. Copy and paste the F-rate template into the contact.
4. Print out the PHN F-rate progress note to provide to CSW

F- Rate Example 1:

Consult staff person

1. Staff Person

2. Start Date: 08/10/2011

3. Contact Purpose: Consult with Staff Person

4. Participants:

Participants
1 Dacoco, Andrea M
2 De Leaver M.D., Margo

5. Method: Written

6. Case Management Services/Referrals:

Case Management Services/Referrals	Wraparound
1 Management Services/Referrals	Wraparound

7. Status: Completed

8. Narrative:

Problem:
-CSW requested PHN to review medical documentation to determine if child meets the criteria for a Specialized Care Rate.

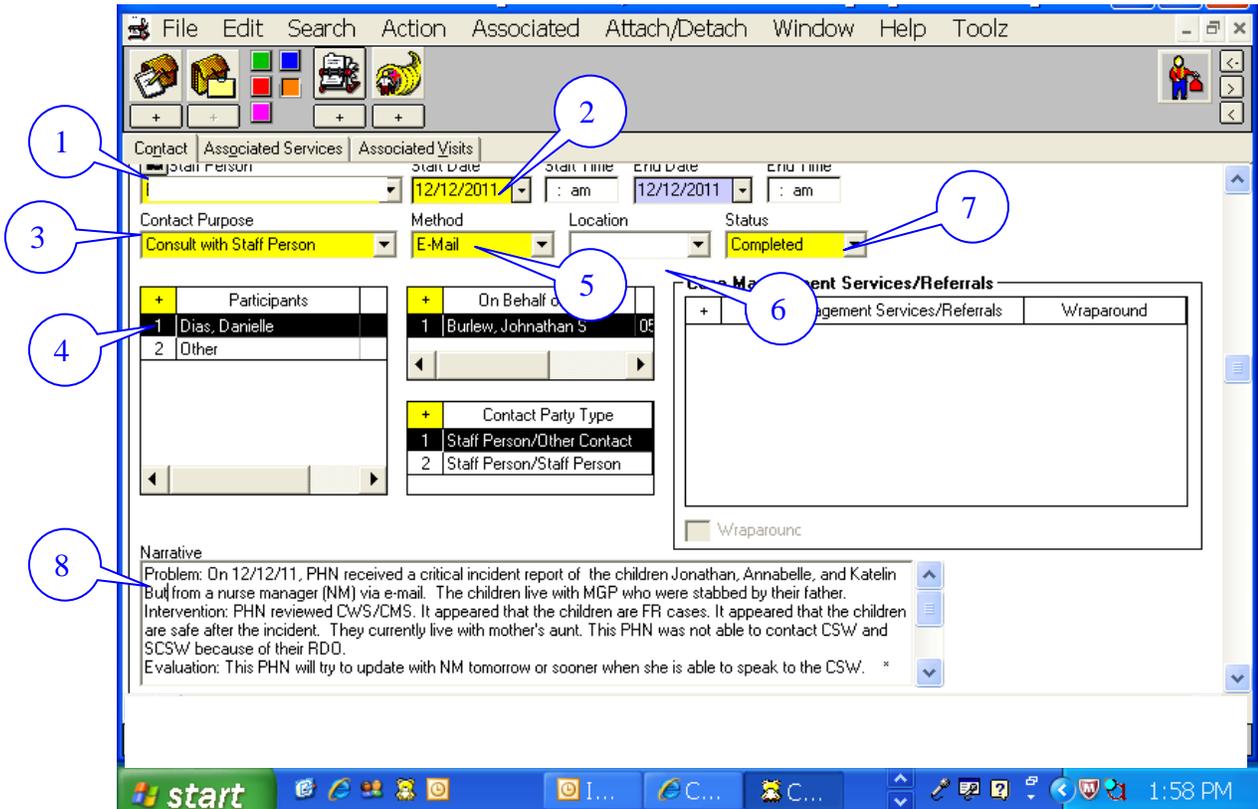
Intervention:
-PHN reviewed a medical care assessment 149(a) by Dr. De Leaver on 6/10/11 as followed:

XIII. CHILD FATALITY, DEATH REVIEW, AND CRITICAL INCIDENT REPORT:

A report sent by DCFS administration when a child has been injured or expired.

1. Document into CWS/CMS how, when, and why PHN received the case consultation as soon as received.
2. Notify the Public Health Nursing Supervisor (PHNS) immediately.
3. Obtain the purple folder and medical records as soon as possible.
4. Review and summarize medical records and send it to your PHNS. The PHNS will send it to the Nurse Manager (NM).
5. When you complete a report, use the guidelines below. Use DCFS 418 form and PIE format:
 - a) Date consultation request received.
 - b) SCSW/CSW.
 - c) Date and description of the incident.
 - d) Location of the child.
 - e) Current status of the child.
 - f) Current status of the sibling (s) if known.
 - g) Summary of the investigation and plan of care.
 - h) Outcome.
6. Copy and paste the summary into the contact only.

Child Fatality, Death Review and Critical Incident Report Section (Delivery Service Log) example:



XIV. DCFS QUALITY REVIEW SERVICES AUDIT (QRS):

The QRS is a DCFS audit which reviews a child's records to assess the comprehensive care of the child.

1. Notify the supervisor if asked to participate in a DCFS audit immediately.
2. Obtain the purple folder and review the case prior to the audit date.
3. Document into CWS/CMS how, when, and why PHN received the audit.

XV: NURSE TO NURSE REPORT:

The Nurse to Nurse (N2N) report form will be utilized when transferring a case from one PHN to another PHN within the HCPCFC and DCFS programs. The purpose is to foster the continuity of care and ensure standardization of case transfer from one PHN to another.

2. The PHN assisting the CSW prior to case transfer will complete the N2N report form prior to transferring and give report to the newly designated PHN.
3. Upon completion of the N2N report form, the PHN will forward the report to the PHNS and PHN involved via email.
4. Create a contact indicating that you sent/received N2N report.

XVI. HOSPITAL LOG:

A hospital log is used to alert DCFS administration and the CSW/SCSW about hospitalized children who are receiving health care or awaiting placement.

1. When using the hospital log, document all pertinent information according to the Hospital Log policy.

XVII. OBESITY, OVERWEIGHT, UNDERWEIGHT, and FAILURE TO THRIVE (FTT):

According to the American Academy of Pediatrics:

- a) **FTT:** BMI is equal to or less than 3rd percentile.
- b) **Underweight:** BMI is greater than 3rd and less than or equal to 5th Percentile.
- c) **Overweight:** BMI is ranging from 85th percentile to 94th percentile.
- d) **Obese:** BMI is ranging from 95th percentile to 98th percentile.
- e) **Obese (severely):** BMI is equal or greater than 99th percentile.

1. Enter BMI into the special project section in CWS/CMS.

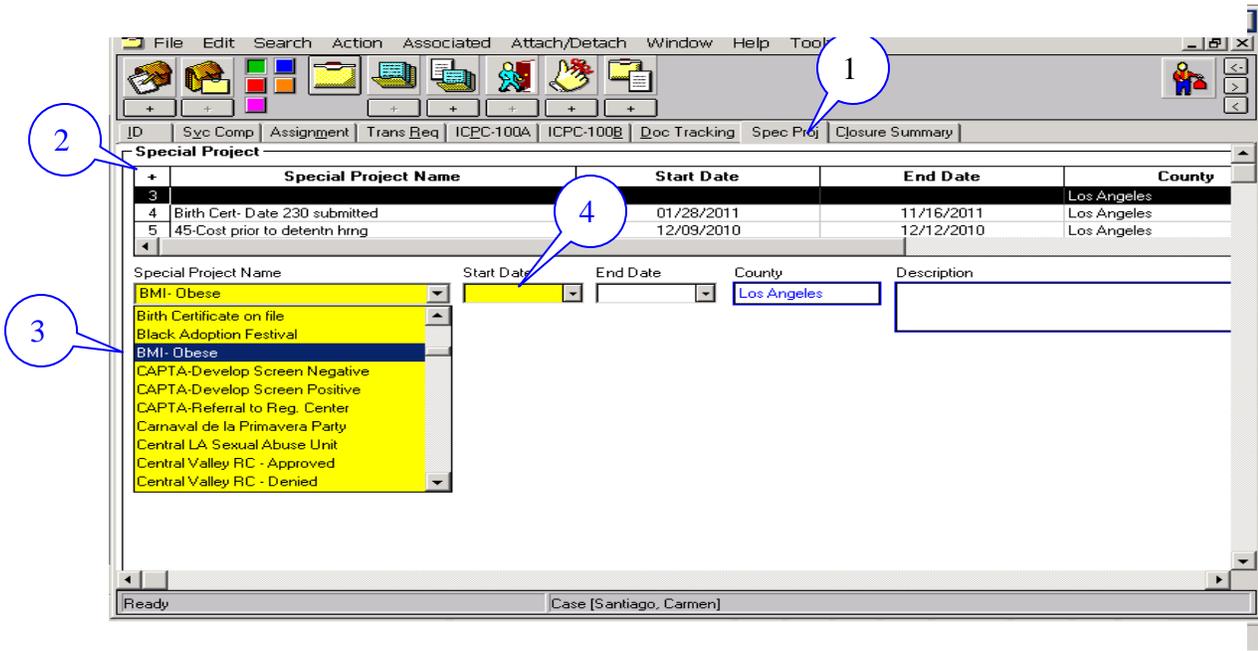
2. Under the diagnosed condition section, enter height, weight, and BMI.
3. Graph the height, weight, and BMI using the Center for Disease Control and Prevention chart (CDC).
4. Contact the provider/caregiver to discuss weight management and document the plan of care.
5. Refer to an agency that assists with the child's condition.
6. PHN will provide literature and reinforce education to the caregiver/child as needed.
7. Follow up in 6 months or sooner if indicated.
8. Provide the CSW a contact (Delivery Service Log).
9. The PHN will conduct a home visit when appropriate.

Obesity Example 1

How to enter BMI in the Special Project section in CWS/CMS:

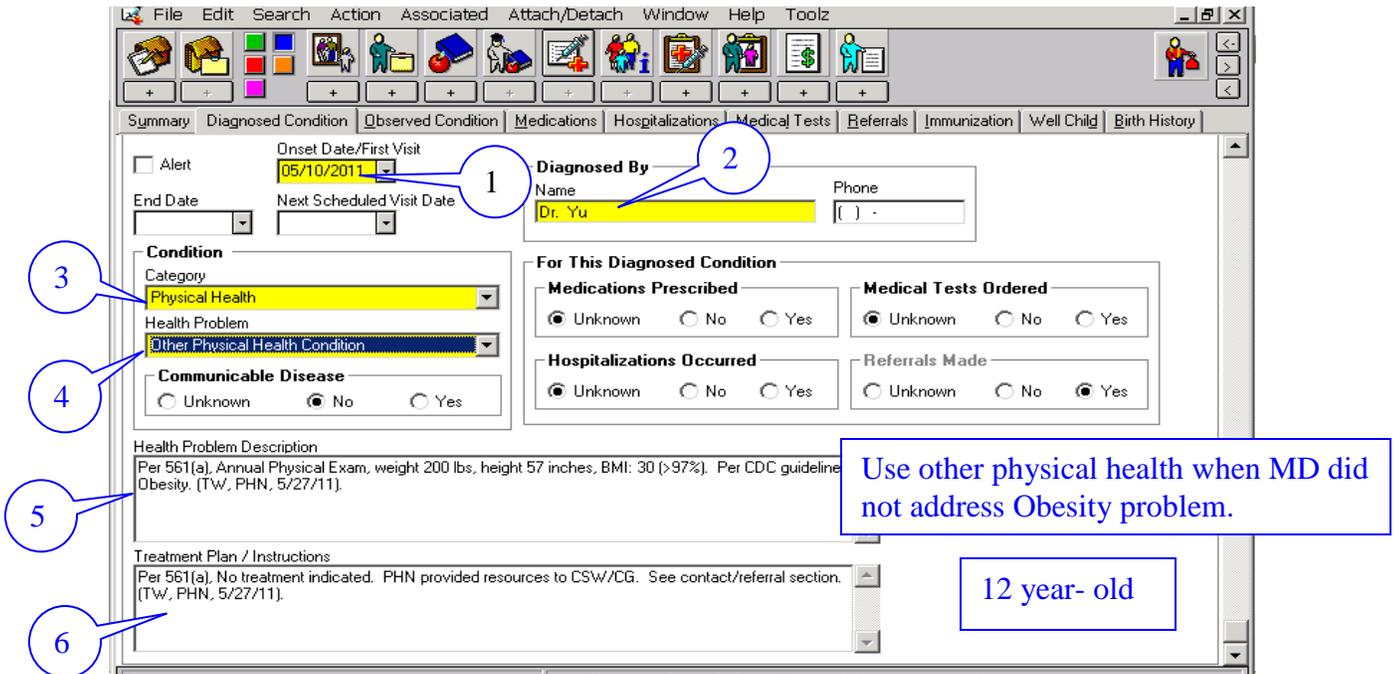
The screenshot displays the CWS/CMS software interface. At the top, a navigation bar includes tabs for ID, Syc Comp, Assignment, Trans Req, ICPC-100A, ICPC-100B, Doc Tracking, **Spec Proj**, and Closure Summary. A blue callout bubble with the number '1' points to the 'Spec Proj' tab. Below the navigation bar, the 'Case Info' section contains fields for Case Name (Santiago, Carmen), Case Number (0612-4127-5889-4047446), Start Date (09/05/2010), End Date, Projected End Date, County (Los Angeles), State (California), and Country (United States). The 'Intervention' section shows a table with one row: 1 General Neglect - Basic Necessities, and a dropdown for Primary Agency Responsible (County Welfare Department). The 'Case Status' section features a table with one row: 1 Court Involvement, Effective Date (01/24/2011), and End Date. A blue callout bubble with the number '2' points to this table. The 'Case Alerts' section is empty. The bottom status bar shows 'Ready' and 'Case [Santiago, Carmen]'. The Windows taskbar at the bottom includes the Start button, several open applications (Del..., CW..., CW..., CA..., My ..., doc...), and the system clock showing 8:09 AM.

After you click the Special Project, this screen will appear:



Obesity and Overweight Example 2

When the provider did not address the plan of care:



Obesity and Overweight Example 3: Refer to the appropriate agency:

The screenshot displays a medical software interface with a toolbar at the top and a navigation menu below it. The main area shows a table of medical referrals. The first row is highlighted, and its details are shown in a form below. Six callout boxes (1-6) point to specific fields in the interface:

- 1: Referral ID (1)
- 2: Client Condition (Other Physical Health Condition)
- 3: Onset Date / First Visit (05/10/2011)
- 4: Referred To (Power Play)
- 5: Date Seen
- 6: Reason (Per 561(a), BMI: 30 (>97%). Per CDC guideline, Obesity. (W, PHN, 5/27/11).)

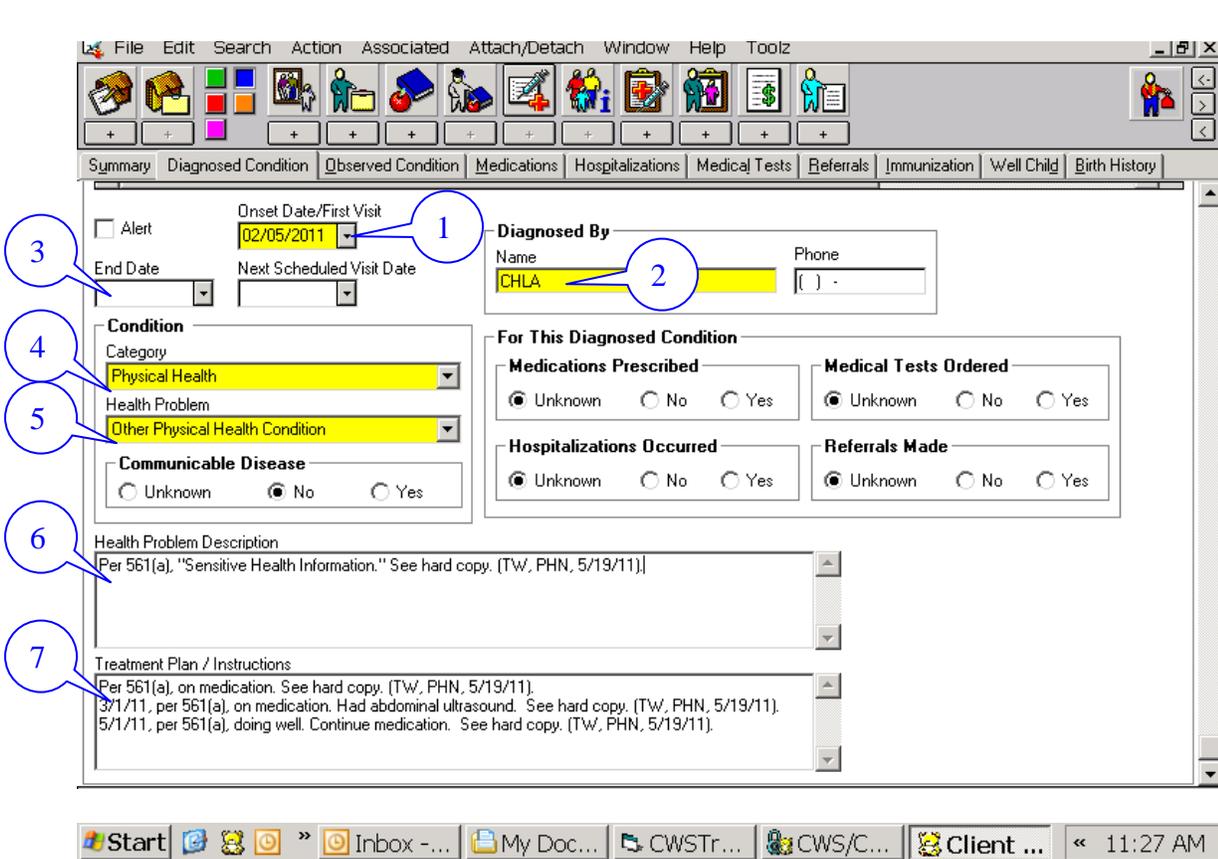
Date Ref. By Provider	Referred To	Client Condition	Referred By
05/10/2011	Power Play	Other Physical Health Condition	T. Works/PHN

Client Condition: Other Physical Health Condition
Onset Date / First Visit: 05/10/2011
End Date:
Date Referral: 05/10/2011
Made By Provider: T. Works/PHN
Referred By: Power Play
Reason: Per 561(a), BMI: 30 (>97%). Per CDC guideline, Obesity. (W, PHN, 5/27/11).
Referral Processed:
Date Seen:
Start | Del... | CW... | CW... | CA... | My ... | doc... | Cli... | 8:38 AM

XVIII. PREGNANCY and STD:

- 1) A child who is pregnant and under DCFS jurisdiction.
- 2) A child who has STD.
- 3) Health Problem: choose “Other Physical Condition”
- 4) Health Problem Description box, PHN input: “Sensitive Health Information,” for STD and Pregnancy.
- 5) In the Treatment Plan/Instruction box, PHN input: on medication(s) (not the name of medication), and follow up visit. See hard copy.

Pregnancy and STD Example:



XIX. HIV:

- 1) A child who has HIV.
- 2) Health Problem: choose “Other Physical Condition”
- 3) Health Problem Description box, PHN will input: “Life Threatening Illness.”
- 4) Treatment Plan/Instruction box, PHN input: on medication(s), (not the name of medication) and follow up visit. See hard copy.

HIV Example 1:

File Edit Search Action Associated Attach/Detach Window Help Toolz

Summary Diagnosed Condition Observed Condition Medications Hospitalizations Medical Tests Referrals Immunization Well Child Birth History

Alert Onset Date/First Visit 02/05/2011

End Date Next Scheduled Visit Date

Diagnosed By

Name CHLA Phone () -

Condition

Category Physical Health

Health Problem Other Physical Health Condition

Communicable Disease

Unknown No Yes

For This Diagnosed Condition

Medications Prescribed

Unknown No Yes

Medical Tests Ordered

Unknown No Yes

Hospitalizations Occurred

Unknown No Yes

Referrals Made

Unknown No Yes

Health Problem Description

Per 561(a), "Life Threatening Illness." See hard copy. (TW, PHN, 5/19/11).

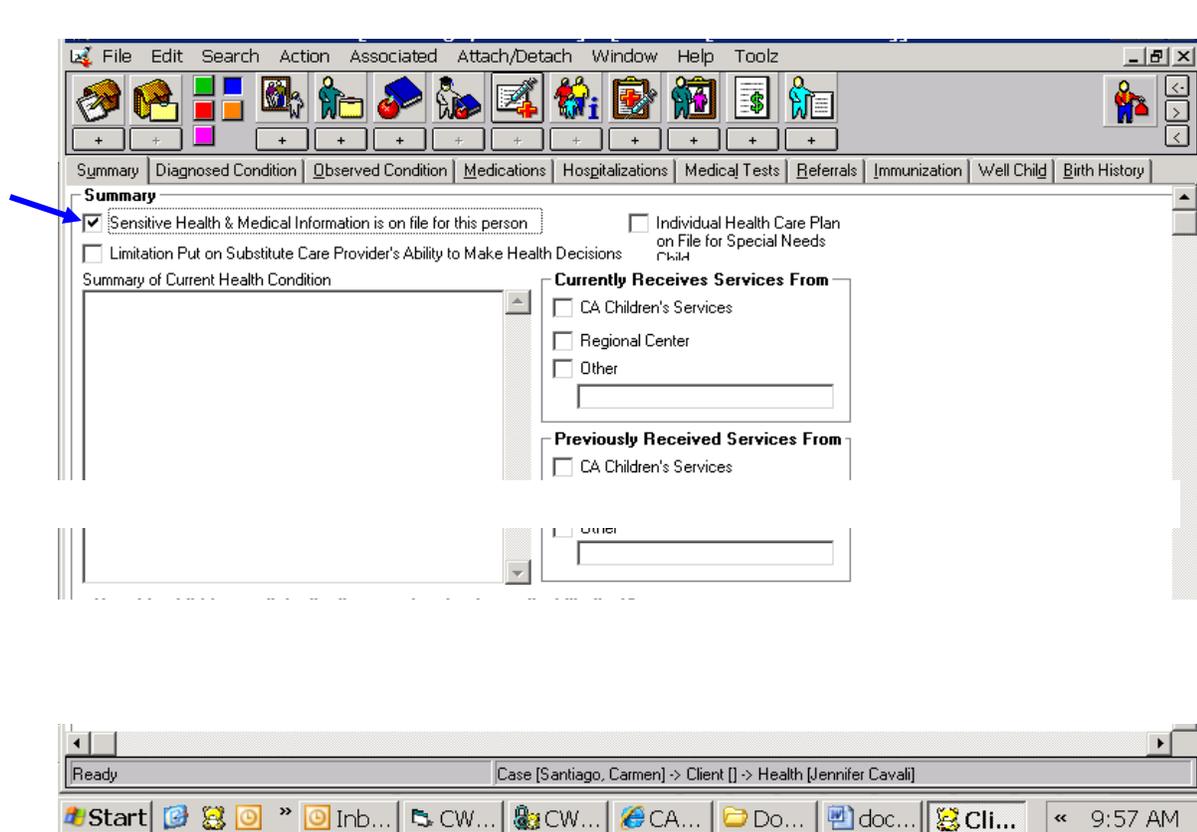
Treatment Plan/Instruction

Per 561(a), on medications. See hard copy. (TW, PHN, 5/19/11).
3/1/11, per 561(a), on medications. See hard copy. (TW, PHN, 5/19/11).
5/1/11, per 561(a), doing well. Continue medications. Follow up in one month. See hard copy. (TW, PHN, 5/19/11).

Start Inbo... My D... CWS... CWS... Clie... 2 M... 11:30 AM

HIV example 2

How to enter in the Summary Section for HIV:



REFERENCES:

1. PMA State Policy (03/26/08).
2. HCPCFC PMA Policy (draft 10/29/09).
3. HCPCFC PM160 Policy (draft 10/26/11).
4. DCFS policy: 0080-505.20-Health and Education Passport (HEP).
5. Health and Education Passport Training (May 20, 2009).
6. DCFS CWS/CMS for New Users. (11/2007).
7. DCFS policy: 0500-504.10 & 0600-502.20- HIV/AIDS confidential information.
8. Confidentiality issues + ICD-9 Code.
9. DCFS F-rate policy 0600-505.10 and 0900-522.11.
10. DCFS Healthy Lifestyle Plan 0600-506.00.
11. Obesity, Overweight, Underweight and Failure to Thrive Policy to follow
12. Nurse To Nurse Policy
13. Hospital Log Policy
14. HCPCFC Pregnancy to follow
15. Center for Disease Control and Prevention (CDC).