



## THE CHDP NEWSLETTER

A publication of HSA Public Health Children's Medical Services  
Winter 2001

### CHDP-LTR Program Update

As you are aware, the Prop 99 Tobacco Tax funds, which partially fund the CHDP-LTR Program, have decreased over the past several years. This situation is creating a serious funding shortfall. Santa Cruz County Health Services Agency has been subsidizing the program at a 3:1 match with the state.

We will keep you updated if any of the existing LTR policies change. Until then please be mindful of this situation and cooperate with us by referring only those children who do not have an insurance source. We will not be providing services for children who have inactive Medi-Cal: please refer these families to Medi-Cal for reinstatement into that program. Also, please continue to help us refer eligible families to the Healthy Families Program.

The CHDP Linked Treatment Reimbursement (LTR) Program funds follow-up diagnostic services and treatment to children with conditions identified on their CHDP exams and who have no other health care coverage. Services provided can include prescription medications, laboratory services, diagnostic testing, eye exams and glasses, and referrals to specialty providers.

The majority of funds are used to provide dental services for children who are not eligible for Medi-Cal or Healthy Families and do not have private insurance which covers dental services. The program spent approximately \$80,000 for dental treatment to Santa Cruz County children in fiscal year 2000/2001.

The LTR Program is an essential program that is intended to fund services to children who would not otherwise receive them. We are committed to providing some level of these services. However, it will be necessary to make some changes within the program to offset some of these expenses.

Norene Bailey, CHDP Deputy Director

### Healthy Families Sponsorship Program

**What is the Healthy Families Sponsorship Program?** If a child is enrolling in Healthy Families for the first time, there are now funds available to pay for an entire year of Healthy Families insurance premiums. It is easy to apply for these funds and only requires that the child be eligible for Healthy Families, be a Santa Cruz County resident and be a new enrollee in Healthy Families.

Sutter Hospital has donated \$25,000 and \$10,000 of Prop 10 funds have been allocated to pay for health care insurance premiums for children who are eligible for Healthy Families insurance ([www.healthyfamilies.ca.gov](http://www.healthyfamilies.ca.gov)). These funds will pay for approximately 100 families to have their children enrolled in health care services and Delta Dental Care for an entire year.

Healthy Families applications in Spanish and English, sponsorship forms and application assistance can be obtained by calling the local Santa Cruz County Health Care Outreach access line in Santa Cruz (831) 454-2515 or Watsonville (831) 763-8568 or at any of the County Health Programs and Clinics, or Human Resource Agency sites.

By: Jeri Ross, MPH

Santa Cruz County Health Care Outreach Coalition

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## MTU NEWS

We're excited about the CCS Medical Therapy Program's positive changes over the past few months.

The Medical Therapy Program (MTP) added a new staff member this past autumn. Nancy Bell is an Occupational Therapist who joined us with many years of clinical pediatric experience, most recently at CCS in Alameda County.

Our Watsonville clinic site (named Duncan Holbert after a much loved local physician, and located on the Rolling Hills campus) has been in need of a "face-lift" for years and it has gotten just that. Pajaro Valley Unified School District did an excellent job of resurfacing floors, walls and ceilings. The finished product is a pleasant and positive environment in which children receive services. Duncan Holbert Medical Therapy Unit (MTU) is now a more comfortable clinic with a professional atmosphere that complements the quality of the services we provide.

CCS is proud to be starting an MTU Transition Clinic, which premiered on December 4<sup>th</sup>. This semi-annual medical therapy clinic will address the special needs of CCS clients turning 21 within the year. The clinic will ease the transition of these young adults by identifying any ongoing needs for equipment, therapy services, and other medical issues; it will also work to join them with appropriate care providers in our community. So, in addition to tying up any "loose ends" that CCS can address before the individual turns 21, we'll also be assisting them to more independently meet their ongoing health care needs.

The Medical Therapy Program will be coordinating trainings with all the school districts in Santa Cruz County to improve the flow and quality of communication between CCS and the schools, particularly with regard to Individual Educational Plans. Stay tuned for more information as this develops!

Dave Kramer-Urner, PT, Supervising Therapist  
Santa Cruz County CCS, 688-8400

## Children's Medical Service Welcomes

*Leslie Hasch* as a bilingual Case Coordinator at CCS! She comes to us from the Medi-Cruz Program.

## BILLING TIPS FROM CCS ACCOUNTING STAFF.

As of May 2001, Benefit ID Cards (BIC) issued by Medi-Cal will inform providers if a child has CCS coverage. The CCS authorization copy sent to providers will include the condition and services for which the child is eligible. Remember that only authorized services for CCS-eligible diagnoses may be billed to Medi-Cal/CCS or Straight/CCS. Healthy Families Services to treat a condition unrelated to the CCS diagnosis must be billed to the Alliance, Healthy Families, or other coverage. If you need help with claims processing, please call Martha or Barbra in Accounting at 763-8900.



**LEAD PRESENTATION**  
**GRAND ROUNDS LUNCHEON**  
**DOMINICAN HOSPITAL**  
**FRIDAY, JANUARY 11<sup>TH</sup> 2002**  
**SPEAKER: MIRIAM SHIPP, MD, MPH**

Children's Medical Services on the Internet (CCS/CHDP)



Information about Children's Medical Services programs is now available on the internet as part of the Health Services Agency site.

To view this resource, go to <http://www.santacruzhealth.org>, or in Spanish <http://www.santacruzsalud.org>

California Children's Services, Child Health and Disability Prevention, and Childhood Lead Poisoning Prevention program information can be found in the public health section of this new web site.

## Finding Health Information on the Internet

The Internet Healthcare Coalition offers the following tips in evaluating the reliability of online health information and advice:

1. Seek information from several sources and do not rely on a single source for information
2. Trust what you see or read on the internet only if you can validate the source of the information. Authors and contributors should always be identified, along with their affiliation and financial interests, if any, in the content. Phone numbers, e-mail addresses or other contact information should also be provided.
3. Question the web sites that credit themselves as the sole source of information on a topic as well as sites that disrespect other sources of knowledge.

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4. Don't be fooled by a comprehensive list of links. Any web site can link to another and this in no way implies endorsement from either site.
5. Find out if the site is professionally managed and reviewed by an editorial board of experts to ensure that the material is both credible and reliable. Sources used to create the content should be clearly referenced and acknowledged.
6. Medical knowledge is continually evolving. Make sure that all clinical content includes the date of publication or modification.
7. Any and all sponsorship, advertising, underwriting, or potential conflicts should and separated from the editorial contact.
8. Avoid any online physician who proposes to diagnose or treat you without a proper physical examination consultation regarding your medical history.
9. Read the web site's privacy statement and make certain that any personal medical or other information you supply will be kept absolutely confidential.
10. Shop around, always get more than one opinion, be suspicious of miracle cures, and always read the fine print.

(Taken from the Internet Healthcare Coalition-Tips for Health Consumers)

## SCREENING FOR LANGUAGE DEVELOPMENT IN BILINGUAL CHILDREN

Because the number of children speaking non-English languages in the United States is expected to increase, "pediatric providers will need to become familiar with normal patterns of bilingual language acquisition and be able to identify abnormal language development in a bilingual child." So state the authors of an article in the July 2001 issue of *Contemporary Pediatrics*. The article reviews patterns of bilingual language development, offers advice on raising a child to be bilingual, and discusses common questions raised by parents and teachers.

The authors point out that there are two major patterns in bilingual language acquisition: In simultaneous bilingualism, the child acquires two languages at the same time before the age of 3 years. The child may mix words or parts of words from both languages in the first stage, combining elements in an undifferentiated system. Stage 2 occurs at 4 years and older when differentiation between the two languages takes place, and the child uses each language as a separate system. Sequential bilingualism also occurs before the child is 3 years old, but the child can draw on the knowledge and experience of the first language while acquiring the second language.

Detecting delays in the speech and language of multilingual children presents a challenge to pediatricians because of a lack of bilingual speech and lan-

guage pathologists and standardized screening procedures in languages other than English. The authors state that "the key is to obtain information about the child's entire language system, not just the primary or secondary language." The following "red flags" may indicate that the child who is simultaneously acquiring two languages is experiencing problems with language development:

- No bilabial sounds by 2-6 months of age;
- Less than one new word per week for 6 to 15-month-old children;
- Less than 20 words (in the two languages combined) by 20 months; and
- No use of word combinations and a very limited vocabulary by age 2-3 years.

Red flags for abnormal language development in the sequential acquisition of two languages include

- Lack of normal milestones in the first language;
- Prolonged or true mutism; and
- Word retrieval difficulties.

The authors offer a number of suggestions that pediatricians can pass on to parents of bilingual children: 1) Be consistent in how and with whom each language is used, 2) speak the language that you are more comfortable with, 3) keep the grammar of each language suitable for the child's age, and 4) keep your child interested and motivated. To parents who are concerned about the negative effects of bilingualism, the authors state, "Research suggests . . . that learning difficulties occur in bilingual children just as they do in monolingual children, and that bilingualism is neither a direct nor indirect cause. . . . A child who has the opportunity to speak more than one language should find that second language an asset, not an obstacle."

(Fierro-Cobas V, Chan E. 2001. Language development in bilingual children: A primer for pediatricians. *Contemporary Pediatrics* 18(7):79-80, 83-84, 86, 91, 94, 96, 98.)

### Local Resources for assessment, screening, and speech therapy

North County:

- Under 3 years old: Early Start Program @ County Office of Education, Dana Cox, 479-5384
- 3-5 years old: (English) Cathy Baker or Joyce Baxter @ 429-3073; (Spanish) Katie Musetelli, 429-3482
- School age refer to proper school district or call individual school.

South County :

- 3 to 5 years old PVUSD (Pajaro Valley Unified School District) Yolanda Grijalva, 786-2100 ext 403
- Under 3 years old: Early Start Program @ San Andres Regional Center, Maria Elena Fernandez, 768-8223

## AAP RELEASES POLICY STATEMENT ON DEVELOPMENTAL SCREENING OF INFANTS AND YOUNG CHILDREN

Pediatricians and other primary care practitioners have the ideal opportunity to screen for developmental and behavioral problems among children during their first 5 years of life, according to a policy statement published in the July issue of Pediatrics by the American Academy of Pediatrics Committee on Children with Disabilities. The committee suggests that early screening may lead to early intervention for the developmental disability, thus allowing the pediatrician to have a "significant impact" on the functioning of infants and young children, and of their families.

The committee states that "the emphasis on earlier identification creates the opportunity to provide the benefits of early intervention but also poses greater challenges in screening." According to the report, pediatricians now have many developmental screening tools to choose from -- and many of those tools have improved in the last 10 years. The report also states that parental reports "are highly predictive of true problems" in some developmental areas and that using them allows parents to be actively involved in the evaluation process and is cost-effective in the short term.

To screen for developmental delays or disabilities and to intervene with identified children and their families, the committee recommends that pediatricians:

- Maintain and update their knowledge about developmental issues, risk factors, screening techniques, and community resources;
- Acquire skills in the administration and interpretation of reliable and valid developmental screening techniques appropriate for the population;
- Develop a strategy to provide periodic screening in the office setting;
- Make timely referrals of children with development delays to the appropriate early intervention, early childhood education, or community-based program;
- Increase parents' awareness of developmental disabilities and resources for intervention; and
- Be available to families to interpret consultants' findings.

The authors conclude that "early identification of children with developmental delays or disabilities can lead to treatment of, or intervention for, a disability and lessen its impact on the functioning of the child and family...Successful early identification of developmental disabilities requires the pediatrician to be skilled in the use of screening techniques, actively seek parental concerns about development, and create links with available resources in the community."

(American Academy of Pediatrics, Committee on Children with Disabilities. 2001, July. Developmental surveillance and screening of infants and young children [policy statement no. RE0062]. Pediatrics 108 (1):192-196.) (MCH Alert, 7/27/01)

## AAP REVISES POLICY STATEMENTS

The American Academy of Pediatrics (AAP) has revised and published a number of policy statements as of November 2001. The Statements appeared in the November issue of Pediatrics: 108(5):1215-1232.

These include statements on:

- media violence
- nondiscrimination in pediatric health care
- a renewed commitment to the psychosocial aspect of pediatric care
- restraint use on aircraft
- the role of the school nurse in providing school health services
- WIC program.

The statements are also available on the AAP Web site at <http://www.aap.org/policy/pprgtoc.cfm>.

## CDC RELEASES REPORT ON YOUTH TOBACCO USE



Youth Tobacco Surveillance—United States, 2000, which appears in the November 2 issue of Morbidity and Mortality Weekly Report, provides clear evidence that adolescent tobacco use continues to be a major public health problem in the United States. The Youth Tobacco Surveillance and Evaluation System was developed to assist states in developing and maintaining their state-based comprehensive tobacco prevention and control programs. The report summarizes data from the 2000 National Youth Tobacco Survey and 29 state Youth Tobacco Surveys conducted the same year. The report is the result of a partnership among the U.S. Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, American Legacy Foundation, CDC Foundation, Macro International, and State Youth Tobacco Survey coordinators. It is available at [http://www.cdc.gov/tobacco/research\\_data/youth/ss50.04.intro.htm](http://www.cdc.gov/tobacco/research_data/youth/ss50.04.intro.htm).



## Respiratory Instability of Term and Near-Term Healthy Newborn Infants in Car Safety Seats

While infant car seats play a critical role in protecting infants during a motor vehicle accident, it is recognized that very young infants who cannot sit or maintain head control require special support to protect them and maintain respiratory stability. This is particularly true for preterm infants. The American Academy of Pediatrics has recommended that all preterm infants < 37 weeks gestation have a period of observation in a car safety seat before hospital discharge to monitor for apnea, bradycardia, and/or oxygen desaturation. However, many full-term nurseries that provide care for healthy, minimally preterm infants may not be aware of or implement this recommendation. The purpose of this study was to determine whether otherwise healthy infants require a period of observation by determining the incidence of car seat-associated events in these infants; the study also included well full-term infants.

The study included 50 preterm infants born at 35-36 weeks gestation and 50 full-term infants. None of the infants in the study required intensive care. The researchers attempted to recruit both infants with normal perinatal histories as well as infants who had experienced some difficulty during labor and delivery. In addition, the researchers attempted to include infants who were small, average, and large for gestational age.

Infants were observed in their own car seats if the seat provided by parents met current safety standards and the child could be positioned securely using blanket rolls around the head and under the crotch belt. In this study, 35% of parents either did not have a car seat for their child or had one that was deemed unsafe. That group of infants was observed in a seat provided by the researchers. While not a focus of this study, it is notable that *all* 100 infants required propping with blanket rolls around the head and an additional 36% of preterm and 16% of term infants also required a blanket roll between their legs for secure positioning. Following adequate positioning, the seat was angled according to manufacturer's recommendations.

Infants were tested 30-60 minutes after a feeding on either the day before or day of hospital discharge. Heart rate, respiration, and pulse oximetry were evaluated first in the supine position for 30 minutes and then while infants were in the seat for an additional 90 minutes. Preterm and term infants did not differ in their oxygen saturation rates in either the supine or seated position. For all infants, mean saturation rates declined throughout

the 90-minute interval and were significantly lower in the seated position within 15 minutes. Seven infants, 4 preterm and 3 term, spent more than 20 minutes in the car seat with saturation values between 85% and 90%. Six preterm infants (12%), though none that were full term, experienced significant apnea or bradycardia in their seats; 3 of these events required stimulation or removal from the car seat to terminate the event. This number of infants is not insignificant, given that 4% to 6% of all infants are born at 35-36 weeks gestation. When this 12% of infants is added to the 24% of preterm infants that were unable to be positioned securely in the seat supplied by their parents, the number is even larger.

**The American Academy of Pediatrics recommends that all newborns be positioned in a car seat at the time of discharge.** As this study clearly points out, there are a number of barriers to this goal. In this study, 35% of parents either did not have a car seat or had one in which, even with blanket rolls, the baby could not be safely and securely positioned. This points to the need to educate parents on both the purchase and use of car seats, something that is not routinely done in hospital nurseries. In addition, all preterm infants, even healthy infants who have been cared for in a full-term nursery, must have a period of observation in their seats. Finally, this study pointed out that all infants, both full and preterm, are susceptible to declining oxygen saturation rates the longer they remain in the seated position. This underscores the need to minimize travel for infants and to discourage the use of swings and other types of upright seating devices in the first few months of life.

(Merchant JR, Worwa C, Porter S, Coleman JM, deRegnier RAO *Pediatrics*. 2001;108:647-652)

## FINGERSTICK TRAINING

The Lead Program is now offering training in fingerstick testing.

- ◆ Increase blood lead screening of high-risk children
- ◆ Utilize increased fee reimbursement
- ◆ Utilize a new blood analyzing lab that provides supplies
- ◆ Reserve your certification training today

Call Karen Long, Program Coordinator @ 763-8937 to reserve your certification training.



## Health & SAFETY NOTES: IS IT SAFE TO PLAY OUTDOORS IN WINTER?

**Fresh air is healthy.** Studies have shown that contrary to the common belief that “exposure to cold air causes a cold,” fresh air is good and healthy. When children and adults spend a long time together in indoor spaces that are small, overheated and poorly ventilated, germs and illnesses pass easily from one person to another. In fresh, outdoor air, children do not have to re-breathe the germs of the group, and the chance for spreading infection is reduced.

**Outdoor play is healthy even in winter.** Children of all ages enjoy and benefit from playing outdoors in all except the most extreme weather. Daily outdoor play is healthy and burns energy. It gives children an opportunity for a change of environment, a balance in play and routine, activities of large muscles (gross-motor development). Even children who are mildly ill but active should go outside if the weather is not severe. Staff and children alike will feel refreshed when fresh air is part of the daily routine. Taking children outdoors daily, even in winter, can be a healthy part of their schedule, and is safe when clothing is appropriate.

**Avoid cold-related injuries.** The way we feel about cold, wet, or snowy weather and indoor temperatures may be affected by where we live and what we are used to. Temperatures above 40°F and below 80°F are generally suitable for routine outdoor play.

**Improve indoor air quality.** Germs causing disease multiply in warm, dark, damp environments, so it is important to keep the environment clean and dry. Adequate ventilation, humidity, and temperature control help us resist illness and increase our ability to get well after sickness. The following measures will improve the indoor air quality in your child care setting:

- Keep the air temperature between 65°F and 75°F if possible.
- Open the windows in every room for a few minutes every day to circulate fresh air, even in winter. Windows must be screened to prevent insects from entering, and should be opened no more than 6 inches (or be protected with guards) to prevent children from falling out.

- Do not allow smoking in any space that children will use.
- Properly vent heating and cooking equipment.
- Avoid strong odors. Some people (including children) are allergic to smoke, perfumes, and room deodorants.
- Reduce the use of toxic pesticides and cleaners and other household chemicals.
- Control dampness and dust.
- Colds, sore throats and other infections of the respiratory system are common in cold weather and are usually caused by viruses. Child care providers have the potential to improve the health of children in their care by opening up windows to improve ventilation, and having children play for extended periods outdoors in the fresh air. They can provide instruction and programs that promote enjoyable, lifelong physical activity. **Remember: Hand washing is the single most effective way to reduce the spread of infection in a child care setting.**

Resources: Keeping Kids Healthy: Preventing and Managing Communicable Disease in Child Care, California Department of Education, 1994; Healthy Young Children: a Manual for Programs, NAEYC, 1995; The Lancet, volume 349, Number 9062, May 10, 1997; Well Beings, the Canadian Pediatric Society, volume 1, 1992. **By Rahman Zamani, MPH (8/25/98)** (California Child Care Health Program 1322 Webster Street, Suite 402 Oakland, CA 94612-3218 ph 510-839-1195 Fax: 510-839-0339 Healthline: 1-800-333-3212; www.childcarehealth.org)

## NEW ISSUE ON SYSTEMS OF CARE FOR CHILDREN'S MENTAL HEALTH SERVICES

The Substance Abuse and Mental Health Services Administration (SAMHSA) has released a series of issue briefs that outline strategies on how to better provide children's mental health services.

The series, entitled "Systems of Care: Promising Practices in Children's Mental Health," is an annual publication focused on children's mental health services provided through the federally-funded Comprehensive Community Mental Health Services for Children and Their Families Program. The briefs provide strategies and guidance for communities and caregivers interested in building strong systems of care that

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support children with mental illness.

The 2001 series issue briefs, along with other supplementary materials, are available at: [www.air.org/cecp/promisingpractices/Default.htm](http://www.air.org/cecp/promisingpractices/Default.htm). ("Promising Practices in Children's Mental Health Systems of Care," SAMHSA, [www.samhsa.gov](http://www.samhsa.gov), November 2001.

## New Child Safety Seat law

Beginning January 1, 2002, California law requires children to ride restrained in a child safety seat until they are at least six years of age or 60 pounds. The expanded law extends the child restraint requirement to include those children who have outgrown a harness-style car seat (generally 40 pounds), but are not tall enough to fit safely in an adult seat belt. Even many children up to eight years old or older may need to use the booster-style car seat. Children prematurely riding in a seat belt can suffer life-threatening injuries, including injury to the spinal cord, the brain or the internal organs of the abdomen.

Parents should be encouraged to use the following test to determine if their older child is ready for an adult belt:

- ◆ Does the child sit with hips all the way back against the auto seat cushion?
- ◆ Do the child's knees bend comfortably at the edge of the auto seat?
- ◆ Is the lap belt on the top part of the thighs?
- ◆ Is the shoulder belt centered on the shoulder and chest?
- ◆ Can the child stay seated in this position for the duration of the trip?

If the child does not meet ANY ONE of these criteria, they should be riding in a booster seat.

Health Services Agency's *SEATS for KIDS* Program education staff is available to conduct in-service trainings at your office to discuss child passenger safety issues and local car seat resources for families. For more information, call Katie LeBaron at 454-5477.




# If you have not received all these notices, contact the CHDP office.




- Provider Information Notice No. 01-02  
Updated Information Regarding New Pediatric Growth Charts and Body Mass Index (BMI) Calculation Tool and Training
- Provider Information Notice No. 01-03  
CHDP Eligibility Determination Table (Effective April 1, 2001)
- Provider Information Notice 01-04  
Pneumococcal Conjugate Vaccine (PCV 7/ Prevnar) Addition as a CHDP Benefit, Reporting Code, Reimbursement For Vaccine Administration, and Updated CHDP Vaccine Benefit and Reimbursement Table
- Provider Information Notice. 01-05  
Centers for Disease Control and Prevention (CDC) Growth Chart Training
- Provider Information Notice. 01-06  
Blood Lead Screening and Anticipatory Guidance On Lead Poisoning, New CHDP Code Numbers for Billing and Reporting Blood Lead Testing, and Increased Reimbursement When Blood Drawing for Lead Testing is Performed by the Health Assessment Provider
- Provider Information Notice 01-07  
Effective Date for Health Assessment Providers to Begin Using the New CHDP Service Codes 23 and 24
- Provider Information Notice. 01-08  
Influenza Vaccine Reimbursement of Vaccine Cost and Administration Free for Children at High Risk of Complication from Influenza

For missing notices call Alaciel Jauregui at 763-8934.

## MARK YOUR CALENDARS

### Hearing and Vision Trainings

 Vision Training with  
 Deborah Babe  
 March 19-20, 2002

 Hearing Training with  
 Steven J. Rawiszer, M.A  
 April 24-25, 2002

Sites to be announced.

For more information call:  
Alaciel Jauregui at 763-8934

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