

Child Health & Disability Prevention



SAN FRANCISCO CHILD HEALTH & DISABILITY PREVENTION (CHDP) PROGRAM NEWSLETTER

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IMMUNIZATION Q & A: PNEUMOCOCCAL VACCINES FOR CHILDREN WITH VP SHUNTS AND OTHER CSF SHUNTS

Children with cochlear implants, basilar skull fractures, and other persistent CSF leaks that communicate with the nasopharynx and oropharynx are at increased risk for pneumococcus and should get PPSV23 (Pneumovax) at age 2, and if underimmunized, an additional dose of PCV13.* However, CDC guidelines are unclear on whether a VP shunt or other CSF shunt is considered a CSF leak. SF CHDP wrote to the CDC for clarification.

Question from SF CHDP: *For the purposes of immunization for high risk conditions, is a VP or other CSF shunt in a child considered to be a CSF leak?*

Response from the National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention: “We don’t have sufficient evidence to be more specific and include VP shunts in the same category as CSF leak indication. Available literature on cerebrospinal fluid leaks appears to suggest persons with a CSF leak, regardless of etiology, may have an increased risk of bacterial meningitis. While pneumococcus is a common cause of bacterial meningitis, and there is evidence in the literature of VPS shunts being associated with meningitis, there is not much evidence of spinal fluid shunts being associated specifically with pneumococcal meningitis. **On a case by case basis, we’ve been leaving this decision up to providers** in terms of considering the ongoing risk related to the procedure allowing some entry into the CSF space.”

*Recommendations for Pneumococcal Vaccines Use in Children and Teens. <http://www.immunize.org/catg.d/p2016.pdf>

In this issue

Immunization Q & A.....	1
AAP Instrument Based Vision Screening Guidelines.....	2-3
New Law Affecting Minor Rights & Sensitive Services..	4
A Salute to Change Champion, Dr. Katrina Liu.....	5
Dental Care Coordination Services in SF.....	5
New Medi-Cal Dental Providers	5
Retirements.....	6
New California WIC Card.....	6
Provider Information Notices	7

AMERICAN ACADEMY OF PEDIATRICS (AAP) INSTRUMENT BASED VISION SCREENING GUIDELINES

References:

AAP presentation slidedeck, https://www.meadjohnson.com/pediatrics/us-en/sites/hcp-usa/files/Pediatric%20Vision%20Screening%20AAP%20Webinar%202013%20final%209-13_0_0.pdf

AAP Letter to Medical Directors, https://www.aap.org/en-us/Documents/payeradvocacy_policy_vision_screen.pdf

Procedures for the Evaluation of the Visual System by Pediatricians, <http://pediatrics.aappublications.org/content/137/1/e20153597>

Visual System Assessment in Infants, Children, and Young Adults by Pediatricians, <http://pediatrics.aappublications.org/content/137/1/e20153596>

In January 2016, the AAP updated their vision screening guidelines with the policy statement *Visual System Assessments In Infants, Children, and Young Adults by Pediatricians* and the clinical report *Procedures for the Evaluation of the Visual System by Pediatricians*. The policy statement explained the screening criteria and methods while the clinical report articulated the various evaluation procedures.

In light of more CHDP providers who are using instrument based screening in their practice, we would like to offer the following reminders based on the AAP updates:

- **Instrument based screening:**
 - ◊ Detects the most common conditions that produce visual impairment in children: amblyopia, high refractive error, and strabismus.
 - ◊ Can be used starting at 12 months of age, but with better success after 18 months of age. The screenings can then be repeated at each annual preventive medicine encounter through 5 years of age.
 - ◊ Suggested use at any age if unable to test visual acuity monocularly with age appropriate optotypes. Use of these techniques in children under 6 years of age may improve the detection of conditions that lead to amblyopia and/or strabismus when compared to traditional methods of assessment.
 - ◊ May be a helpful alternative in screening developmentally delayed children of all ages.
- Visual acuity testing using optotypes is still preferred for children 5 years of age or older, or once a child can easily read an eye chart.

Two types of instrument based screening are available for use in ambulatory care settings:

<ul style="list-style-type: none"> • Photoscreening devices: Identifies optical characteristics of the eyes to estimate refractive error, media clarity, ocular alignment, and eyelid position. Abnormalities in these areas indicate risk factors for the presence or development of amblyopia. 	<ul style="list-style-type: none"> • Autorefraction instruments: Handheld autorefractors are limited in their ability to detect strabismus in the absence of an abnormal refractive error as they estimate the refractive error of each eye individually. However, autorefractors may still be useful to detect anisometropia in the absence of strabismus, the most common cause of amblyopia not detected at an early age.
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**Although neither type provides a direct assessment of visual acuity, they can identify ocular risk factors that may lead to early vision loss in children.*

Continued on page 3

The American Association for Pediatric Ophthalmology and Strabismus has developed refractive criteria (see Table 2) to assist primary care providers in ascertaining the refractive error levels known to increase the risk of amblyopia. Referral criteria may vary depending on the screening instrument used and its associated sensitivity and specificity level.

TABLE 2: Amblyopia Risk Factor Targets Recommended by the American Association for Pediatric Ophthalmology and Strabismus

Refractive Risk Factor Targets				
Age, mo	Astigmatism, D	Hyperopia, D	Anisometropia, D	Myopia, D
12–30	>2.0	>4.5	>2.5	>–3.5
31–48	>2.0	>4.5	>2.0	>–3.0
>48	>1.5	>3.0	>1.5	>–1.5
Nonrefractive Risk Factor Targets				
All ages	Media opacity >1 mm			
	Manifest strabismus >8 prism D in primary position			

•D, diopters

In addition to visual acuity and instrument based screening, please note that other visual system assessments must still be conducted per AAP guidelines at specific age groups (see Table 1).

TABLE 1: Periodicity Schedule for Visual System Assessment in Infants, Children, and Young Adults

Assessment	Newborn to 6 mo	6–12 mo	1–3 y	4–5 y	6 y and older
Ocular history	x	x	x	x	x
External inspection of lids and eyes	x	x	x	x	x
Red reflex testing	x	x	x	x	x
Pupil examination	x	x	x	x	x
Ocular motility assessment	—	x	x	x	x
Instrument-based screening ^a when available	—	^b	x	x	^c
Visual acuity fixate and follow response	x ^f	x	x	—	—
Visual acuity age- appropriate optotype ^d assessment	—	—	x ^e	x	x

a. *Current Procedural Terminology* code 99174.

b. The American Academy of Ophthalmology (AAO) has recommended instrument-based screening at age 6 mo. However, the rate of false-positive results is high for this age group, and the likelihood of ophthalmic intervention is low.¹⁶ A future AAO policy statement will likely reconcile what appears to be a discrepancy.

c. Instrument-based screening at any age is suggested if unable to test visual acuity monocularly with age-appropriate optotypes.

d. *Current Procedural Terminology* code 99173.

e. Visual acuity screening may be attempted in cooperative 3-y-old children.

f. Development of fixating on and following a target should occur by 6 months of age; children who do not meet this milestone should be referred.

Table 2 from *Procedures for the Evaluation of the Visual System by Pediatricians*, <http://pediatrics.aappublications.org/content/137/1/e20153597>

Table 1 from *Visual System Assessment in Infants, Children, and Young Adults by Pediatricians*, <http://pediatrics.aappublications.org/content/137/1/e20153596>

NEW LAW AFFECTING MINOR RIGHTS & SENSITIVE SERVICES

For the complete version of California Family Code, section 6930: http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=FAM&division=11.&title=&part=4.&chapter=3.&article=

Another resource for minor rights, and providing care to adolescents - The Adolescent Health Working Group (AHWG): <https://ahwg.net/>

As a part of the CHDP facility review, providers are asked to show evidence that there is written office policies and procedures around Sensitive Services and Minor Rights. Providers should also be able to show documentation of an annual training to ensure staff has basic knowledge in this area.

The National Center for Youth Law has developed resources outlining the rights of minors in many aspects of their health care, along with the situations in which they themselves may consent for their own care. The center also outlines instances where other adults can consent to a care on a minor's behalf. A chart summarizing the Minor Consent and Confidentiality Laws in California can be found at www.teenhealthlaw.org

A new law, Assembly Bill number 3189, was recently passed in January 2019. It allows minors to consent to treatment for intimate partner violence. Section 6930 has been added to the California Family Code.

CALIFORNIA MINOR CONSENT AND CONFIDENTIALITY LAWS*

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A PARENT ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
<p>INTIMATE PARTNER VIOLENCE*</p> <p>*For the purposes of minor consent health care alone, "intimate partner violence" means an intentional or reckless infliction of bodily harm that is perpetrated by a person with whom the minor has or has had a sexual, dating, or spousal relationship." If the minor is seeking services as a result of a rape or sexual assault, minor consent services should be provided under the "sexual assault" or "rape" minor consent laws rather than this law. (Cal. Family Code § 6930(b)).</p>	<p><u>THIS LAW GOES INTO EFFECT IN JANUARY 2019:</u></p> <p>"A minor who is 12 years of age or older and who states he or she is injured as a result of intimate partner violence may consent to medical care related to the diagnosis or treatment of the injury and the collection of medical evidence with regard to the alleged intimate partner violence." (Cal. Family Code § 6930).</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. The provider can only share the minor's medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110 (a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</p> <p>If the health provider providing treatment believes that the injuries require a child abuse report, the health provider shall do both of the following: (1) Inform the minor that the report will be made and (2) Attempt to contact the minor's parent or guardian and inform them of the report. The health practitioner shall note in the minor's treatment record the date and time of the attempt to contact the parent or guardian and whether the attempt was successful or unsuccessful. This paragraph does not apply if the health practitioner reasonably believes that the minor's parent or guardian committed the intimate partner violence on the minor. (Cal. Family Code § 6930(c)).</p>

A SALUTE TO CHANGE CHAMPION, DR. KATRINA LIU

Dr. Katrina Liu, Pediatric Team Leader at the North East Medical Services (NEMS) primary care clinics is no stranger to working under the pressure of “so much to do yet so little time.” Recognizing that 50% of SF Unified School District children living in Chinatown had dental decay by the time they reached kindergarten*, Dr. Liu had a vision that the children served by NEMS clinics would be offered the protection they deserved. She was able to implement the application of fluoride varnish (FV) to all NEMS pediatric patients under 6 years old, recommended by the Centers for Disease Control, American Academy of Pediatrics, and US Preventive Services Task Force. Though Dr. Liu has championed many areas of improvement at NEMS, we would like to highlight the journey she took in making FV application a reality across all 7 NEMS medical clinics in SF.

Prior to implementation, Dr. Liu worked with the NEMS Information Technology department to create FV fields in their electronic medical record system. Next, she met with NEMS leadership to plan the implementation: determine which periodic well child visits to offer FV, establish work flow within each clinic, and create a curriculum and plan to train clinic staff. Finally, partnering with the SF CHDP program and working with NEMS clinic nurse managers, Dr. Liu coordinated FV training sessions for the pediatric medical staff. It took concerted effort and commitment from all disciplines to institute this positive change in improving the quality of preventative services in their practices.

NEMS went from offering no FV in 2014 during medical well child exams to protecting approximately 1,000 children every year since 2016 with FV applications. Children in SF who are seen in NEMS primary care clinics are now assured this preventative dental treatment. Dr. Liu’s and the NEMS staff efforts are a model for other medical practices in SF. Thank you, Dr. Liu!

Change champions are critical players in supporting both innovation-specific and transformative change efforts. Find out more at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3535479/>

DENTAL CARE COORDINATION SERVICES IN SF

Finding the right dentist/clinic for complicated dental cases can be challenging. Use this guide to get help with Care Coordination for dental services in SF: https://www.sfdph.org/dph/files/MCHdocs/CHDP/CHDP_DentalCareCoordinationResources_2019.pdf



Dr. Katrina Liu

*<https://www.sfdph.org/dph/files/dentalSvcdocs/Kindergarten-Dental-Assessment-Data-Brief.pdf>

NEW MEDI-CAL DENTAL PROVIDERS:

Dr. Emegio Beronilla
Accepts ages 1 and up
2480 Mission Street,
Suite 214
San Francisco, CA 94110
(415) 655-3614

HealthRight 360
Accepts ages 1 and up
Dental Clinic – Saturdays
Only for Kids – Beginning in April!
1563 Mission Street, 5th Fl
San Francisco, CA 94102
(415) 742-8520





Margaret Fisher, RDHAP
CHDP Oral Health Consultant



Dr. Raymond Li



RETIREMENTS

Margaret Fisher, CHDP Oral Health Consultant

After 11 years with CHDP at the Department of Public Health, I am announcing my retirement and my last day will be March 28. It has been an honor to have had the opportunity to serve both the children of San Francisco, as well as CHDP medical providers and staff, who work endless hours to protect the health and welfare of their patients. It's been a privilege to work alongside many brilliant and inspiring health care professionals and to improve access to preventive dental services our city's vulnerable and low-income children. I appreciate the amazing, seemingly tireless efforts, that each of you offer to the greater good. With deep gratitude, I leave my position more energized knowing that our CHDP medical providers and my colleagues will continue their work here at SF CHDP. Thank you!

Dr. Raymond Li, CHDP Provider

The CHDP team would like to recognize Dr. Raymond Li for his 46 years of service and significant contributions to the people of San Francisco and Chinatown. He helped found the Chinese Community Health Care Association (CCHCA) and has served as a leader in the community as the President of the Board of Trustees of the Chinese Hospital in 2003 and President of the Board of Directors of CCHCA in 2014. As a result of his unwavering commitment in advocating for community-oriented healthcare services and promoting healthy living in the Asian Pacific Islander American community, the City and County of San Francisco awarded him commendation in 2004 and also declared September 10, his birthday, Dr. Raymond Li Day in 2010 and 2018. His compassion, commitment, and exceptional pediatric care has touched the lives of thousands. Please join us in wishing him the best in the next steps of his journey!

NEW CALIFORNIA WIC CARD COMING AUGUST 2019

The Women, Infants & Children (WIC) program is excited to introduce the California WIC Card. The WIC Card will replace the current paper food checks. Each family will receive one WIC Card for all of their family's food benefits and will provide a more convenient way for families to shop for WIC foods.

The WIC program provides supplemental foods, nutrition counseling, breastfeeding education and support, and referral to health care and community services. Be sure to refer your patients age 0-5 years to the San Francisco WIC program at (415) 515-5788 or <https://www.sfdph.org/dph/comupg/oprograms/NutritionSvcs/WIC/default.asp>.

CHDP PROVIDER INFORMATION NOTICES

<http://www.dhcs.ca.gov/services/chdp/Pages/CHDPPLPIN.aspx>

No new Provider Information Notices at this time.

All CHDP providers are required to comply with the most recent AAP Bright Futures Guidelines and the AAP Bright Futures Recommendations for Preventive Pediatric Health Care (periodicity table). In addition, CHDP providers are also required to comply with any additional state regulatory requirements for risk assessments and testing as outlined in the CHDP HAG (*Health Assessment Guidelines*).

Medi-Cal NewsFlash <http://www.medi-cal.ca.gov/>

PAVE e-Form for Eligible Applicants and Providers – released January 4, 2019

A provider bulletin has been published on the Provider Enrollment page of the Medi-Cal website titled, *Medi-Cal Enrollment Requirements and Procedures for Applicants and Providers Currently Eligible to Use the Provider Application and Validation for Enrollment (PAVE) 'Medi-Cal Provider e-Form Application' (e-Form)*. Providers are encouraged to visit the Provider Enrollment page to stay up-to-date with the most recent provider bulletins.

PAVE UPDATES: On March 5, 2019, paper applications are being eliminated for fee-for-service (FFS) Medi-Cal providers. If you haven't yet made the switch to Medi-Cal's faster, easier electronic enrollment system, you can go to <https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx> to learn more about a streamlined provider application process. You can also view the topics that were covered in a past webinar (Thursday February 21, 2019).

PAVE 101 Webinar Training on Thursdays 3/21 and 3/28: Both sessions will be from 12 - 2 p.m. All PAVE users are welcome. Click here https://gcc01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fzoom.us%2Fwebinar%2Fregister%2FWN_dHiJmDIQoWm23GNEdPeoQ&data=02%7C01%7C%7Cbdb15b67cc5748429c6e08d6a710681e%7C265c2dcd2a6e43aab2e826421a8c8526%7C0%7C0%7C636880086232758583&sdata=8B8GYsM3U%2B1muFSEUtL4SjyZdgdCM6BHey7LI24QnB0%3D&reserved=0 to register for the PAVE 101 training webinars.

New Med-Cal Benefit for Hepatitis B Vaccine – released February 5, 2019

Effective retroactively for dates of service on or after March 1, 2018, CPT code 90739 (hepatitis B vaccine [Hep B], adult dosage, 2 dose schedule, for intramuscular use) is a Medi-Cal benefit. System implementation is expected to take place in the coming months. Providers should NOT bill until the system changes take place and are encouraged to check the Medi-Cal website for updates on implementation. No action is required of providers. An Erroneous Payment Correction (EPC) will be initiated to reprocess denied claims. Following implementation, providers will be allowed to bill retroactively from dates of services on or after March 1, 2018.

CHDP Bulletin highlights – for details, please use the following link. <http://www.medi-cal.ca.gov/>, click on Provider Bulletins, scroll to bottom. Click on CHDP Gateway to Health Coverage under Specialty Programs

Bulletin # 170 – December 2018 – no updates

Bulletin # 171 – January 2019 – no updates

Bulletin # 172 – February 2019

1. New Aid Code 5L: Emergency Assistance Foster Care

Effective July 1, 2018, aid code 5L (emergency assistance foster care) is used in cases where there is an emergency need or compelling reason to place the child or youth in foster care.

2. A New Way to Subscribe – Contact Medi-Cal Subscription Service Representatives

Providers can now contact MCSS representatives directly at MCSSCalifornia@conduent.com to subscribe and for assistance with managing subscriptions. This is just another way to subscribe in addition to either online or email subscription.

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