



# CHDP NEWS

San Francisco Child Health & Disability Prevention (CHDP) Program



Volume VI, Issue III

Fall 2013

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## Rethink Your Drink for Obesity Prevention by Jodi Stookey PhD, Epidemiologist

If your patients want to avoid obesity, do they know their beverage options?

National and statewide obesity prevention campaigns are urging people to *Rethink Your Drink*<sup>1,2</sup>. Each day, everyday, at breakfast, lunch, dinner, and snacks, people think about drinks, and make beverage choices that impact their risk of excess energy intake. To inform these choices, this article highlights how drinking water automatically avoids excess energy intake, while other caloric beverages requires conscious self-monitoring and food restriction to avoid excess energy intake.

Only the lunch beverage differed week-to-week. The lunch foods were weighed before and after the meal.

**Drink water to automatically avoid excess energy intake - OR - Drink a caloric beverage, but consciously restrict food intake to avoid excess energy intake**

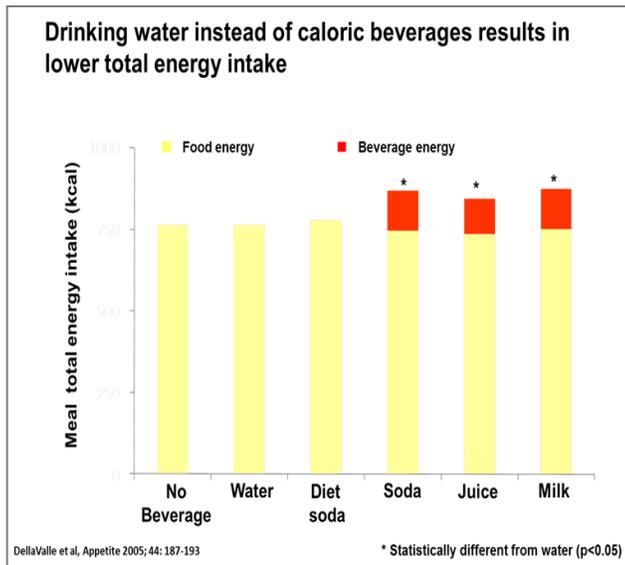
The yellow bars in the figure show that the study partici-

pants consumed the same amount of food each week, regardless of the type of beverage served with the meal.

When lunch was paired with drinking water, the study participants did not unconsciously increase the amount of food consumed to compensate for the lack of beverage calories. The red bars show that the calories in the beverages simply added on top of the calories consumed in food. The caloric drinks, not only soda and juice, but also milk, resulted in excess energy intake at lunch, compared with lunch served with drinking water. The caloric excess was essentially equivalent to the energy content of the drinks consumed.

Many frequently consumed beverages provide over 200 calories per serving, which is enough energy to walk for an hour. Avoid excess calories.

ARTICLE CONTINUES ON PAGE 2



### Option 1: Drink water

Well-controlled experiments consistently observe that people automatically eat a remarkably constant amount of food, by weight or volume, regardless of the type of drink they pair with it.

In a study by DellaValle et al<sup>3</sup>, for example, forty-four healthy, normal weight and overweight women, who were not depressed, dieting or restrained eaters, ate lunch in the laboratory once a week for 6 weeks. Each week, the same ad-libitum lunch foods were offered.

**One annual application of fluoride varnish cuts risk of dental decay by 50% for high risk children!**  
See Page 3 for details on billing for this valuable service

The experimental data imply that each time a caloric beverage is chosen under ad-libitum conditions, energy expenditure might need to be increased by about an hour's walk to avoid net positive energy balance.

Over the course of the day, it is reasonable to expect repeated intake of caloric beverages to seriously impact energy balance. People in the US frequently choose caloric beverage instead of drinking water. Drinking water accounts for less than half of the beverage water consumed by US children and adults<sup>4,5</sup>.

Over time free-living individuals, outside of the laboratory, may partially compensate for some of the beverage calories, by decreasing food intake, so the caloric excess is less than the sum of all caloric beverages consumed<sup>6</sup>. The ability to compensate varies. Young children are better able to compensate for beverage calories than older children and adults<sup>7</sup>. Consumers of caloric beverages, nevertheless, have significantly higher total energy intake than water drinkers<sup>8</sup>.

Given the significant impact that beverage choice has on energy intake, patients and their families should know why and when to choose drinking water or caloric beverages. Juice and milk are ideal for underweight children to automatically increase energy intake. Drinking water is best for normal- and overweight children to automatically avoid excess calories.

### Option 2: Caloric beverages plus conscious compensation

Not everyone can or wants to drink water at every meal.

Many factors, including availability, price, convenience, taste and cultural norms, influence beverage choice. People who need or wish to consume caloric beverages, without risk of excess calorie intake, and without hours of extra exercise, should be warned of the need to consciously restrict food intake to compensate for beverage calories.

Drink	Calories in 20 fl oz serving
Fruit punch	320
100% apple juice	300
100% orange juice	280
Lemonade	280
Regular cola	227
Sports drink	165
	Calories in 8 fl oz serving
Chocolate milk (whole)	208
Chocolate milk (2% reduced fat)	190
Chocolate milk (1% low-fat)	158
Whole milk (unflavored)	150
2% reduced fat milk (unflavored)	120
1% low-fat milk (unflavored)	105
Fat-free milk (unflavored)	90
Plain drinking water	0
Carbonated water	0

### References

<sup>1</sup>[http://www.cdc.gov/healthyweight/healthy\\_eating/drinks.html](http://www.cdc.gov/healthyweight/healthy_eating/drinks.html)

<sup>2</sup><http://www.cdph.ca.gov/programs/wicworks/Pages/WICRethinkYourDrink.aspx>

<sup>3</sup>DellaValle D et al. Does the consumption of caloric and non-caloric beverages with a meal affect energy intake? *Appetite* 2005;44(2):187-93.

<sup>4</sup>Drewnowski et al. Water and beverage consumption among children age 4-13y in the United States: analyses of 2005-2010 NHANES data. *Nutr J* 2013; 12:85.

<sup>5</sup>LaComb R et al. Beverage choices of US Adults, What we eat in America, NHANES 2007-2008. USDA Food Surveys Research Group, Dietary Data Brief No. 6 August 2011.

<sup>6</sup>Reid et al. Long-term dietary compensation for added sugar: effects of supplementary sucrose drinks over a 4-week period. *Br J Nutr* 2007;97:193-203.

<sup>7</sup>Cecil et al. Energy intakes of children after preloads: adjustment not compensation. *Am J Clin Nutr* 2005; 82(2):302-8.

<sup>8</sup>Stookey et al. Replacing sweetened caloric beverages with drinking water is associated with lower energy intake. *Obesity* 2007; 15:3013-22.

### Brochures for Parents

<http://dev.kickthecan.info/files/documents/WIC-RethinkYourDrink-Handout.pdf>  
<http://www.nutritionnc.com/snp/pdf/kidsesmm/KidsESMMParentWater.pdf>  
[http://www.cdc.gov/nccdphp/dnpa/nutrition/pdf/rethink\\_your\\_drink.pdf](http://www.cdc.gov/nccdphp/dnpa/nutrition/pdf/rethink_your_drink.pdf)  
[http://www.fns.usda.gov/cnd/healthierschoolday/pdf/24\\_TNES-MBBC.pdf](http://www.fns.usda.gov/cnd/healthierschoolday/pdf/24_TNES-MBBC.pdf) SPAN /ENG

### Drink Water Websites

<http://www.sodafreesummer.org/tools.php>  
<http://dev.kickthecan.info/fact-sheets-0>  
<http://www.drinkwaterfirst.com/You-Can-Do-It.html>  
<http://www.cutsugarydrinks.org/en/resources>  
<http://www.californiaprojectclean.org/>

## Drinking “Sugars” and Tooth Decay

Although the primary public health measure most effective in combating dental decay is the use of topical fluorides and consumption of fluoridated water, the reduction of frequent exposures to **sugars** remains an important component of defeating the dental caries process.

Nationally, soda consumption has increased from approximately 20 gallons per person a year in 1970, to more than 50 gallons per person a year in 2004. The UCLA Center for Health Policy Research reports that 42.1% of San Francisco adolescents (ages 12-17) consume one or more sodas per day as part of their diet. More alarming is that 21.5% of San Francisco’s children (ages 2-11) consume the same amount.

**Soda consumption nearly doubles the risk of dental caries in children, and increases the likelihood of cavities in adults.**

Consumption of regular soda pop, regular powdered beverages, and, to a lesser extent, 100% juice is associated with increased caries risk. Milk was found to have a neutral association with caries for older children, but allowing a baby to drink from a bottle for a prolonged period of time, can cause “baby bottle” tooth decay, also known as Early Childhood Caries (ECC).

Compared to milk and juice, soda puts children at higher risk for decay.



### Offer older babies water for thirst!

Research shows American children and adolescents are more likely to consume beverages with their main meals. Efforts to promote water intake should not only continue to promote plain water for snacks, but also should recognize the importance of replacing sweetened beverages at meal time with plain water.

**Juice, even 100% natural juice, is associated with increased risk of tooth decay.**

<http://ajcn.nutrition.org/content/78/4/893S.full.pdf+html>  
[www.jdentaled.org/content/65/10/1017.full.pdf](http://www.jdentaled.org/content/65/10/1017.full.pdf)  
[www.ncbi.nlm.nih.gov/pubmed/11699972](http://www.ncbi.nlm.nih.gov/pubmed/11699972)  
[www.ncbi.nlm.nih.gov/pubmed/12949310/](http://www.ncbi.nlm.nih.gov/pubmed/12949310/)  
[http://www.aapd.org/media/Policies\\_Guidelines/P\\_ECCClassifications.pdf](http://www.aapd.org/media/Policies_Guidelines/P_ECCClassifications.pdf)  
<http://jda.ada.org/content/139/7/959.abstract>  
[http://www.publichealthadvocacy.org/PDFs/Bubbling\\_PolicyBrief.pdf](http://www.publichealthadvocacy.org/PDFs/Bubbling_PolicyBrief.pdf)  
[http://www.waterinschools.org/pdfs/kids\\_water\\_nhanes\\_study.pdf](http://www.waterinschools.org/pdfs/kids_water_nhanes_study.pdf)  
[http://www.aapd.org/media/Policies\\_Guidelines/P\\_ECCClassifications.pdf](http://www.aapd.org/media/Policies_Guidelines/P_ECCClassifications.pdf)

## **NEW HCPCS code D1206 for topical application of fluoride varnish!**

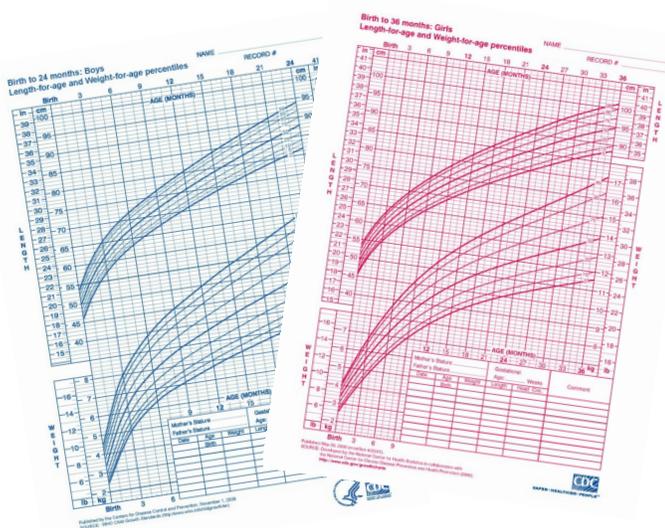
**HCPCS codes D1203 (topical application of fluoride [prophylaxis not included] – child) and D1204 (topical application of fluoride – adult) will be terminated for dates of service on or after September 1, 2013.**

★ **After September 1, 2013, use HCPCS code D1206**

Fluoride Varnish remains a Medi-Cal benefit for children younger than 6 years of age, up to three times in a 12-month period. The rate is \$18 per service. When the procedure is delegated to them and follows a protocol established by the attending physician, nurses, physicians and other medical personnel are legally permitted to apply fluoride varnish. [dental \(1\)](#)

**One annual application cuts risk of dental decay in 1/2 for high risk children!**

## WHO Growth Standards Now Recommended by AAP, CDC and the CHDP Program for Use for Infants and Children Aged 0 to 24 Months



In September 2010, the Centers for Disease Control (CDC), the National Institutes of Health, and the American Academy of Pediatrics (AAP) recommended that health care providers use WHO growth standards for assessment of growth of infants from birth to two years in the United States. The CDC growth charts published in 2000 continue to be recommended for children ages 2 to 20:

In accordance with best practice guidelines and community standards, CHDP is requiring that all providers begin using the WHO growth charts for clients aged 0 to 24 months by November 30, 2013.

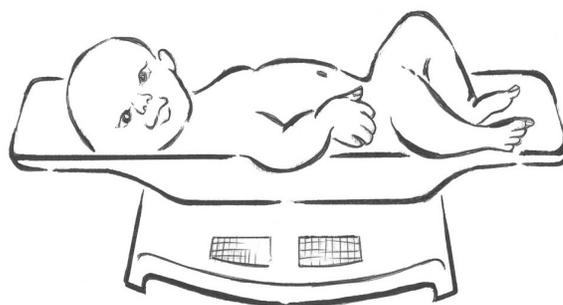
**Why use WHO growth standards for infants and children ages 0 to 2 years of age in the U.S?**

- The WHO standards establish growth of the breastfed infant as the norm for growth.

Breastfeeding is the recommended standard for infant feeding. The WHO charts reflect growth patterns among children who were predominantly breastfed for at least 4 months and still breastfeeding at 12 months.

- **The WHO standards provide a better description of physiological growth in infancy.** Clinicians often use the CDC growth charts as standards on how young children should grow. However the CDC growth charts are references; they identify how typical children in the US did grow during a specific time period. Typical growth patterns may not be ideal growth patterns. The WHO growth charts are standards; they identify how children should grow when provided optimal conditions.

- **The WHO standards are based on a high-quality study designed explicitly for creating growth charts.** The WHO standards were constructed using longitudinal length and weight data measured at frequent intervals. For the CDC growth charts, weight data were not available between birth and 3 months of age and the sample sizes were small for sex and age groups during the first 6 months of age.



## Best Practice Guidelines for Failed Vision and Hearing Screens

We all know that early detection is the key to prevention! In that context, vision (Snellen or equivalent) and audiometric screenings are two of the most valuable services that CHDP providers deliver to high-risk children.

Consider the following statistics:

- Children of parents lacking health insurance are 3x more likely to have amblyopia
- Amblyopia is the leading cause of vision loss in children and young adults (est. 500,000 pre-K)
- >29% children in Head Start programs have one or more vision disorders
- 25 % of students K-6 have a serious vision problem that can impede learning (APHA)
- 60% of students marked as problem learners have undetected vision problems (AOA)
- Est. 80% of learning-disabled children have an undiagnosed vision problem (VCA)
- Est. 70% of juvenile delinquents have a vision problem.

These dire statistics are just some of the reasons that the CHDP program requires that vision and audiometric

screens begin at age 3 and continue regularly per the CHDP periodicity schedule.

However, sometimes our 3 year-old, and even 4 year-old, patients are unable to complete a vision and or audiometric screen on the same day of their well-child check. **When that happens, be sure that your practice is following best practice guidelines:**

- For a 3-year-old who is unable to cooperate for vision testing, a second attempt should be made 4 to 6 months later.<sup>1</sup>
- For children 4 years and older, the second attempt should be made in 1 month.<sup>1</sup>
- When vision re-testing is unsuccessful, children should be referred to an ophthalmologist or optometrist experienced in the care of children for an eye evaluation.<sup>1</sup>

<sup>1</sup> Joint Statement of the American Academy of Pediatrics, The American Academy of Certified Orthoptists, American Association for Pediatric Ophthalmology and Strabismus, and American Academy of Ophthalmology (2003): Eye Examination in Infants, Children, and Young Adults by Pediatricians. PEDIATRICS, 111(4): 903-907 (reaffirmed 2007)

## Flu Season is here!

Every year, over 6,000 Californians die of complications from influenza. Getting an annual influenza vaccination continues to be the best thing that Californians can do to prevent hospitalizations and deaths related to influenza. Beginning with the 2013-2014 influenza season, everyone who is at least 6 months of age should get a flu vaccine this season. Vaccination should begin in September, or as soon as vaccine is available.

For CHDP billing purposes, please note the following: There is no longer a requirement for a high risk factor for Inactivated influenza vaccine for children 6 months through 20 years. Please use the following table as a guide to bill:

Vaccine	Code	Source	Age	Rate
Influenza	53	VFC	6mos to 18yrs   1mos	\$9.00
Influenza	54	Purchased	36mos to 20yrs, 1 1mos	\$13.76
Influenza (Pres.-Free)	80	Purchased	6mos to 35mos	\$18.71
FluMist	71	VFC	2yrs to 18yrs, 1 1mos	\$9.00

### Other resources for getting a flu vaccine:

- SF AITC Immunization and Travel Clinic, 415-554-2863. *AITC offer flu vaccine for infants and children 6 months and up.* <http://www.sfcdep.org/aitcservices.html>
- Find a community health center in San Francisco: <http://www.sfcdep.org/IZlocations.html>
- Go to a public flu clinic. For a complete list of flu shot clinics in San Francisco: <http://www.sfcdep.org/flu vaccine.html> and click on “Where to get a Flu Vaccine”
- For further assistance in San Francisco, call 311
- Other links for flu information and update: <http://www.cdc.gov/flu/> and <http://www.cdc.gov/h1n1flu/>

## CHDP Providers Information

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



**CHDP Pin No. 12-08: By November 30, 2013, ALL CHDP providers MUST integrate the use of the WHO growth charts for CHDP exams.**

**NO Provider Information Notices in 2013 yet!**

## CHDP Bulletin



<http://www.medi-cal.ca.gov/> Click on Provider Bulletins, scroll to bottom. Click on CHDP Gateway to Health Coverage under Specialty Programs

### **Bulletin # 104 – June 2013**

**1. New Aid Code for Non-Citizen Trafficking and Crime Victims** – Effective retroactively for dates of service on or after October 1, 2012, aid code R1 is used to identify non-citizen trafficking and crime victims who are ineligible for federal services and benefits, but are eligible for state-only cash assistance and full-scope Medi-Cal benefits with no Share of Cost.

**2. Affordable Care Act Rate Increase for Certain Primary Care Services**

Effective for dates of service on or after January 1, 2013 through December 31, 2014, the Patient Protection and Affordable Care Act (PPACA) requires payments be increased for certain primary care services.

- CPT-4 Evaluation and Management (E&M) Codes 99201 through 99499
- Services related to immunization administration for vaccines and toxoids procedure codes 90460, 90461, 90471, 90472, 90473, and 90474.

For more information on the payment increase regarding implementation, eligibility, rendering providers, local code crosswalks and annual reviews, see the [Payment for Certain Primary Care Services](#) document on the Medi-Cal website.

- Genetically Handicapped Persons Program (GHPP)
- Abortion
- Family PACT (Planning, Access, Care and Treatment)
- Healthy Families (HF)
- Child Health and Disability Prevention (CHDP)

**2. ICD-10: New FAQs Page**

The [HIPAA:ICD-10](#) page of the Medi-Cal website now includes the ICD-1- frequently asked questions page to help providers prepare for the upcoming ICD-1- code transition. The FAQs page provides an overview of the transition to ICD-10 and answers some questions that providers may have about the upcoming ICD-10 code transition.

Providers may also submit ICD-10-related questions to the Medi-Cal ICD-10 mailbox at [ICD-10Medi-Cal@xerox.com](mailto:ICD-10Medi-Cal@xerox.com).

**3. HIPAA 5010 Companion Guide Updated**

An updated version of the Guide is now available on the [HIPAA 5010 page](#) of the Medi-Cal website under the “Technical Specifications” heading.

### **Bulletin # 105 – July 2013**

**1. Medi-Cal Checkwrite Schedule Updated -**

Effective July 1, 2013, the checkwrite schedule is updated for fiscal year 2013-2014. The schedule reflects warrant release dates and Electronic Fund Transfer (EFT) dates of deposit for all programs, including the following:

- Medi-Cal
- California Children’s Services (CCS)

# Upcoming Events & Trainings



**New "Tap Water" Poster!!**

To get these Colorful (8 1/2 x 11 inch) Posters:  
 Call 415-575-5719 or  
 Email [margaret.fisher@sfdph.org](mailto:margaret.fisher@sfdph.org)

**FREE**  
 Colorful Oral Health Brochures  
 Order online ~  
<http://www.mchoralhealth.org/order/index.html>  
 Or Call: 575-5719



**Free CHDP Trainings** can be scheduled and conducted at your clinic by licensed CHDP staff members:

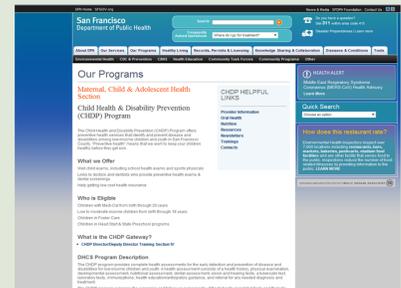
- PM 160 Training
- Oral Health Training
- Fluoride Varnish in the Medical Office Training
- Assessing Child Growth Using the Body Mass Index (BMI)-for-Age Growth Charts
- Counseling the Overweight Child
- For more information, contact: your CHDP nurse consultant, dental hygienist or nutritionist (listed on address page)

## Our new SF CHDP webpage is now up!

Check our recently created SF CHDP Website for:

- Answers to your frequently asked questions
- Forms
- Patient resources
- Updates

<http://www.sfdph.org/dph/comupg/oprograms/MCH/CHDP.asp>



## Find a SF Denti-Cal dentist online: Summer 2013 SF CHDP Dental Directory

<http://www.sfdph.org/dph/comupg/oprograms/MCH/CHDPORal.asp>



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94102

CHDP website:  
[http://www.dhcs.ca.gov/  
services/chdp/Pages/  
default.aspx](http://www.dhcs.ca.gov/services/chdp/Pages/default.aspx)

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**Nutritionist:**

Vacant position

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