California Title V Block Grant Program

Appendix to the 2014 Report/ 2016 Application

9/22/2015 DRAFT

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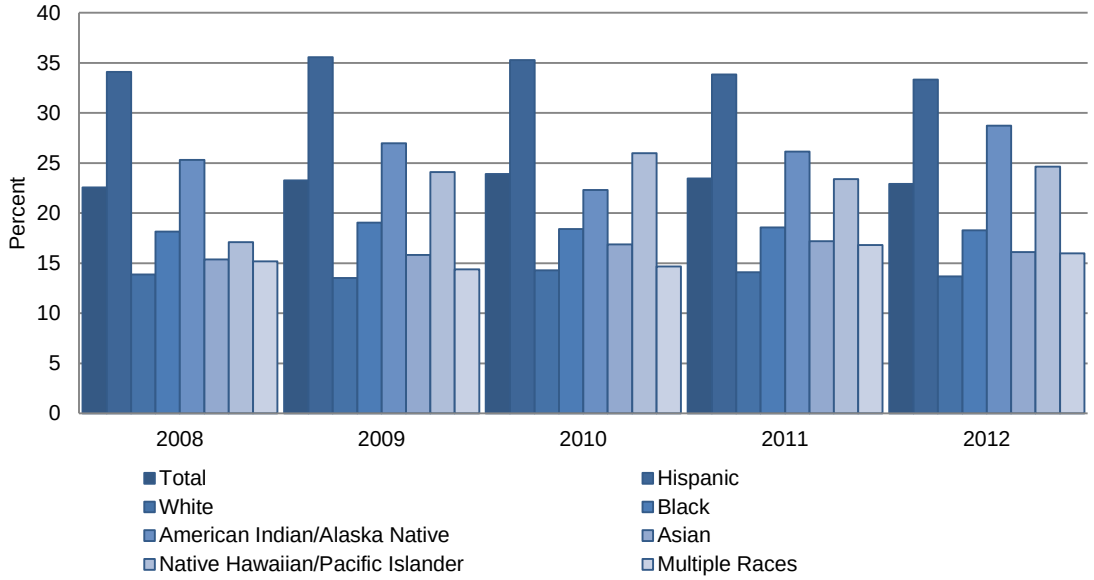
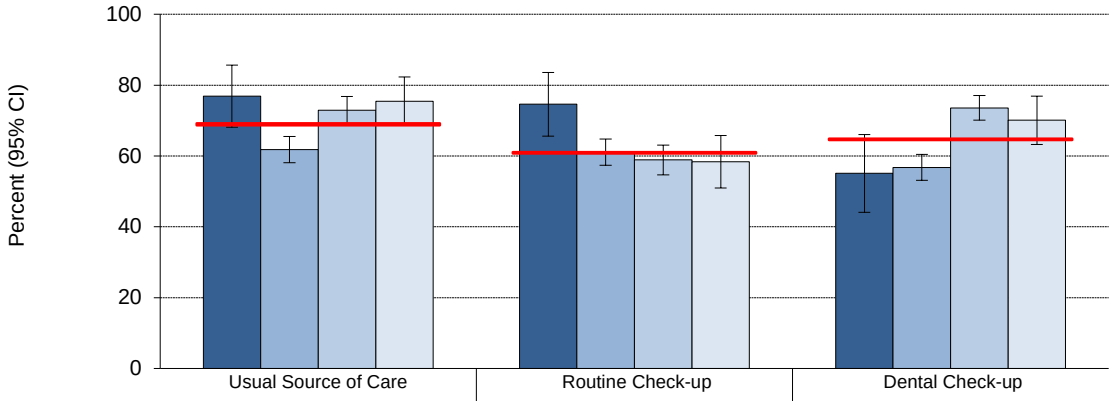


Data source: Annual American Community Survey, 2008-2012. recent live birth, by race/ethnicity group: 2012.

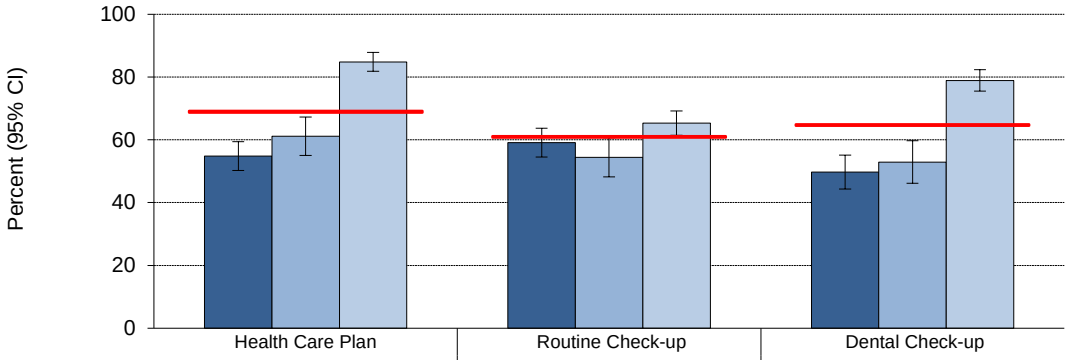
Figure 2. Usual source of care and checkups within past year. Percent (95% CI) of non-pregnant California women ages 18 through 44, by race/ethnicity: 2013.



	Usual Source of Care	Routine Check-up	Dental Check-up
Black	76.9	74.6	55.1
Hispanic	61.8	61.1	56.8
White	72.9	58.9	73.6
Other	75.5	58.4	70.1
State Line	0.5	0.4	0.4
State Total	68.7	60.7	64.5

Data source: California Behavioral Risk Factor Survey (BRFS).

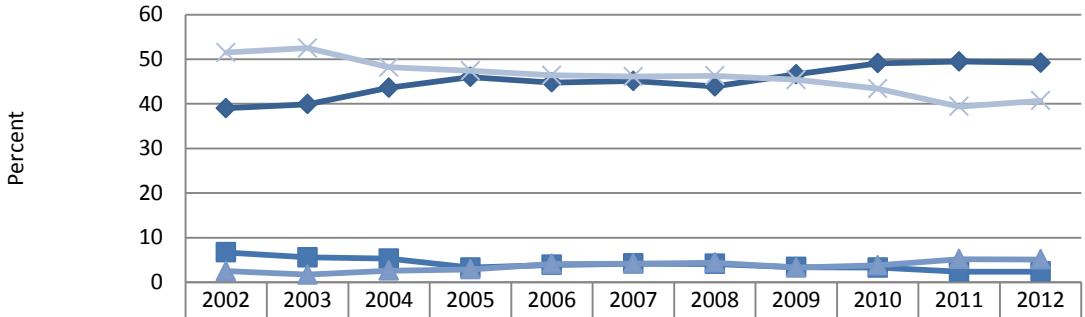
Figure 3. Usual source of care and checkups within past year. Percent (95% CI) of non-pregnant California women ages 18 through 44, by income: 2013.



	Health Care Plan	Routine Check-up	Dental Check-up
0-99%	54.8	59.1	49.7
100-200%	61.1	54.4	52.9
>=201%	84.8	65.3	78.9
State Line	0.5	0.4	0.4
State Total	68.7	60.7	64.5

Data source: California Behavioral Risk Factor Survey (BRFS). Notes: Income shown as a percent of the federal poverty level (FPL).

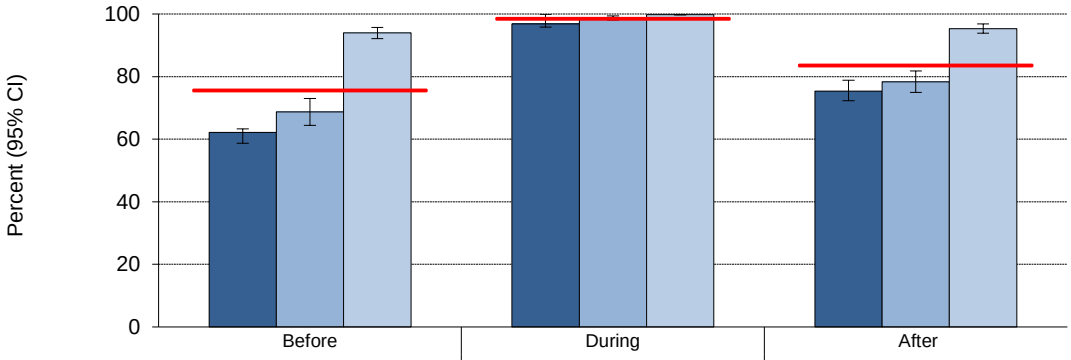
Figure 4. Infant health insurance. Percent of mothers with a recent live birth: 2002-2012.



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Medi-Cal	39.0	39.9	43.6	46	44.8	45.1	43.9	46.6	49.1	49.5	49.2
Uninsured	6.7	5.6	5.3	3.3	3.9	4.2	4.1	3.4	3.3	2.4	2.4
HF	2.5	1.7	2.6	2.9	4.1	4.2	4.4	3.3	3.8	5.2	5.1
Private	51.5	52.5	48.2	47.4	46.4	46.1	46.3	45.4	43.4	39.4	40.7

Data source: Maternal and Infant Health Assessment Survey (MIHA). Note: HF = Healthy Families.

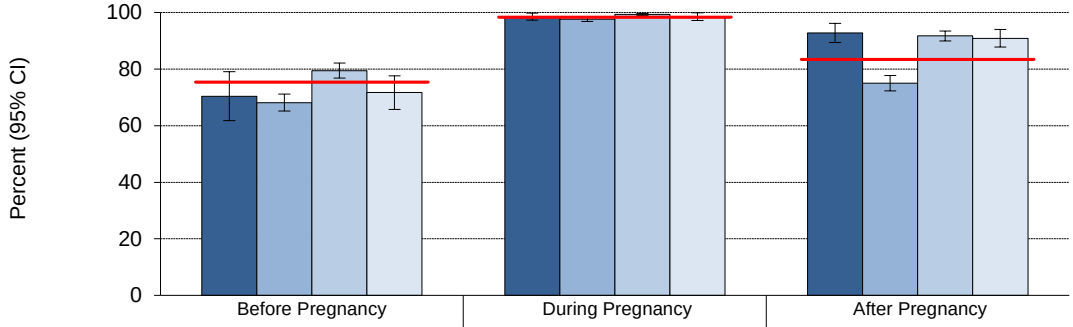
Figure 5. Maternal health insurance during and after pregnancy. Percent (95% CI) of mothers with a recent live birth, by income: 2012.



	Before	During	After
0-100%	62.2	96.9	75.3
101-200	68.7	98.7	78.4
> 200%	94.0	99.8	95.4
State Line	0.4	0.4	0.4
State Total	75.3	98.3	83.3

Data source: Maternal and Infant Health Assessment Survey (MIHA). Note: Income shown as a percent of the federal poverty level (FPL).

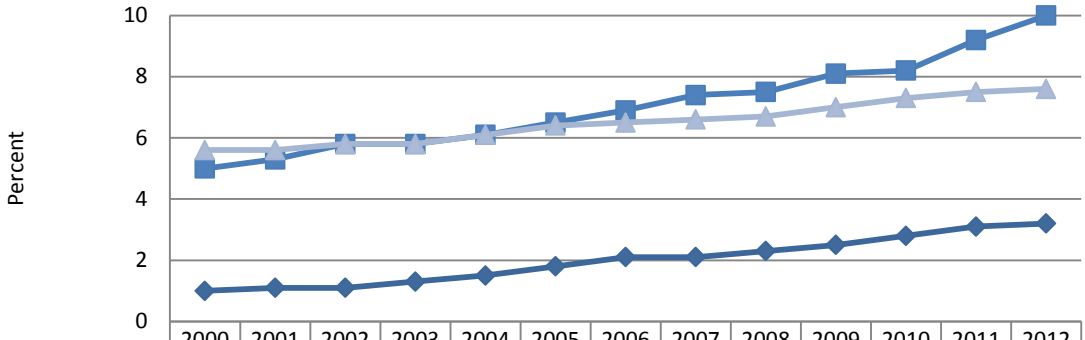
Figure 6. Maternal health insurance. Percent (95% CI) of mothers with a recent live birth, by race/ethnicity group: 2012.



	Before Pregnancy	During Pregnancy	After Pregnancy
Black	70.4	98.5	92.8
Hispanic	68.2	97.7	75.0
White	79.4	99.3	91.7
Asian/PI	71.7	98.5	90.9
State Line	0.1	0.1	0.1
State Total	75.3	98.3	83.3

Data source: Maternal and Infant Health Assessment Survey (MIHA). Notes: PI = Pacific Islander.

Figure 7. Chronic health conditions at delivery. Percent of labor and delivery hospitalizations: 2000-2012.



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Asthma	1.0	1.1	1.1	1.3	1.5	1.8	2.1	2.1	2.3	2.5	2.8	3.1	3.2
Diabetes	5.0	5.3	5.8	5.8	6.1	6.5	6.9	7.4	7.5	8.1	8.2	9.2	10.0
HTN	5.6	5.6	5.8	5.8	6.1	6.4	6.5	6.6	6.7	7	7.3	7.5	7.6

Data source: Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data. Notes: HTN = Hypertension; ICD9-CM codes 493 (asthma); 250, 775.1, 648.0, 648.8 (diabetes); 401-405, 642 (hypertension).

Figure 8. Percent of overweight and obese mothers with a recent live birth, by race/ethnicity: 2012

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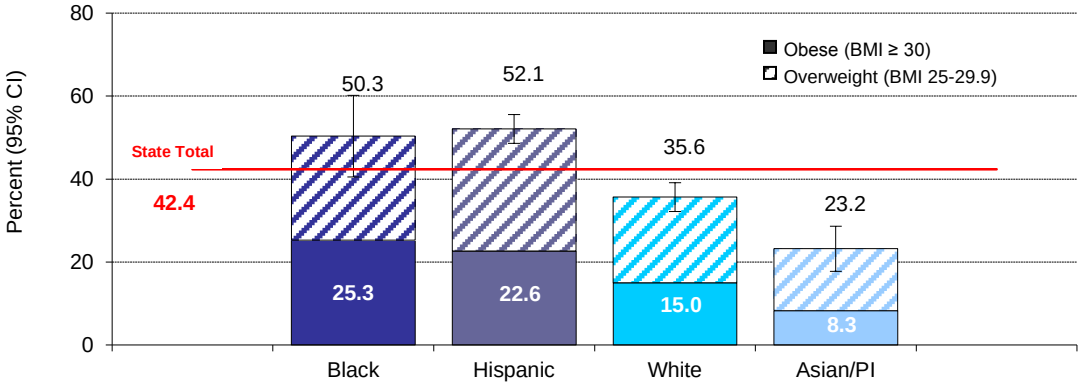
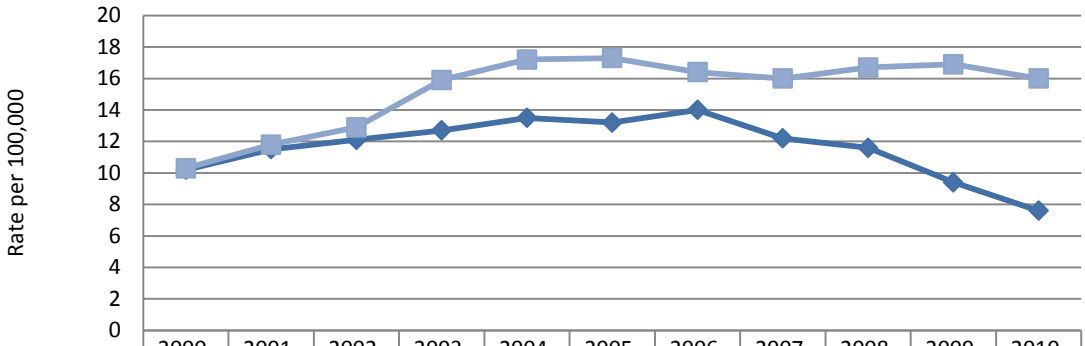


Data source: Maternal and Infant Health Assessment Survey (MIHA). Notes: BMI = Body Mass Index; PI = Pacific Islander.

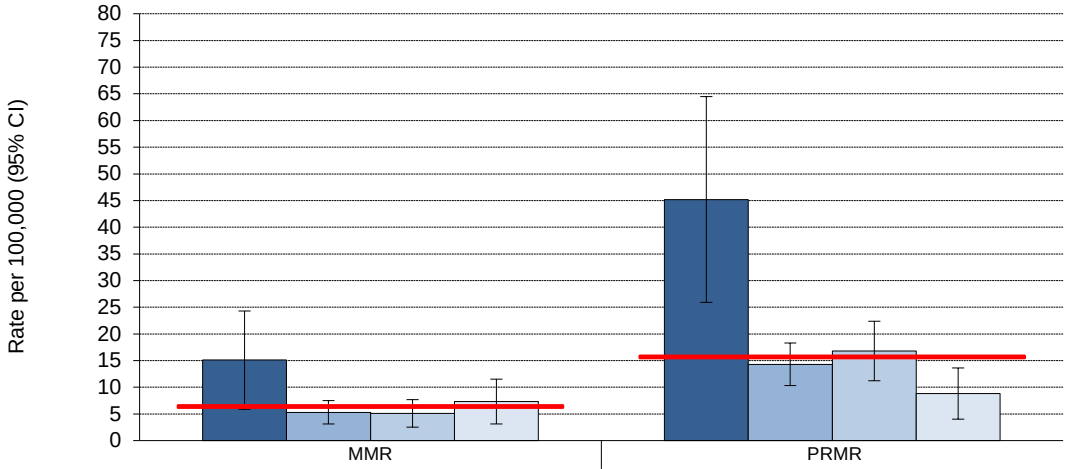
Figure 9. Maternal and pregnancy-related mortality. Rate per 100,000 live births in 3 year aggregates: 2000-2012.



	2000-2002	2001-2003	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012
MMR	10.2	11.5	12.1	12.7	13.5	13.2	14.0	12.2	11.6	9.4	7.6
PRMR	10.3	11.8	12.9	15.9	17.2	17.3	16.4	16.0	16.7	16.9	16.0

Data sources: Birth and Death Statistical Master Files (BSMF/DSMF). Notes: MMR = maternal mortality rate (deaths within 42 days postpartum); PRMR = pregnancy-related mortality rate (deaths within 1 year postpartum).

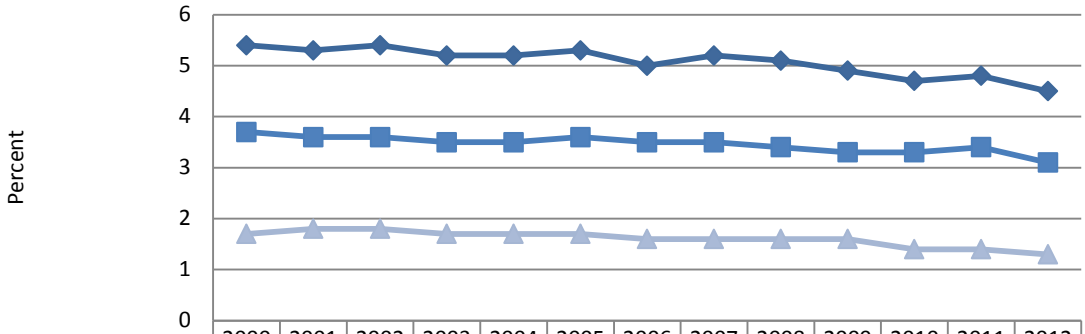
Figure 10. Maternal and pregnancy-related mortality. Rate per 100,000 live births (95% CI), by race/ethnicity: 2012.



	MMR	PRMR
Black	15.1	45.2
Hispanic	5.3	14.3
White	5.1	16.8
Asian	7.3	8.8
State Line	0.4	0.4
State Total	6.2	15.5

Data sources: Birth and Death Statistical Master Files (BSMF/DSMF). Notes: MMR = maternal mortality rate (deaths within 42 days postpartum); PRMR = pregnancy-related mortality rate (deaths within 1 year postpartum).

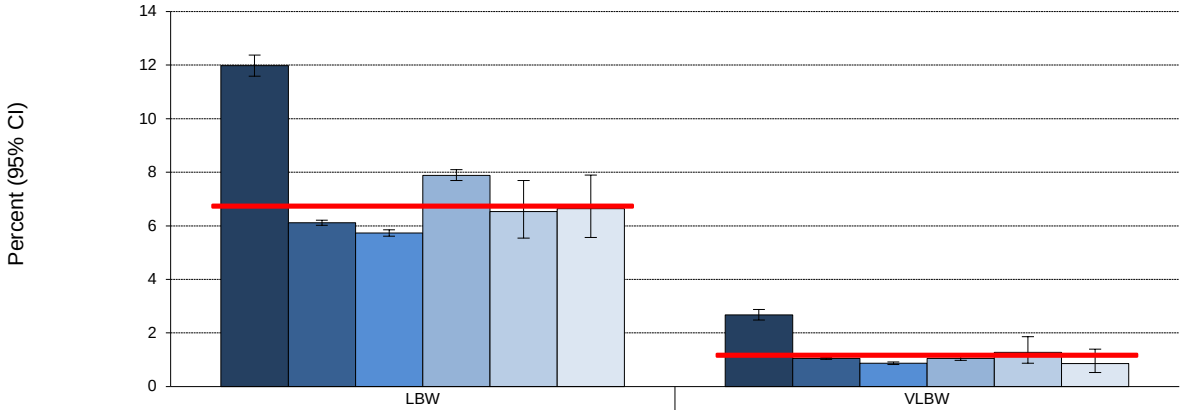
Figure 11. Infant mortality. Rate per 1,000 live births: 2000-2012.



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Infant	5.4	5.3	5.4	5.2	5.2	5.3	5.0	5.2	5.1	4.9	4.7	4.8	4.5
Neonatal	3.7	3.6	3.6	3.5	3.5	3.6	3.5	3.5	3.4	3.3	3.3	3.4	3.1
Postneonatal	1.7	1.8	1.8	1.7	1.7	1.7	1.6	1.6	1.6	1.6	1.4	1.4	1.3

Data sources: Birth and Death Statistical Master Files (BSMF/DSMF). Notes: Infant deaths < 1 year; neonatal < 28 days; postneonatal 28 days – 1 year.

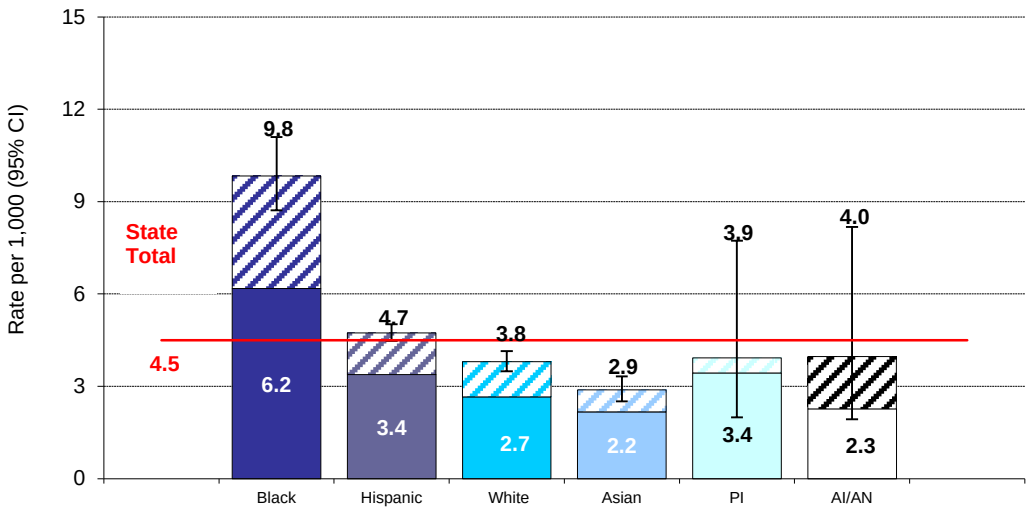
Figure 12. Low birth weight and very low birth weight. Percent (95% CI) of all live births, by race/ethnicity: 2012.



	LBW	VLBW
Black	12.0	2.7
Hispanic	6.1	1.0
White	5.7	0.9
Asian	7.9	1.1
PI	6.5	1.3
AI/NA	6.6	0.9
State Line	0.1	0.1
State Total	6.7	1.1

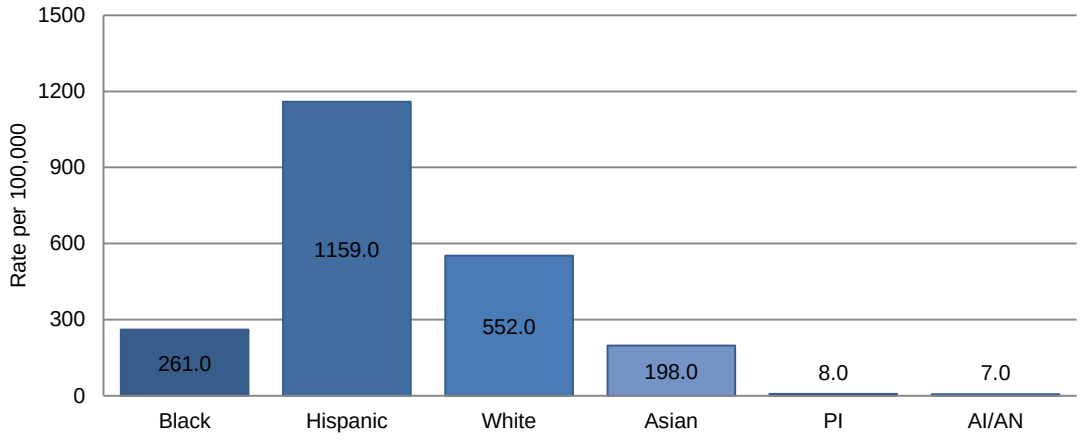
Data source: Birth Statistical Master Files (BSMF). Notes: LBW = low birth weight (<2,500 grams); VLBW = very low birth weight (<1,500 grams); births weighting <227 grams or >8165 grams were excluded from the analysis; PI = Pacific Islander; AI/AN = American Indian/Alaska Native

Figure 13. Infant mortality. Rate per 1,000 live births (95% CI), by race/ethnicity: 2012.



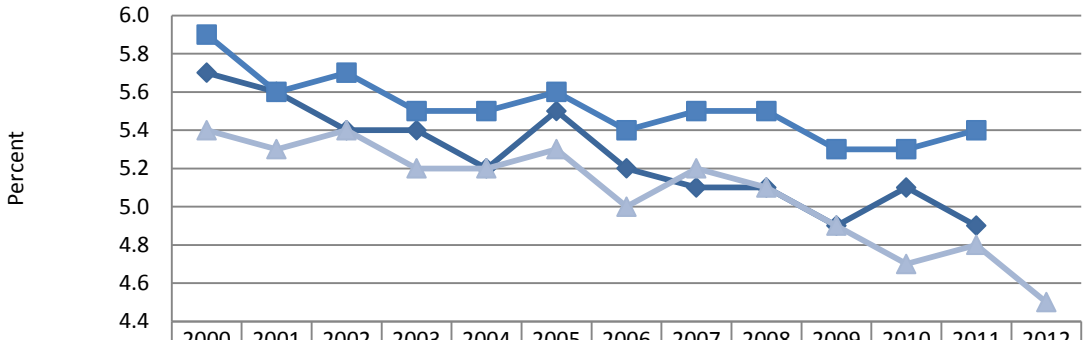
Data sources: Birth and Death Statistical Master Files (BSMF/DSMF). Notes: Neonatal < 28 days; postneonatal 28 days – 1 year; PI = Pacific Islander; AI/AN = American Indian/Alaska Native.

Figure 14. Number of Infant Deaths. Number of deaths, by race/ethnicity: 2012.



Data sources: Birth and Death Statistical Master Files (BSMF/DSMF). Notes: PI = Pacific Islander; AI/AN = American Indian/Alaska Native.

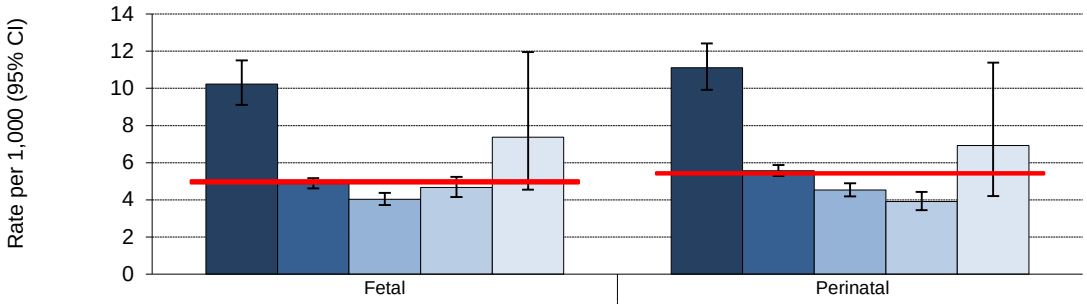
Figure 15. Fetal, perinatal, and infant deaths. Rate per 1,000 live births/fetal deaths: 2000-2012.



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Fetal	5.7	5.6	5.4	5.4	5.2	5.5	5.2	5.1	5.1	4.9	5.1	4.9	
Perinatal	5.9	5.6	5.7	5.5	5.5	5.6	5.4	5.5	5.5	5.3	5.3	5.4	
Infant	5.4	5.3	5.4	5.2	5.2	5.3	5	5.2	5.1	4.9	4.7	4.8	4.5

Data sources: Birth and Death Statistical Master Files (BSMF/DSMF). Notes: Fetal (≥20 weeks gestation); perinatal (28 weeks gestation-7 days postpartum); deaths per 1,000 live births and fetal deaths; infant death (>1 year) per 1,000 live births.

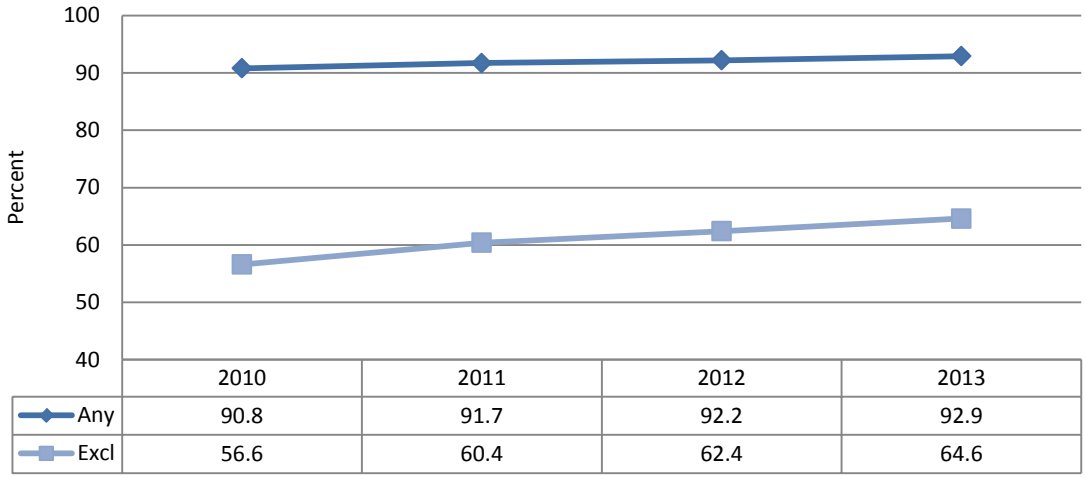
Figure 16. Fetal and perinatal deaths. Rate per 1,000 live births/fetal deaths (95% CI), by race/ethnicity: 2011.



	Fetal	Perinatal
Black	10.2	11.1
Hispanic	4.9	5.6
White	4.0	4.5
Asian	4.7	3.9
PI	7.4	6.9
State Line	0.15	0.1
State Total	4.9	5.4

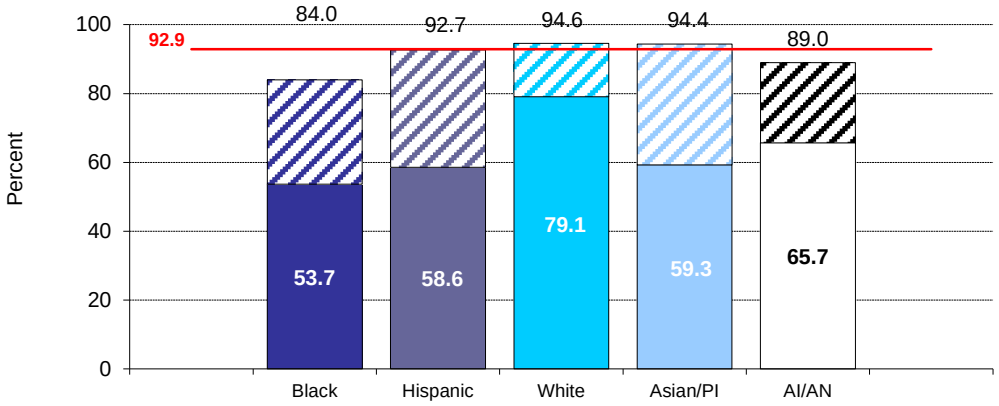
Data sources: Birth and Death Statistical Master Files (BSMF/DSMF). Notes: Fetal (≥20 weeks gestation); perinatal (28 weeks gestation-7 days postpartum); deaths per 1,000 live births and fetal deaths; PI = Pacific Islander.

Figure 17. Any and exclusive in-hospital breastfeeding. Percent of mothers with a recent live birth: 2010-2013.



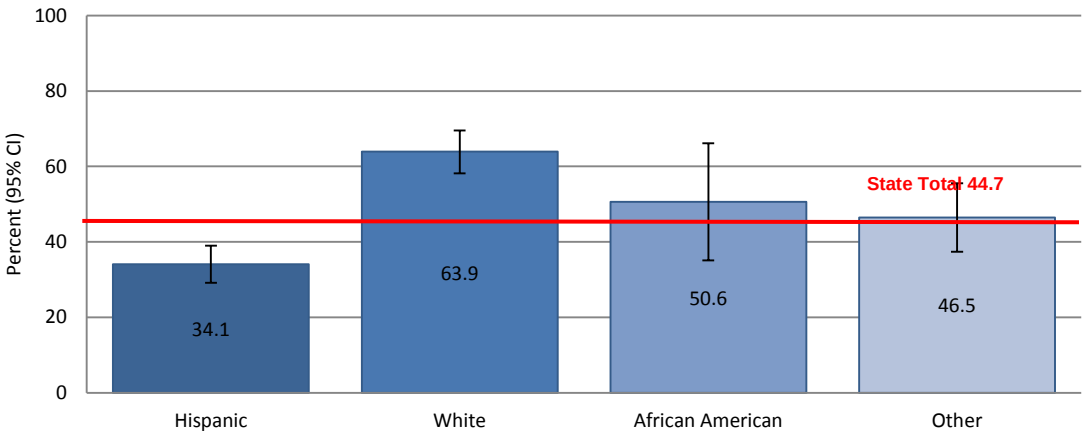
Data source: California Department of Public Health, Genetic Disease Screening Program, Newborn Screening Database.

Figure 18. In-hospital breastfeeding. Percent of mothers with a recent live birth, by race/ethnicity: 2013.



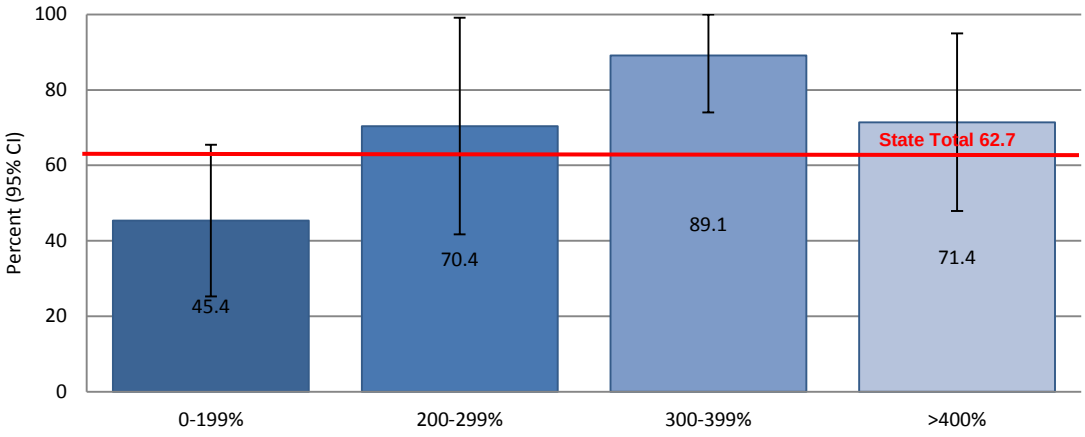
Data source: California Department of Public Health, Genetic Disease Screening Program, Newborn Screening Database. Notes: PI = Pacific Islander; AI/AN = American Indian/Alaska Native.

Figure 19. Children with a medical home. Percent of children ages 0 through 17, by race/ethnicity group: 2012.



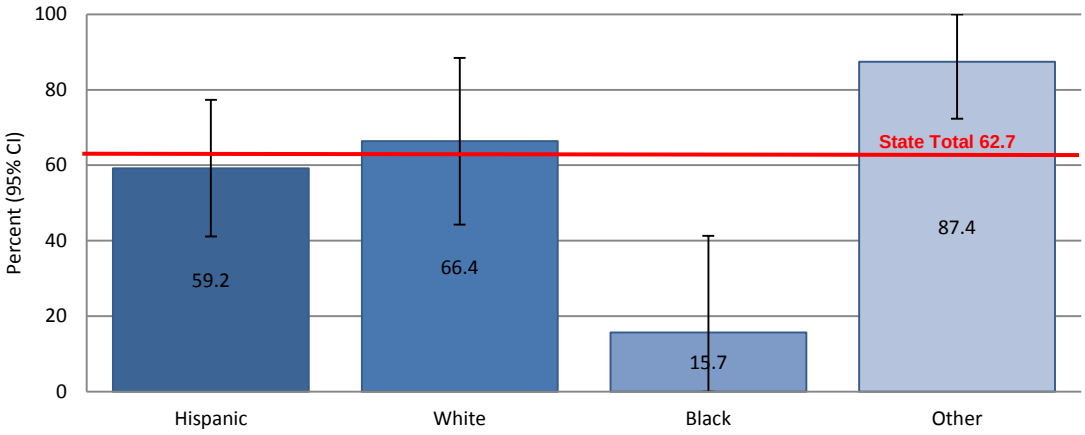
Data source: National Survey of Children's Health.

Figure 20. Treatment for mental/behavioral condition. Percent of California children ages 0-17th a mental or behavioral condition who received treatment, by federal poverty level: 2012.



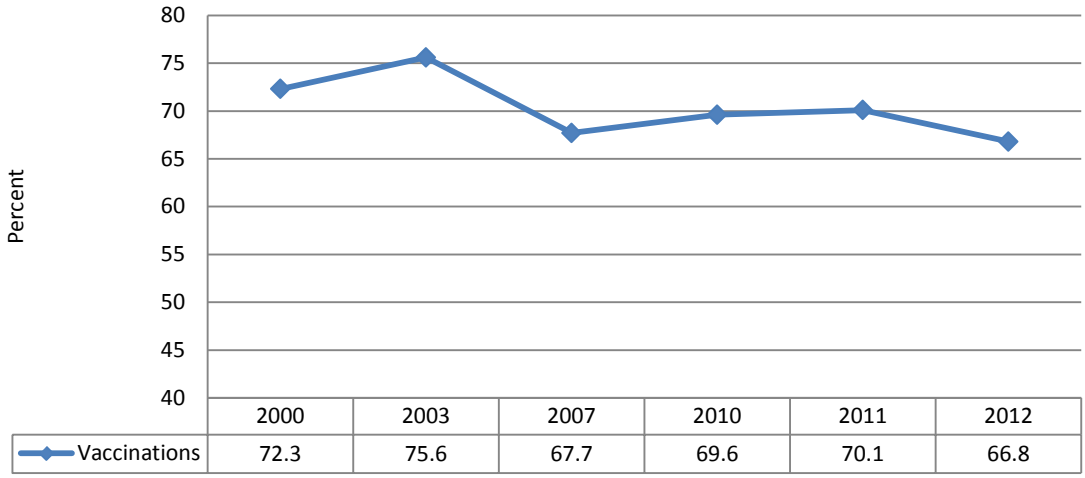
Data source: National Survey of Children's Health.

Figure 21. Treatment for mental/behavioral condition. Percent of California children ages 0-17th a mental or behavioral condition who received treatment, by race/ethnicity group: 2012.



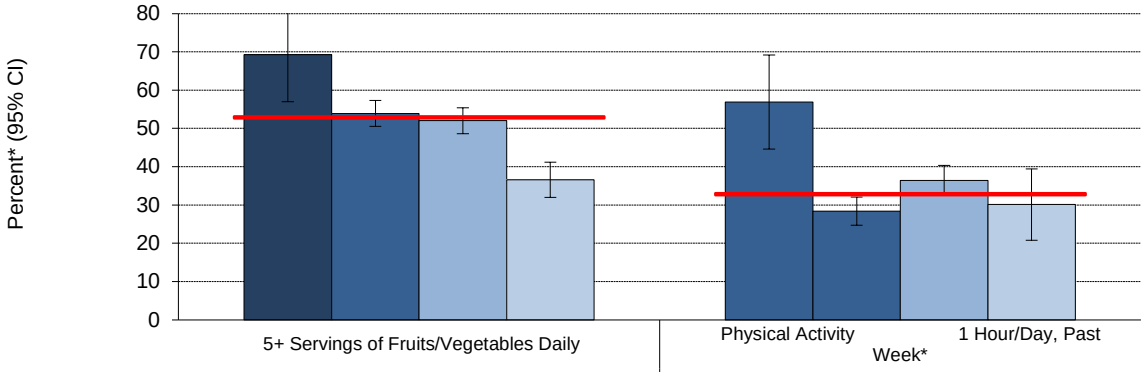
Data source: National Survey of Children's Health.

Figure 22. Combined series of vaccinations. Percent of California children ages 19-35 months who received combined series of vaccines: 2000-2012.



Data source: National Immunization Survey: 2013.

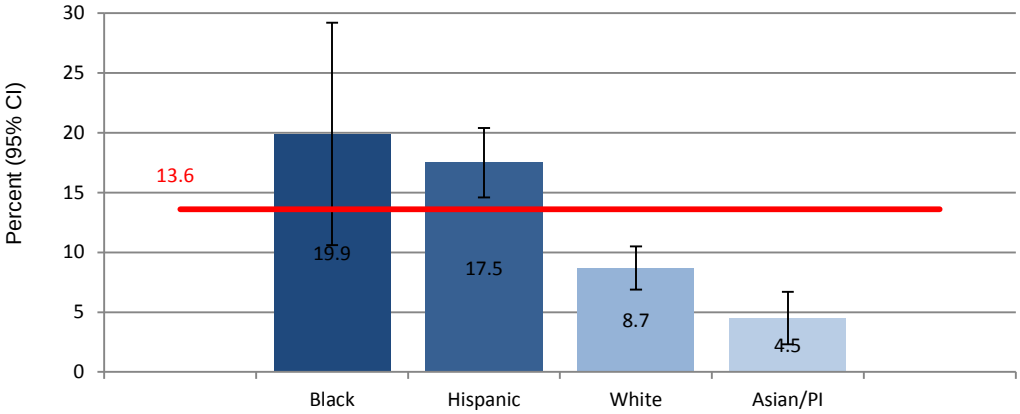
Figure 23. Percentage of children meeting age- appropriate recommendations for diet and physical activity, by race/ethnicity: 2011-2012.



	5+ Servings of Fruits/Vegetables Daily	Physical Activity 1 Hour/Day, Past Week*
Black	69.3	56.9
Hispanic	53.9	28.4
White	52	36.4
Asian/PI	36.6	30.1
State Line	0.5	0.5
State Total	52.6	32.6

Data Source: California Health Interview Survey (CHIS). Notes: Only asked of children ages 5-11: excluding physical education at school. PI = Pacific Islander.

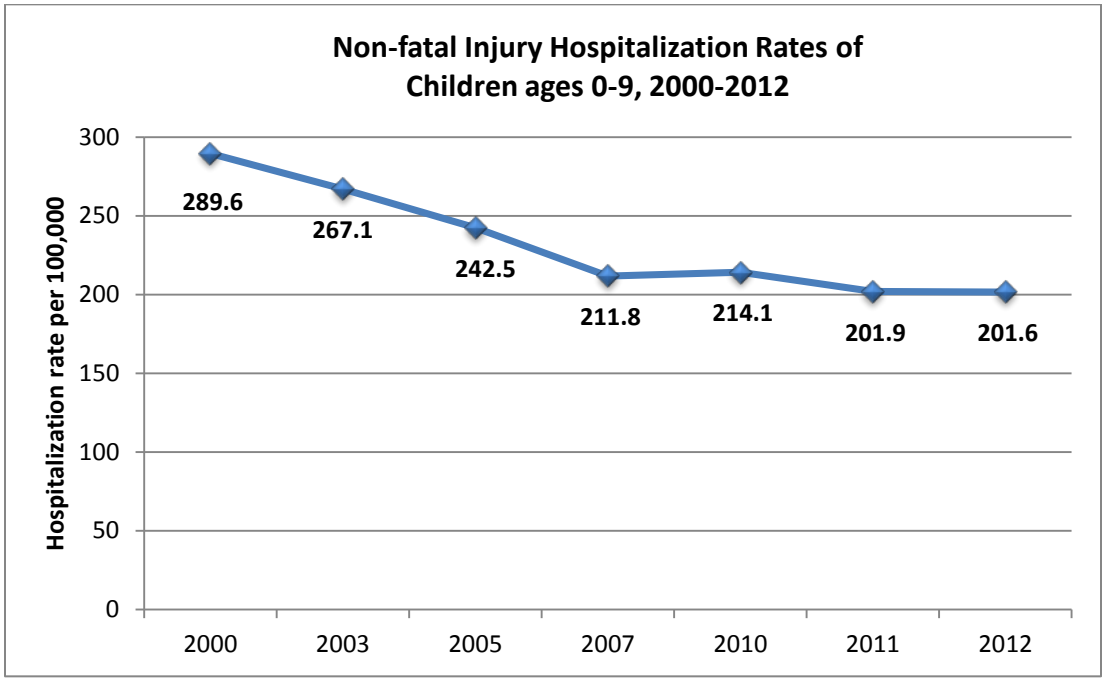
Figure 24. Overweight for age. Percent (95% CI) of children ages 2 through 11, by race/ethnicity: 2011-2012.



Data source: California Health Interview Survey (CHIS). Notes: Weight ≥ 95th percentile for age and gender; does not account for height. PI = Pacific Islander.

Figure 25. Non-fatal Injury Hospitalization Rates

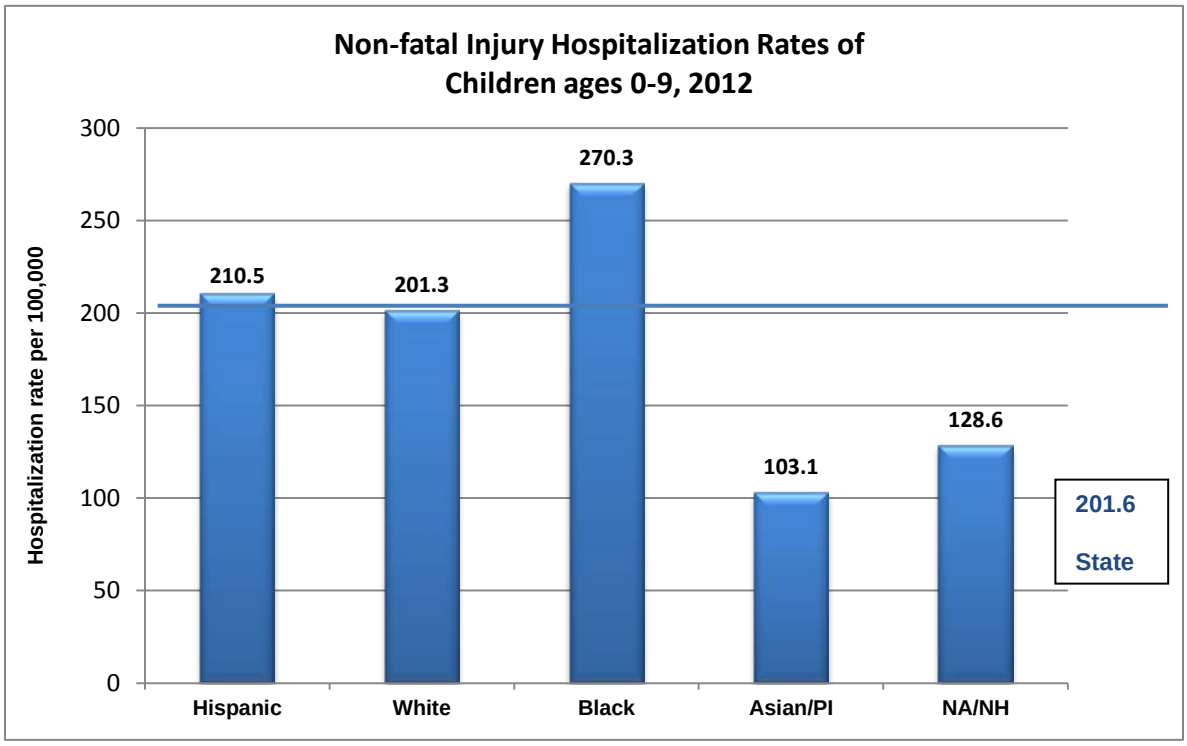
Hospitalization rates of child, ages 0-9, 2000-2012



Data source: National Survey of Children's Health (NSCH).

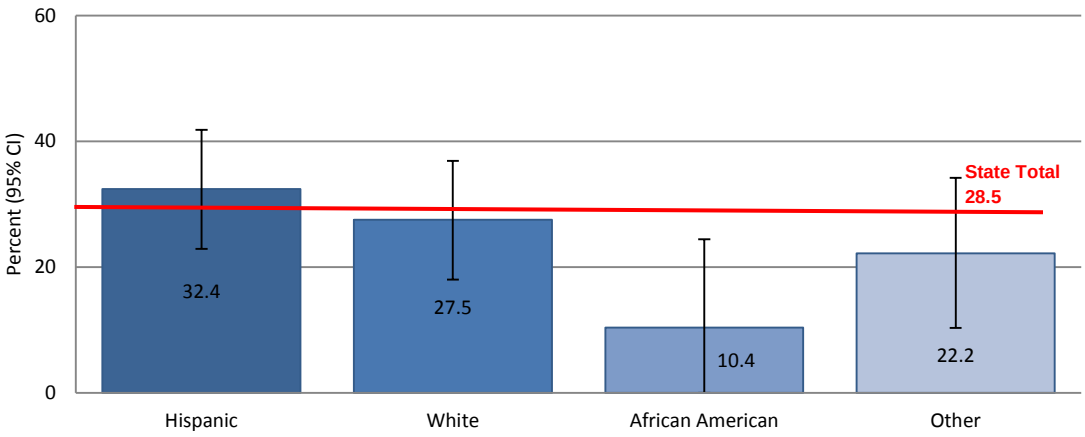
Figure 26. Non-fatal Injury Hospitalization Rates

Hospitalization rates of child, ages 0-9, by race/ethnicity, 2012



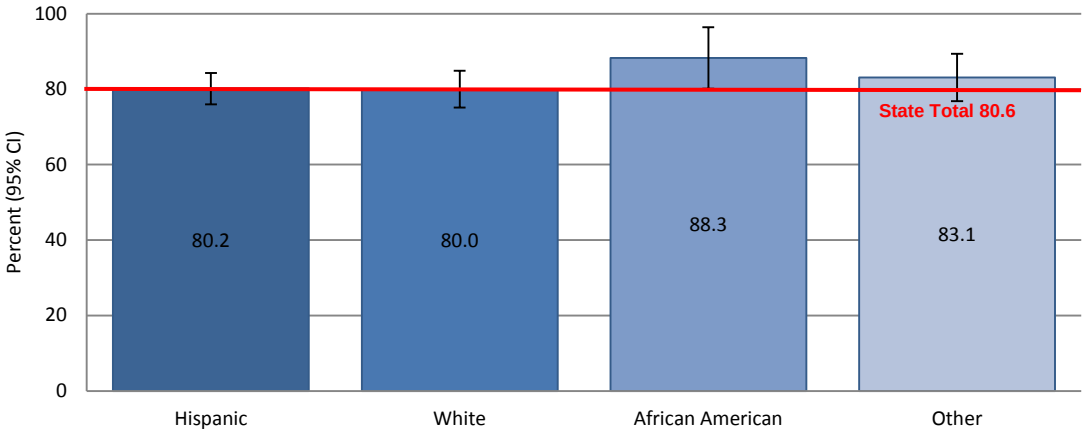
Data source: National Survey of Children's Health (NSCH).

Figure 27. Percent of California children ages 9-71 months screened for developmental, behavioral and social delays, by race/ethnicity group: 2012.



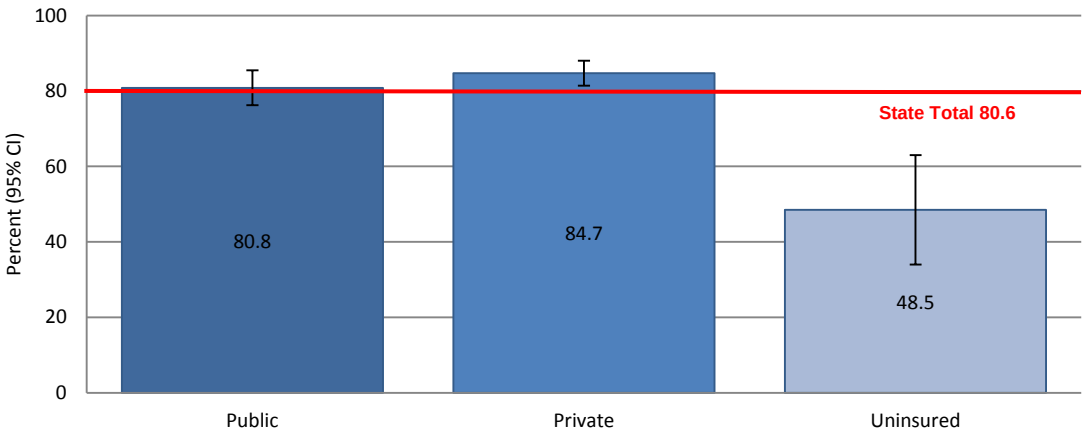
Data source: National Survey of Children's Health (NSCH).

Figure 28. Preventative services visit. Percent of children and adolescents ages 0-17, by race/ethnicity group: 2012.



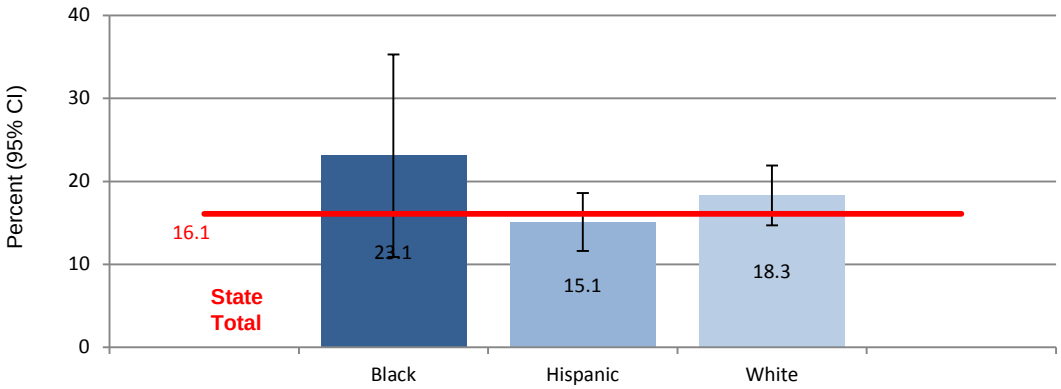
Data source: National Survey of Children's Health.

Figure 29. Preventative services visit, percent of children and adolescents ages 0-17, by insurance status: 2012.



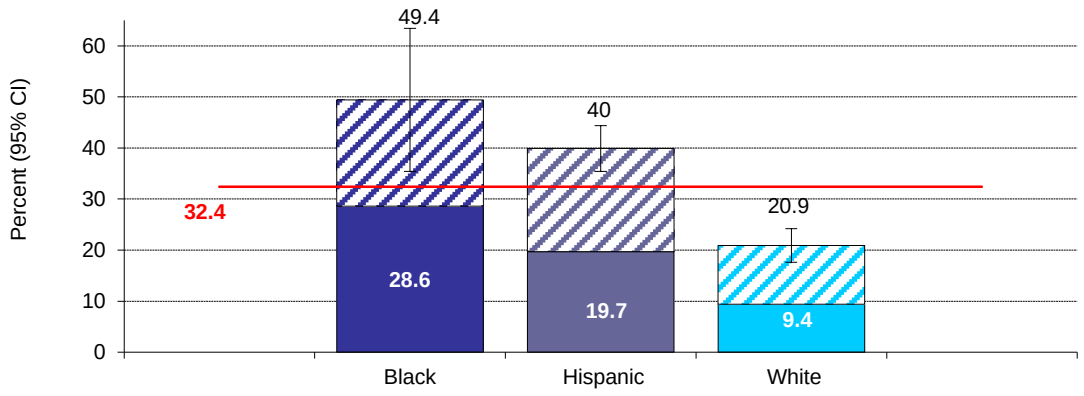
Data source: National Survey of Children's Health.

Figure 30. Percentage of adolescents ages 12-17 that are physically active at least 1 hour per day, by race/ethnicity: 2011-2012.



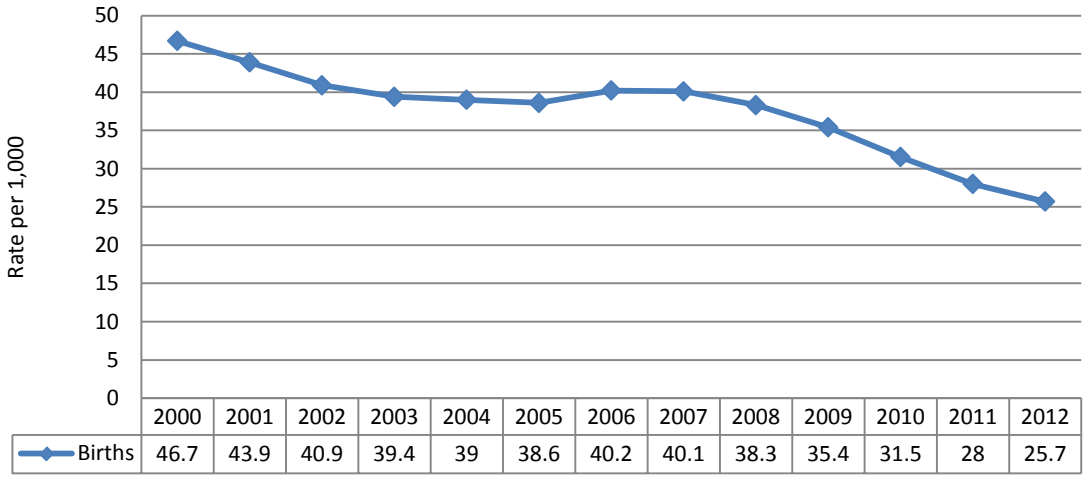
Data source: National Survey of Children's Health (NSCH).

Figure 31. Overweight and obesity. Percent (95% CI) of adolescents ages 12 through 17, by race/ethnicity: 2011-12.



Data source: California Health Interview Survey (CHIS). Notes: BMI = Body Mass Index

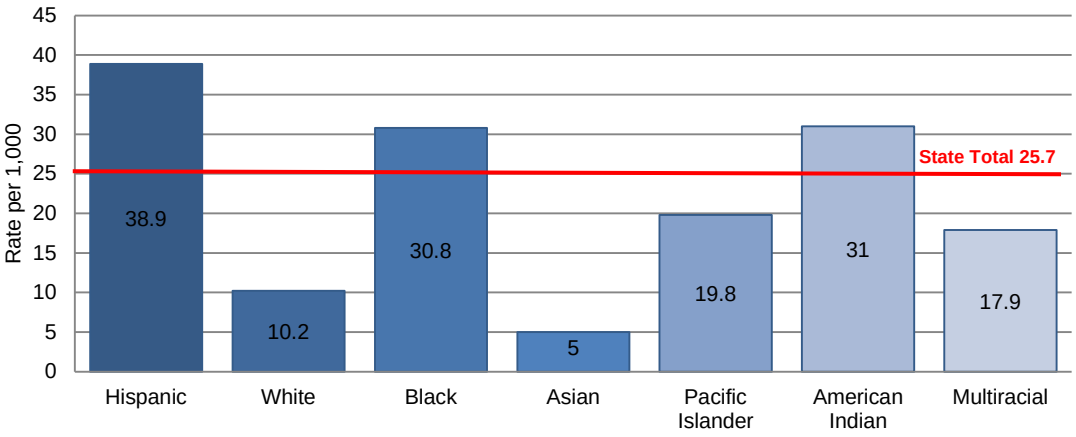
Figure 32. Teen birth rate. Rate per 1,000 females ages 15-19: 2000-2012.



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Births	46.7	43.9	40.9	39.4	39	38.6	40.2	40.1	38.3	35.4	31.5	28	25.7

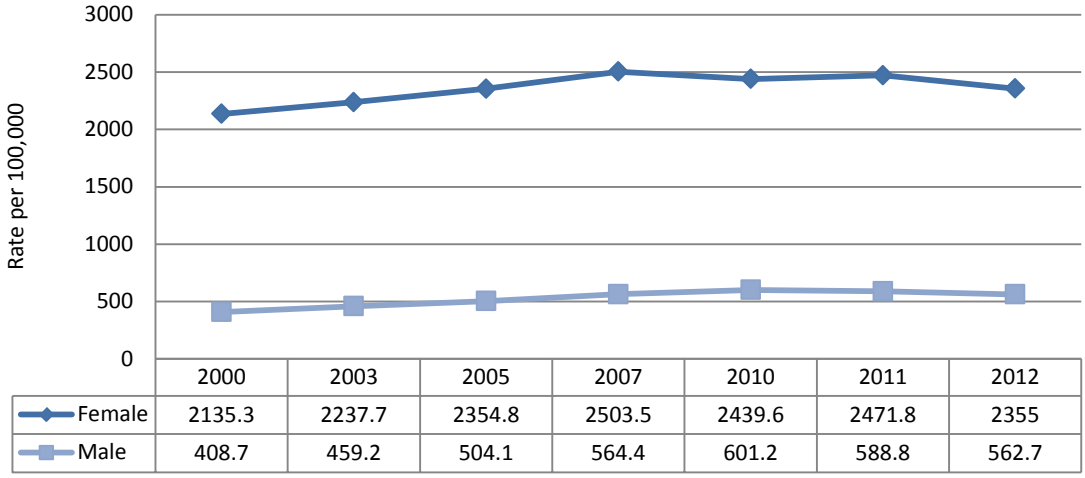
Data source: MCAH California Teen Birth Rate Press Release.

Figure 33. Teen birth rate. Rate per 1,000 females ages 15-19, by race/ethnicity group: 2012.



Data source: MCAH California Teen Birth Rate Press Release.

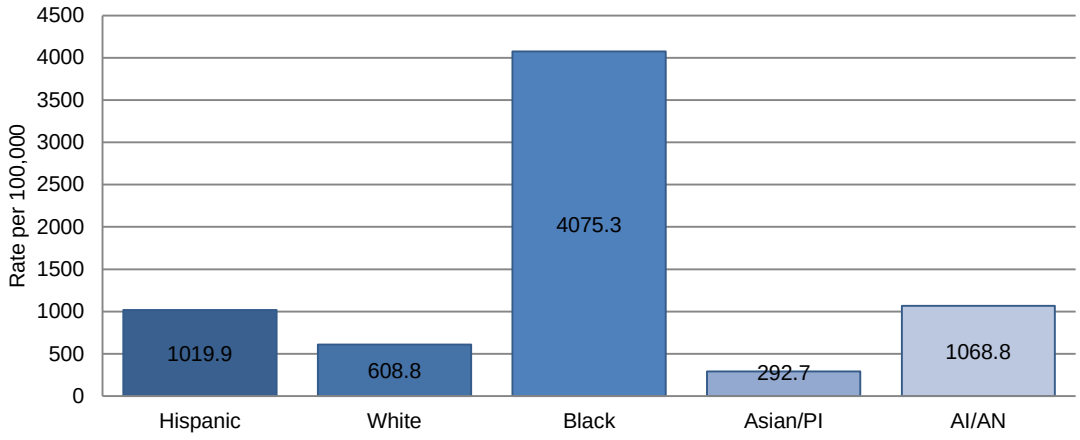
Figure 34. Chlamydia incidence rates. Incidence rates of adolescents, ages 15-19, by sex: 2000-2012.



	2000	2003	2005	2007	2010	2011	2012
Female	2135.3	2237.7	2354.8	2503.5	2439.6	2471.8	2355
Male	408.7	459.2	504.1	564.4	601.2	588.8	562.7

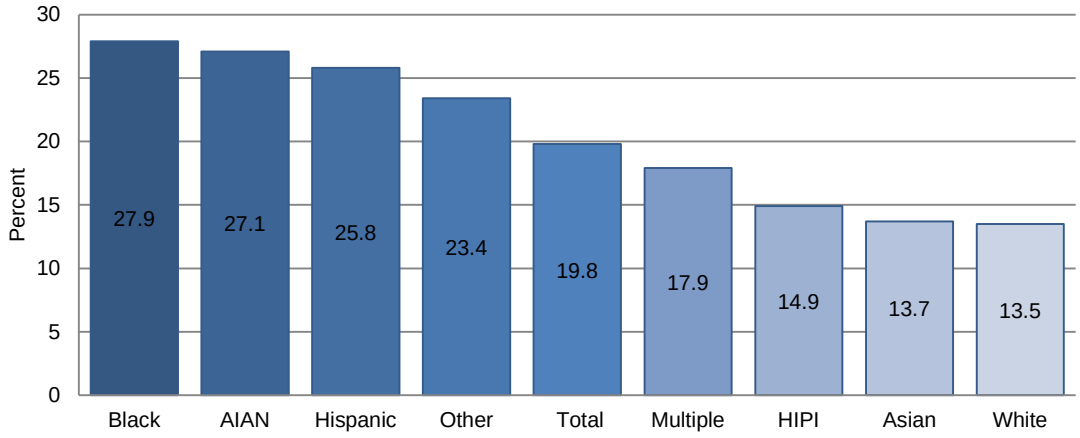
Data source: California Department of Public Health, Sexually Transmitted Disease (CDPH STD).

Figure 35. Chlamydia incidence rates. Incidence rates of adolescents, ages 15-19, by race/ethnicity group: 2012.



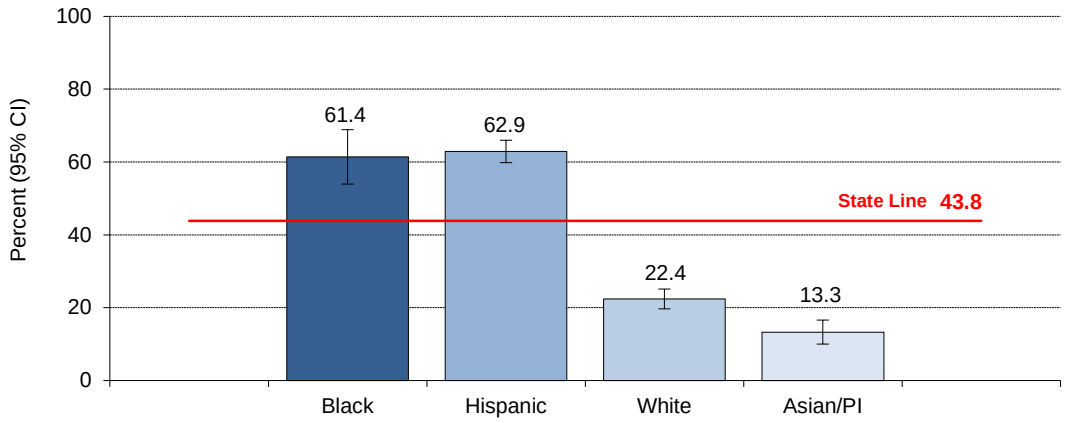
Data source: California Department of Public Health, Sexually Transmitted Disease (CDPH STD).

Figure 36. Percentage of reproductive age women 15-44 in California that are below 100 percent of the federal poverty level, by race/ethnicity group: 2010-2012.



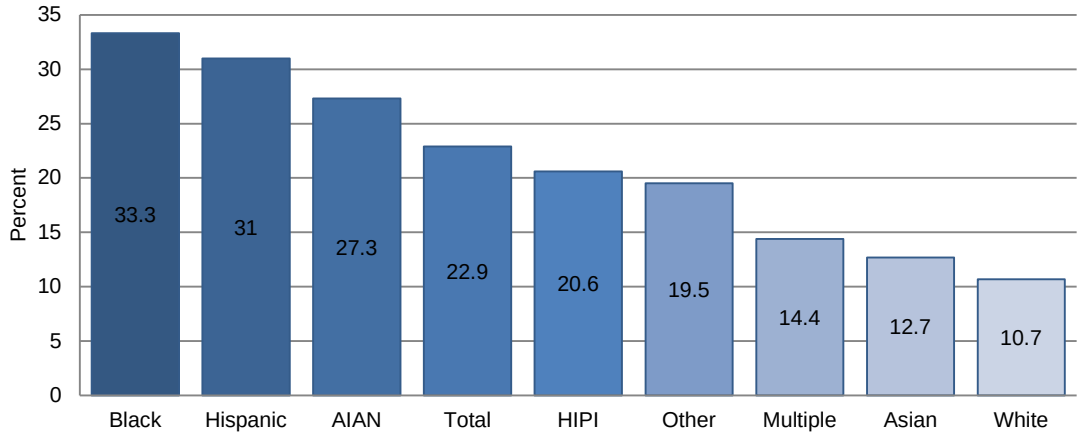
Data source: Analysis of the aggregated 3-year (2010-2012) American Community Survey. Notes: AIAN = American Indian/Alaskan Native; HIPI = Native Hawaiian/Pacific Islander.

Figure 37. Percentage of mothers with a Recent Live Birth below 100 percent of the federal poverty level, by race/ethnicity: 2011.



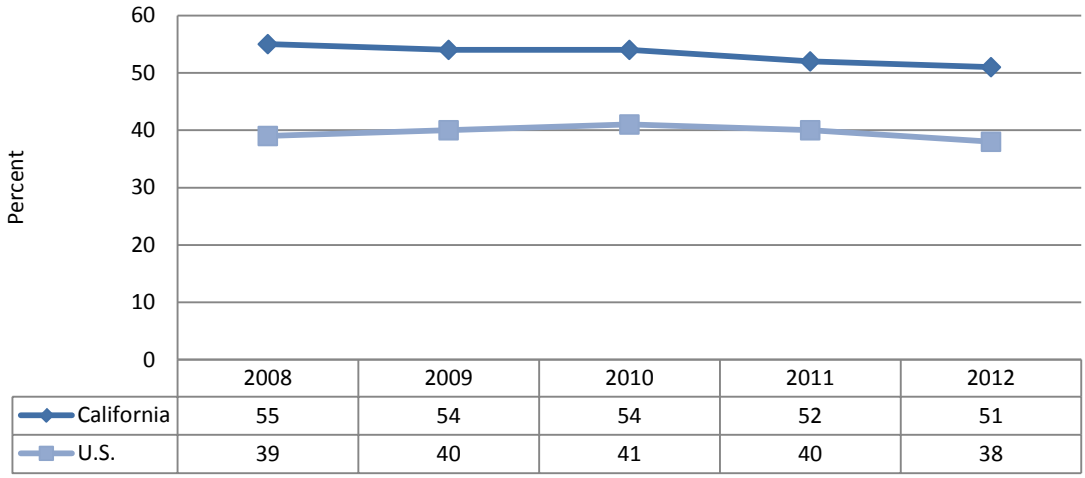
Data source: Maternal and Infant Health Assessment Survey (MIHA). Notes: PI = Pacific Islander.

Figure 38. Percentage of children ages 0-17 in California that are below 100 percent of the federal poverty level, by race/ethnicity group: 2010-2012.



Data source: Analysis of the aggregated 3-year (2010-2012) American Community Survey. Notes: AIAN = American Indian/Alaskan Native; HIPI = Native Hawaiian/Pacific Islander.

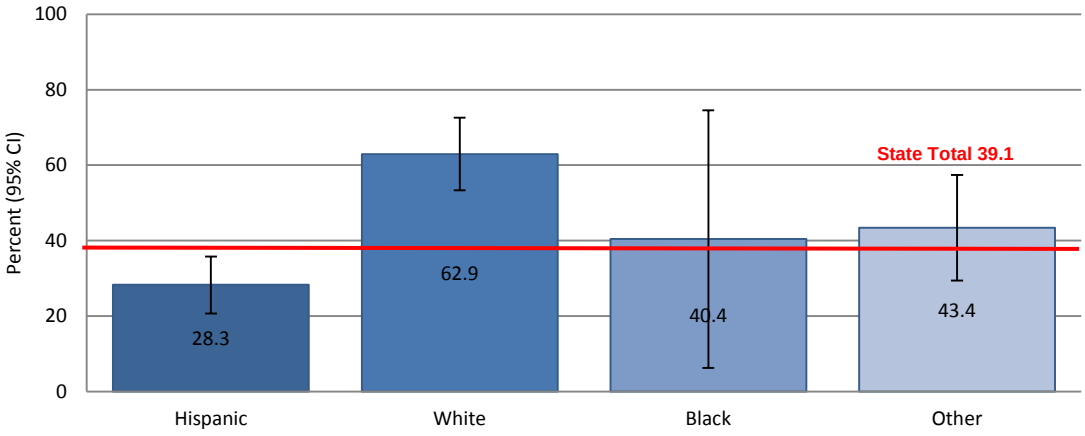
Figure 39. Percentage of children ages 0-17 living in with a high housing cost burden, CA and USA: 2008-2012.



	2008	2009	2010	2011	2012
California	55	54	54	52	51
U.S.	39	40	41	40	38

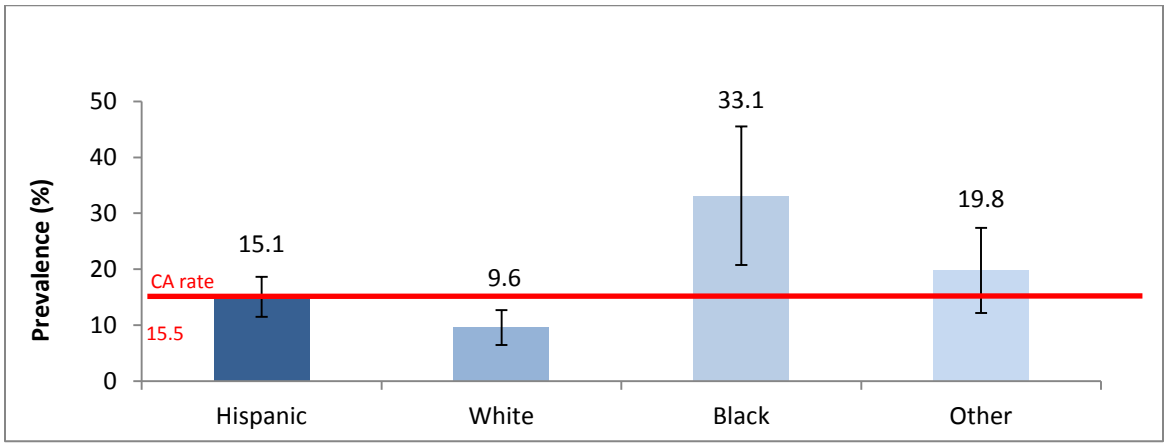
Data source: American Community Survey, 2008-2012, analyzed by the Population Reference Bureau.

Figure 40. Every day reading books. Percent of children ages 0-5, by race/ethnicity: 2012.



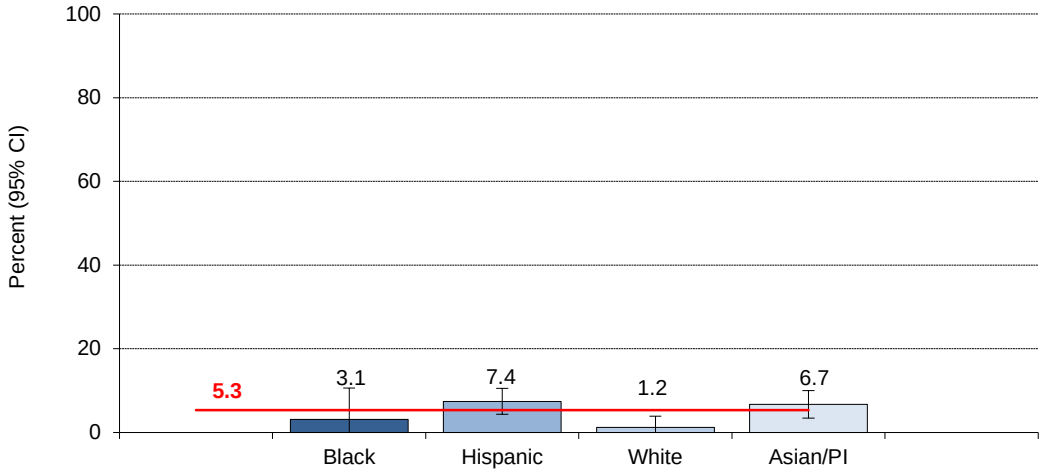
Data source: National Survey of Children's Health.

Figure 41. Race Discrimination among non-pregnant women age 18-44, by race/ethnicity group: 2013.



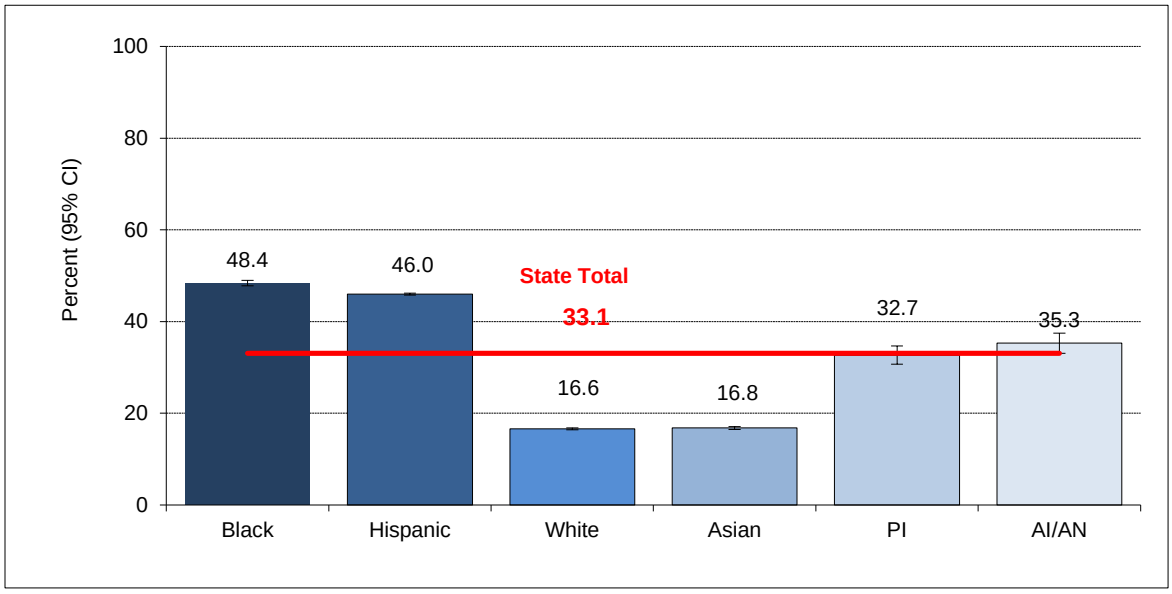
Data source: Behavioral Risk Factor Surveillance System, California.

Figure 42. Percentage of women with a recent live birth who had no practical or emotional support, by race/ethnicity: 2011.



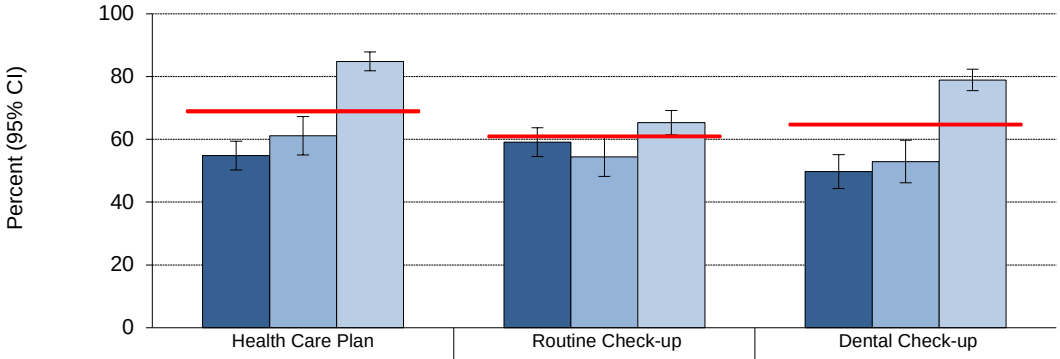
Data source: Maternal and Infant Health Assessment Survey (MIHA). Notes: PI = Pacific Islander

Figure 43. Births in areas of concentrated poverty. Percent (95% CI) of live births, by race/ethnicity: 2012.



Data sources: Birth Statistical Master File (BSMF) American Community Survey 5-yr File (2008-2012) Notes: PI = Pacific Islander; AI/AN = American Indian/Alaska Native.

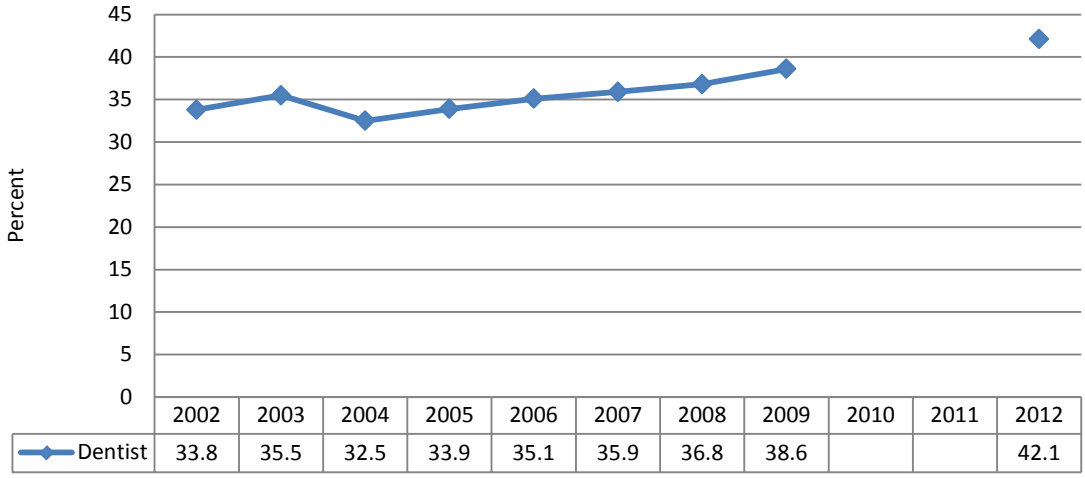
Figure 44. Percentage of California women age 18-44 with usual source of care, routine and dental checkups within the past year, by income: 2013.



	Health Care Plan	Routine Check-up	Dental Check-up
0-99%	54.8	59.1	49.7
100-200%	61.1	54.4	52.9
>=201%	84.8	65.3	78.9
State Line	0.5	0.4	0.4
State Total	68.7	60.7	64.5

Data source: California Behavioral Risk Factor Survey (BRFS). Notes: Income shown as a percent of the Federal Poverty Level (FPL).

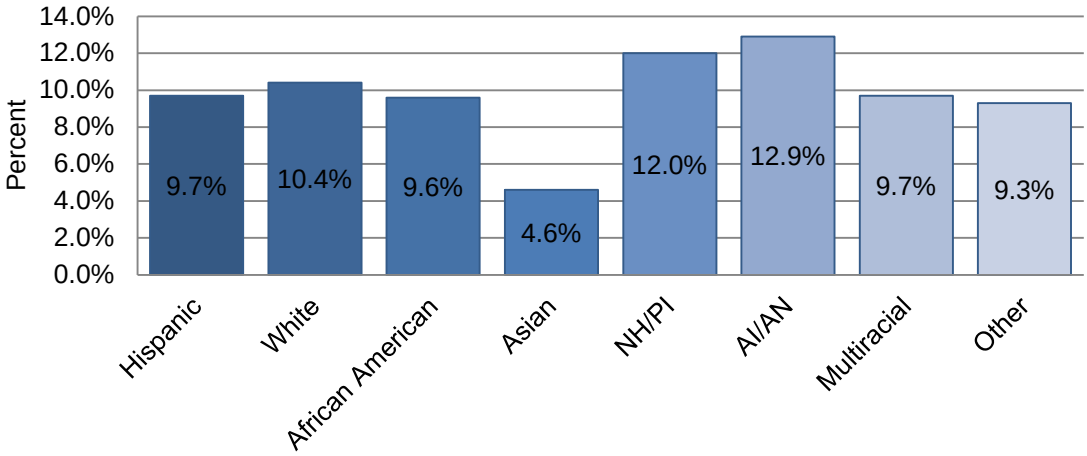
Figure 45. Visit a dentist during pregnancy. Percent of mothers with a recent live birth: 2000-2012.



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Dentist	33.8	35.5	32.5	33.9	35.1	35.9	36.8	38.6			42.1

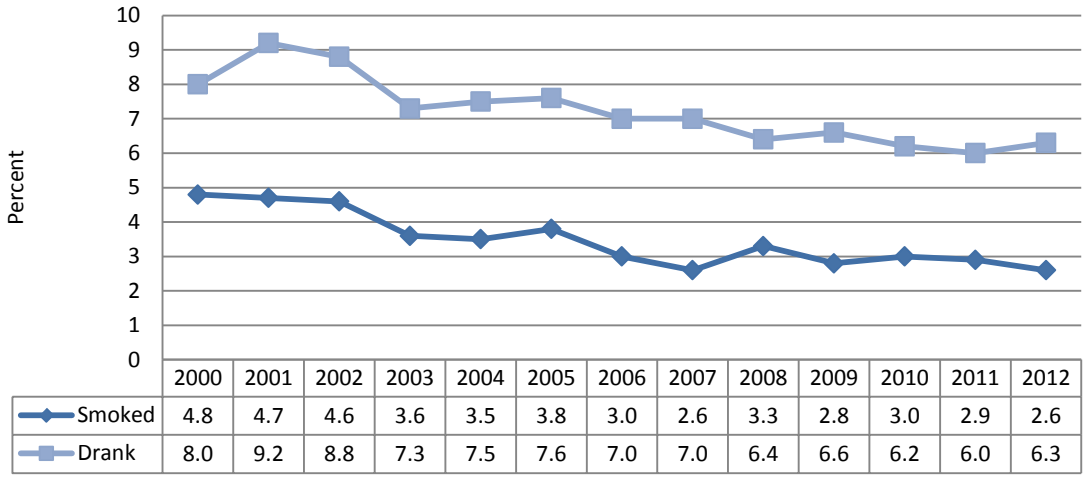
Data source: Maternal and Infant Health Assessment (MIHA). Notes: Data not available in 2010-2011.

Figure 46. Cigarette use in past month. Percent of adolescents in grades 7, 9, and 11 who smoked at least one cigarette in the past 30 days: 2008-2010.



Data source: California Healthy Kids Survey (CHKS). Notes: Recall that these two need to have smoking and drinking separated

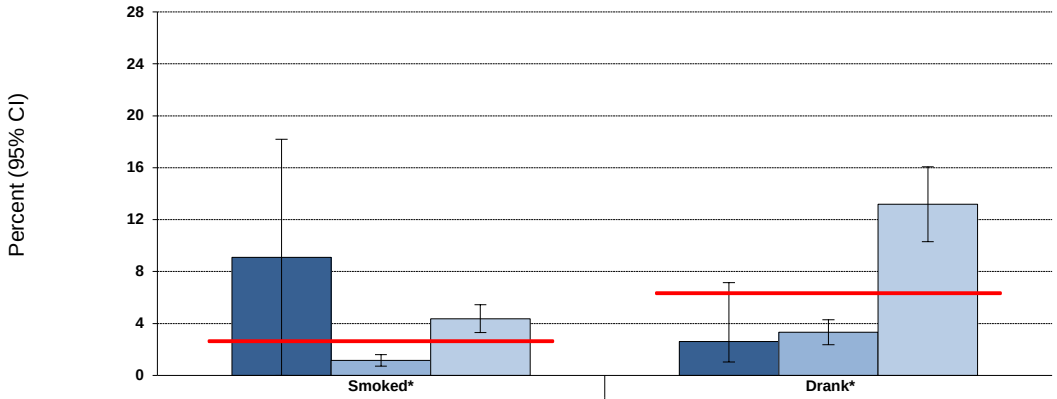
Figure 47. Smoking and drinking during pregnancy. Percent of mothers with a recent live birth: 2000-2012.



	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Smoked	4.8	4.7	4.6	3.6	3.5	3.8	3.0	2.6	3.3	2.8	3.0	2.9	2.6
Drank	8.0	9.2	8.8	7.3	7.5	7.6	7.0	7.0	6.4	6.6	6.2	6.0	6.3

Data source: Maternal and Infant Health Assessment Survey (MIHA). Notes: Smoked during the 3rd trimester; drank during the 3rd trimester.

Figure 48. Smoking and drinking during pregnancy. Percent (95% CI) of mothers with a recent live birth, by race/ethnicity: 2012.

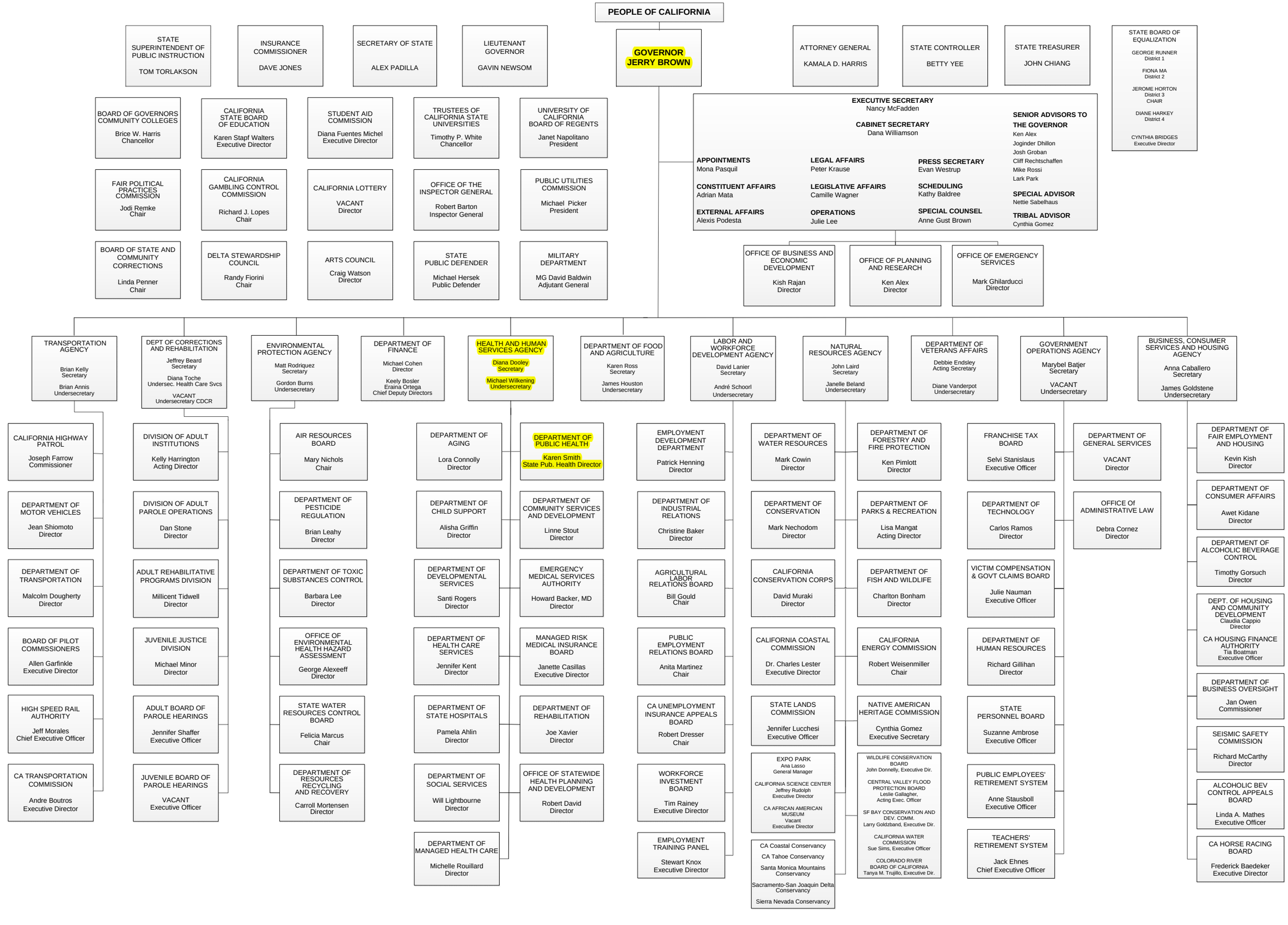


	Smoked*	Drank*
Black	9.1	2.6
Hispanic	1.2	3.3
White	4.4	13.2
State Total	0.1	0.1
Asian/PI	2.6	6.3

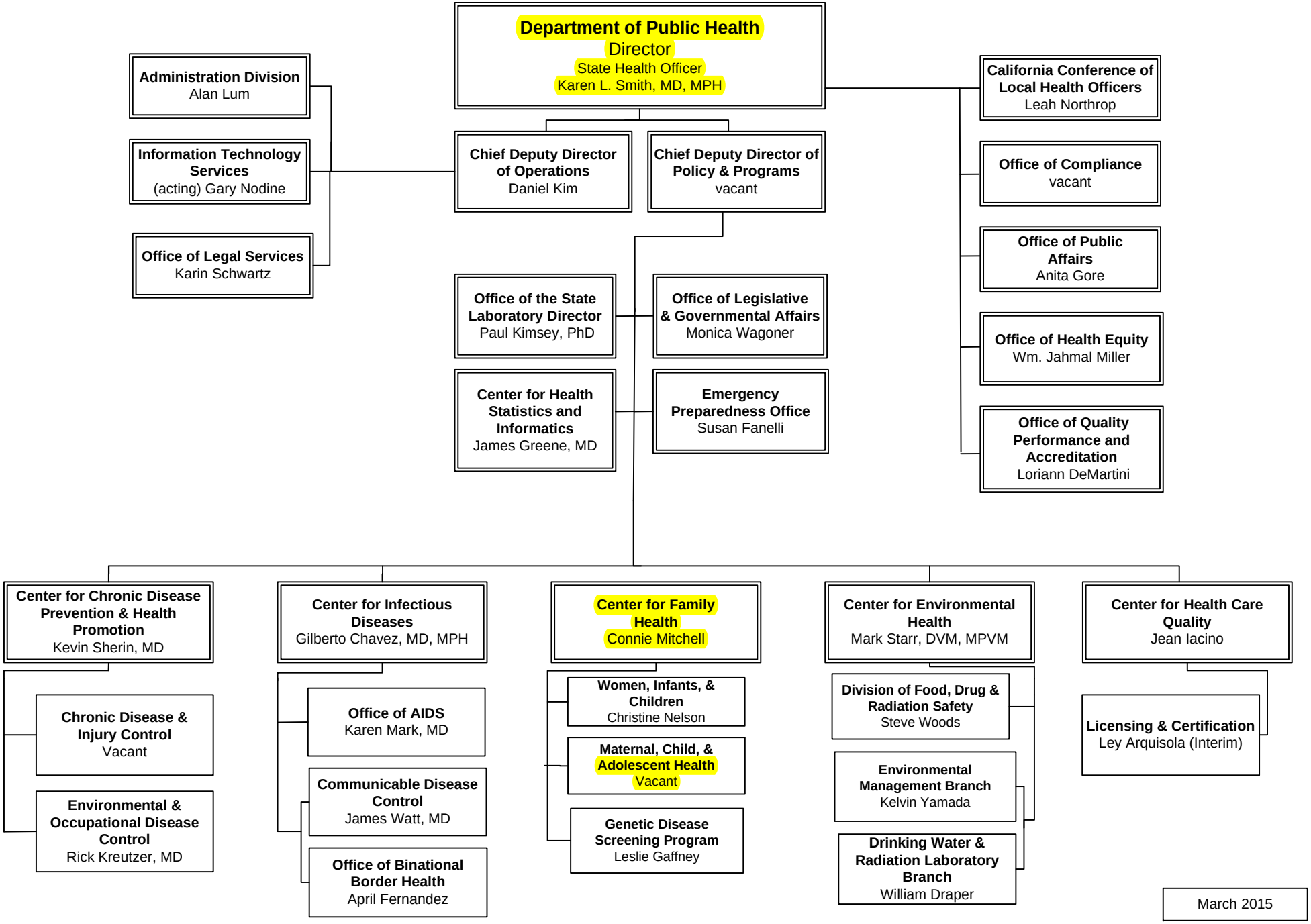
Data source: Maternal and Infant Health Assessment Survey (MIHA). Notes: Smoked during the 3rd trimester; drank during the 3rd trimester.

Attachment 1 - Organizational Charts

CALIFORNIA STATE GOVERNMENT – THE EXECUTIVE BRANCH

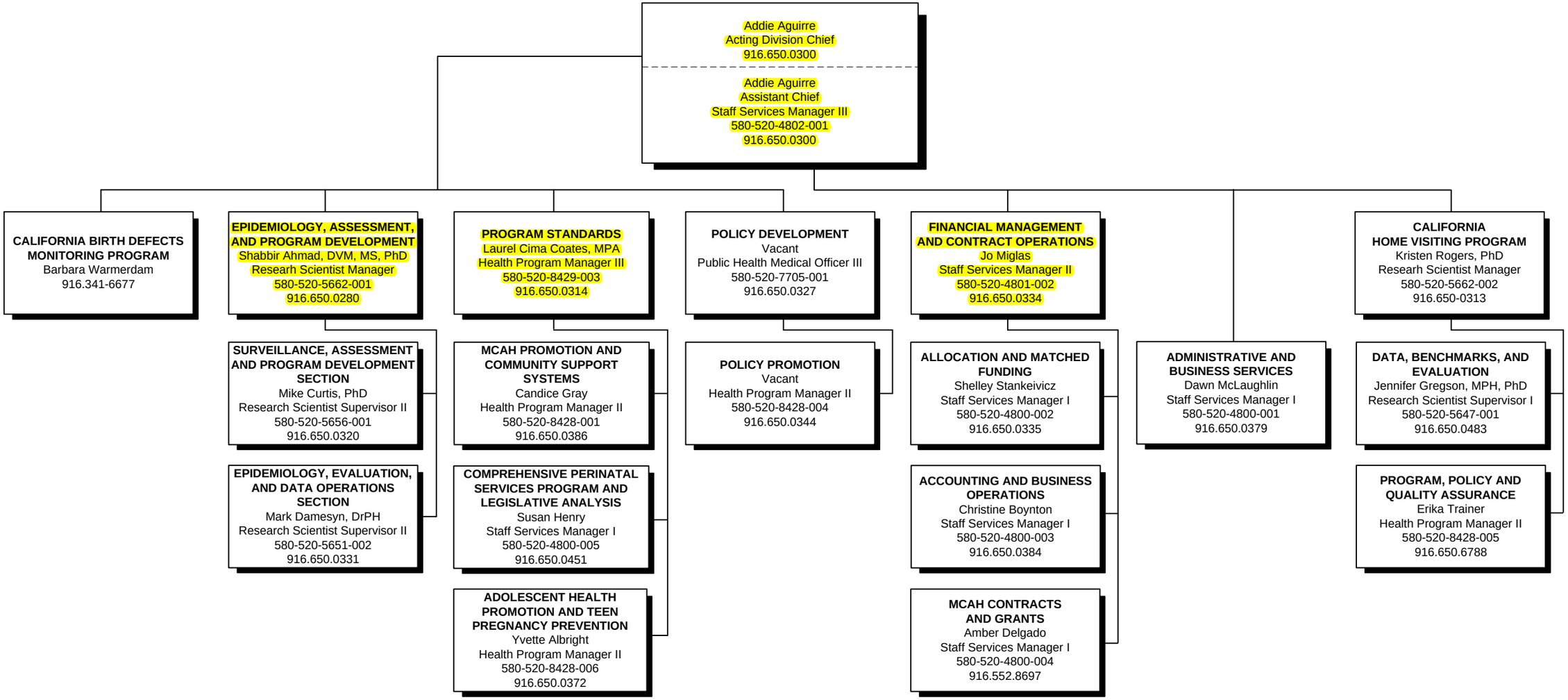


California Department of Public Health



March 2015

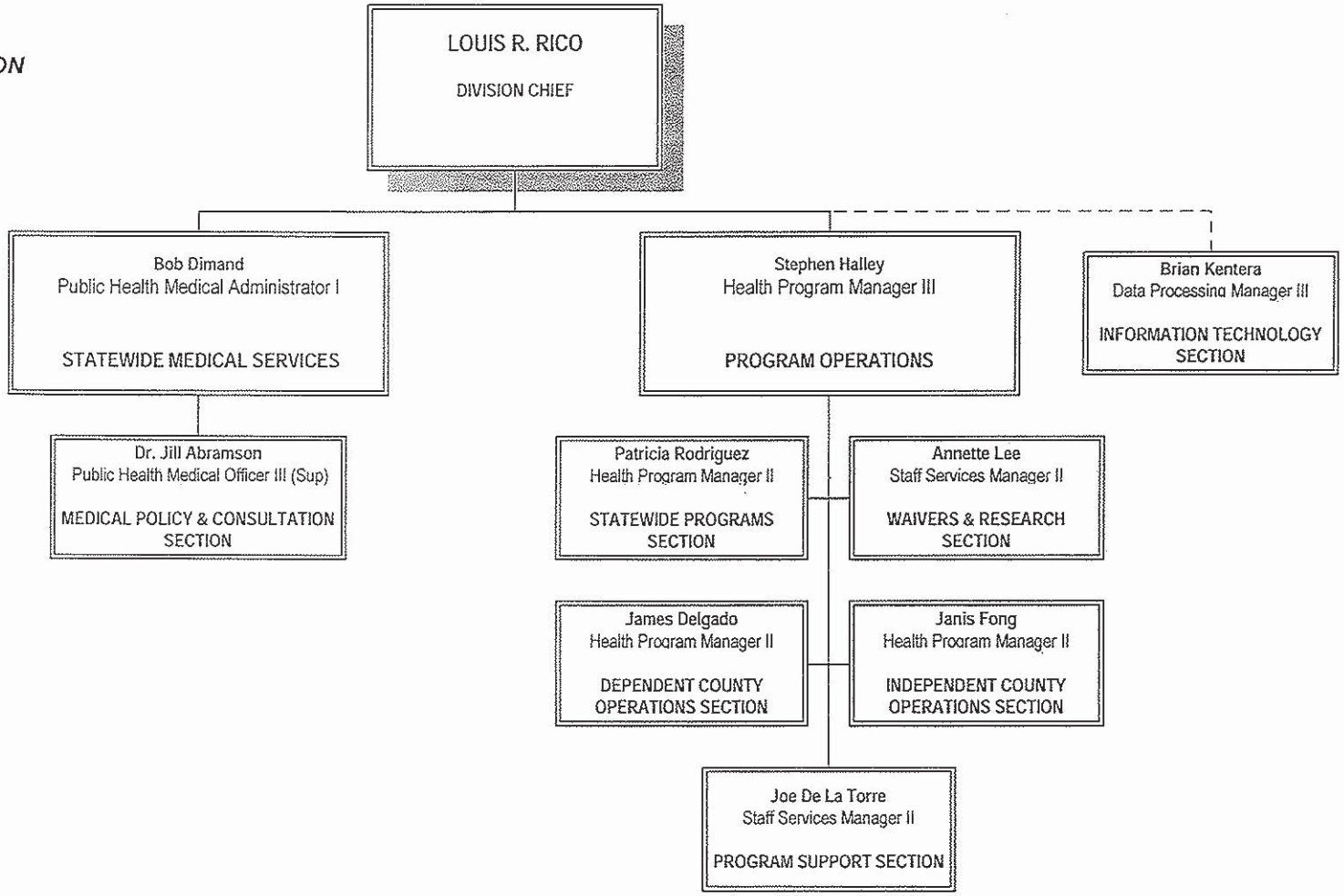
California Department of Public Health
Center for Family Health
Maternal, Child and Adolescent Health Division



November 6, 2014

CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
SYSTEMS OF CARE DIVISION
CALIFORNIA CHILDREN'S SERVICES
1515 K Street, MS 8100, P.O. Box 997413, Sacramento, CA 95899-7413 (916) 327-1400

SYSTEMS OF CARE DIVISION



11/18/2014

Attachment 2 - Program Descriptions

Attachment 2, Program Descriptions

ADOLESCENT FAMILY LIFE PROGRAM (AFLP)

AFLP aims to promote healthy development of adolescents and their children, healthy lifestyle decisions, including immunization and pregnancy prevention and continuation of adolescents' education. It uses a case management model to address the social, medical, educational, and economic consequences of adolescent pregnancy, repeat pregnancy and parenting on the adolescent, her child, family, and society. It also links clients to mental health, drug and alcohol treatment, foster youth, family planning and dental care services and direct services available through Medi-Cal and Temporary Assistance for Needy Families (TANF) or Cal Works as it is known in California.

ADOLESCENT SEXUAL HEALTH WORK GROUP (ASHWG)

ASHWG is a collaborative of 23 organizations from CDPH, CDE and non-governmental organizations who address sexual and reproductive health needs of youth. Its vision is to create a coordinated, collaborative, and integrated system among government and non-government organizations to promote and protect the sexual and reproductive health of youth in California.

BRANAGH INFORMATION GROUP

MCAH contracted with the Branagh Information Group to develop, maintain, and provide technical assistance for LodeStar, a comprehensive software package for AFLP agencies conducting case management for pregnant and parenting teens and their children.

BLACK INFANT HEALTH (BIH)

BIH which has the goal of reducing African American infant mortality in California uses case management and group interventions to support African American women in their pregnancies and improve birth outcomes.

BREASTFEEDING TECHNICAL ASSISTANCE PROGRAM

This program promotes and supports efforts to make breastfeeding the infant feeding norm. Its website (http://www.cdph.ca.gov/programs/breastfeeding/Pages/default.aspx) contains targeted breastfeeding information for families and providers. It has piloted BBC to assist hospitals to improve their exclusive breastfeeding rates and collaborated with Medi-Cal, WIC and the CA Breastfeeding Coalition to improve hospital support for breastfeeding.

CALIFORNIA BIRTH DEFECTS MONITORING PROGRAM (CBDMP)

CBDMP collects and analyzes data to identify opportunities for preventing birth defects and improving the health of babies.

CALIFORNIA CHILDREN'S SERVICES (CCS) PROGRAM

CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases producing major sequelae.

CALIFORNIA DIABETES AND PREGNANCY PROGRAM (CDAPP)

CDAPP promotes optimal management of diabetes in at-risk women, before, during and after pregnancy. Regional teams of dietitians, nurses, behavioral specialists and diabetic educators provide training and technical assistance to promote quality care

provided by local Sweet Success providers and to recruit and train new Sweet Success providers in areas of need.

CALIFORNIA EARLY CHILDHOOD COMPREHENSIVE SYSTEMS (ECCS)

ECCS promotes universal and standardized social, emotional, and developmental screening. ECCS collaborative efforts provide CHDP with guidance on validated and standardized developmental/social-emotional health screening tools for earlier identification of children with developmental delays.

CALIFORNIA PERINATAL QUALITY CARE COLLABORATIVE (CPQCC)

CPQCC is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals and business groups. It develops perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels

COMPREHENSIVE PERINATAL SERVICES PROGRAM (CPSP)

CPSP provides comprehensive perinatal care including obstetrical, nutrition, health education, and psychosocial services from qualified providers to Medi-Cal eligible women.

CALIFORNIA HOME VISITING PROGRAM (CHVP)

CHVP aims to improve service coordination for at-risk communities to promote improvements in maternal and infant health, school readiness, reduction of child maltreatment, improved community referral systems, and reductions in crime and domestic violence.>Human Stem Cell Research Program (HSCR)

HSCR develops comprehensive guidelines to address the ethical, legal, and social aspects of stem cell research and ensure the systematic monitoring and reporting of HSCR activity that is not fully funded by Proposition 71 money granted through the California Institute for Regenerative Medicine. A diverse group of 13 national and

international specialists serve on a HSCR Advisory Committee to advise CDPH on statewide guidelines for HSCR.

CALIFORNIA PERSONAL RESPONSIBILITY EDUCATION PROGRAM (CA PREP)

CA PREP educates high-risk adolescents on both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, through replication of evidence-based programs to delay sexual activity, increase contraceptive use or reduce pregnancy. CA PREP also implements activities to prepare young people for adulthood and are also referred to family planning related health care services

CALIFORNIA MATERNAL QUALITY CARE COLLABORATIVE (CMQCC)

CMQCC is the statewide umbrella organization for assessing the current state of knowledge of maternal illness and complications and transforming this knowledge into targeted, evidence-based, data-driven clinical quality improvement interventions and public health strategies statewide and at the local level. CMQCC's mission is to end preventable maternal morbidity and mortality by improving the quality of care women receive during pregnancy, childbirth, and postpartum. CMQCC maintains an informative website of resources and policies for both public and private use (www.cmqcc.org) and provides educational outreach to health professionals.

CALIFORNIA STATE UNIVERSITY, SACRAMENTO (CSUS)

CSUS provides and coordinates CPSP Provider Overview and Steps To TakeTraining, is developing on-line provider training, and supports statewide meetings.

CALIFORNIA CHILDREN’S SERVICES (CCS) PROGRAM

The California Children's Services (CCS) Program works in cooperation with medical and administrative staff in 58 counties to provide utilization management and authorization of services for CSHCN. The local CCS programs are administered at the county level for 31 independent counties and at state offices for 27 dependent counties (counties with populations under 200,000). The SCD is responsible for administration and oversight of the CCS Program.

The SCD provides ongoing, current training for internal medical and administrative staff and medical and administrative staff employed by 58 partnering counties. Much of the training over the past year was been directed toward ensuring that CCS Program clients receive appropriate, timely and coordinated services. Specifically, the Service Authorization Request (SAR) process has been in transition for the past three years, and now is completely electronic. Over the past year, eight trainings were facilitated in Northern and Southern regions of the State to teach State and county staff how to review, adjudicate, and monitor SARs using the CMS Net case management database network. Specific areas of training focus included: Durable Medical Equipment (DME) authorization extensions; extension of treatment authorizations; annual medical reviews; adjudication of pending SARs concentrating on denials and not open cases; and adjudication of services.

Specialized trainings on Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and cochlear implant policies and procedures were also conducted throughout the year, on an "as needed" basis, for select State/County staff. The SCD staff nurses also have weekly conference calls with County nursing staff to discuss new policies and procedures; emerging issues of concern; and to provide related technical assistance. In addition, monthly Dependent County conference calls are held on the third Thursday of each month to discuss changes in policy and the related impact on CCS Program services.

County trainings, facilitated by SCD managers are conducted annually in the Northern Region of the State, and once per year in the Southern region of the State with SCD staff present, to review State Plan procedures and fiscal guidelines for reimbursement for CCS Program and local county staff services.

To increase inter-county consistency and streamline processes, a CCS Medical Eligibility workgroup comprised of state CCS Program and local county staff developed

medical eligibility guidelines that are easier to follow than the Title 22 regulations. These guidelines will be released in 2015.

To enhance the case management function of the CCS Program, several local CCS programs have developed a stratification system, in which clients with more complex conditions have more contact with the CCS case manager.

CALIFORNIA LEAD POISONING PREVENTION BRANCH (CLPPB)

The SCD, CLPPB of the California Department of Public Health and the Head Start Program monitor and follow up on lead testing of children prior to entry into head start programs. The SCD works with MMCD of DHCS, which has instructed Medi-Cal managed care plans to follow the bright futures health assessment periodicity schedule which includes blood lead screening at ages 12 and 24 months, and at age 3 if no documented lead level at 24 months.

CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM

CMS administers the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, called the CHDP Program. CHDP provides preventive services and referral to diagnostic and treatment services for Medi-Cal participants up to age 21. Uninsured children up to age 19 in households at or below 200% of the FPL can pre-enroll in Medi-Cal through the Gateway process.

CHILD HEALTH DISABILITY PREVENTION (CHDP) PROGRAM

Health assessments are a key component of a functioning health system, and the SCD-supported Child Health and Disability Prevention Program (CHDP) Program provides a mechanism so that EPSDT-eligible children receive necessary preventive health assessments. The expansion of Medi-Cal increased the number of children eligible for preventive care. The majority of children eligible for Medi-Cal are mandatorily enrolled in a Medi-Cal Managed Care plan. The CHDP Program collaborates with the DHCS Medi-Cal Managed Care Division (MMCD) as technical advisors with regard to the health assessment schedule recommended by Bright Futures. The CHDP Program

also works with the Immunization Branch of the California Department of Public Health (CDPH) to ensure that administration of federally approved vaccines by Vaccines for Children (VFC) providers is payable.

CHILDREN'S REGIONAL INTEGRATED SERVICES SYSTEM (CRISS)

Children's Regional Integrated Service System (CRISS) brings together CCS programs, family support organizations, and pediatric providers and hospitals in a 27-county region of Northern California in a cohesive regional coalition with the goal of creating a regional seamless care for CCS clients. The organization includes over 50 member organizations, including local county CCS programs, FVCA, local family support organizations, children's hospitals, and pediatric provider organizations (AAP and pediatric sub-specialists). CRISS has been an active participant in the CCS Program redesign effort, the Title V Needs Assessment, and the 1115 Bridge to Reform Waiver stakeholder process. The semi-annual CRISS Family-Centered Care newsletter informs groups and constituencies as well as Family Voices about policies and resources that enhance the lives of CSHCN. CRISS has worked actively on supporting medical homes, including disseminating the following materials: medical home index information, parent health notebook, a sample medical home binder from one county's successful medical home project. CRISS has worked on transition issues through both the CRISS Family-Centered Care and MTP workgroups and has collected and disseminated information that focuses on the whole young adult with an emphasis on primary care and specialty needs, vocational needs, and residential and leisure/recreational needs.

CRITICAL CONGENITAL HEART DISEASE (CCHD) SCREENING

In 2014, the SCD released a policy stating that an in-patient Critical Congenital Heart Disease (CCHD) Screening Provider shall be any general acute care hospital with licensed perinatal services, any intermediate, community and regional-level NICUs. The NICUs are encouraged to develop policies to screen admitted neonates whose clinical course and care would be unlikely to detect CCHD before discharge.

The DHCS is attempting to evaluate hospital CCHD screening of ~500,000 infants/year. Currently, DHCS asks all CCHD screening hospitals to submit pulse oximetry screening data in order for DHCS to evaluate hospital-level screening program completeness and sensitivity. The DHCS asks all State-approved cardiac centers to report data the will enable DHCS to evaluate hospital-level screening program specificity.

DEVELOPMENT/BEHAVIORAL SCREENING

The Child Health and Disability Prevention (CHDP) Program providers follow the American Academy of Pediatrics (AAP) Bright Futures periodicity schedule, which includes two developmental screenings and two autism screenings, in addition to developmental surveillance at each health assessment.

FAMILY HEALTH OUTCOMES PROJECT (FHOP)

At the University of California, San Francisco FHOP provides technical assistance and training, analyzes data for LHJs, provides a current web listing of useful resources, assists in establishing guidelines, and prepares special state reports for

FAMILY VOICES OF CALIFORNIA

The SCD collaborates with Family Voices of California (FVCA), which serves parents of CSHCN with and without CCS Program eligible conditions. The CCS Program participates in FVCA webinars and the FVCA annual Health Summit. In 2014, FVCA collaborated with DHCS and other partners on various committees, taskforces, senate hearings, and stakeholder groups related to the 1115 Bridge to Reform Waiver, the CCS Program redesign, and the Title V Needs Assessment, ensuring that parents and community members are involved in these processes. The FVCA has provided financial support to families to enable their involvement, and has facilitated providing parent and community member input through key informant interviews and focus groups. Some FVCA Council Member Agencies continue to renew their Parent Health Liaison contracts with their local CCS programs, continue to train CCS Program staff on

family perspectives, and provide conflict resolution assistance for CCS Program staff and family members.

CRISS is monitoring implementation of Covered California (California's Affordable Care Act exchange), particularly services available for CSHCN and impact on families of out-of-pocket costs and limits to durable medical equipment and other services embedded in the benchmark plan service package. In addition, rural counties in California recently moved to mandatory enrollment in Medicaid managed care, and CRISS is monitoring the impact on CSHCN. For example, CRISS conducted two surveys six months apart to capture the adequacy of plan networks in those counties for CSHCN (both surveys demonstrated clear problems in network adequacy for CSHCN), and will continue to monitor the situation.

FETAL INFANT MORTALITY REVIEW PROGRAM (FIMR)

Sixteen local LHJs have FIMR Programs that enable them to identify and address contributing factors to fetal and infant mortality.

GENETICALLY HANDICAPPED PERSONS PROGRAM (GHPP)

GHPP provides case management and funding for medically necessary services to people with certain genetic conditions. Most GHPP clients are adults, but 4.6 percent are children under 21 years. The GHPP serves eligible children of higher family incomes who are ineligible for the CCS program.

GENETICALLY HANDICAPPED PERSONS PROGRAM

The Genetically Handicapped Persons Program (GHPP) provides case management and funding for medically necessary services to eligible clients with certain genetic conditions as reflected in Title 17, Section 2932. Most GHPP clients are adults, but in 2012-2013 approximately one percent (.87 percent) were identified as clients under 21

years of age. The GHPP serves eligible clients of higher family incomes who are ineligible for the CCS Program.

The GHPP is a voluntary state program with yearly renewals with annual fees based on adjusted gross income (AGI). The GHPP provides all medical and administrative case management services for approximately 1,750 clients statewide with serious, often life-threatening, genetic conditions (e.g., hemophilia, cystic fibrosis, and hemoglobin problems such as sickle cell anemia, metabolic disorders such as Phenylketonuria [PKU], and nerve disorders). When GHPP clients are Medi-Cal eligible with no share of cost, they may be enrolled in a managed care health plan and services are directed to the managed care plan.

HEALTH CARE PROGRAM FOR CHILDREN IN FOSTER CARE (HCPCFC)

The Health Care Program for Children in Foster Care (HCPCFC) is a public health nursing program currently administered by DHCS CHDP Program through the local CHDP programs with public health nurses (PHNs) located in county welfare agencies and probation departments. The PHNs provide medical case management for children and youth in foster care, expertise needed to help obtain and follow-up with medical, dental, mental and developmental services. Historically, the HCPCFC was funded by State general funds provided to DHCS by the California Department of Social Services (CDSS) through an interagency agreement and matched with enhanced Title XIX funds. However, as a result of the Public Safety Realignment Initiative of 2011, State funding for the HCPCFC has been redirected to county welfare agencies for administration of the HCPCFC. The DHCS is collaborating with the CDSS and county welfare agencies to implement county realignment. For calendar year 2013, there was an active statewide caseload of 59,276 children and youth in out-of-home foster care placement.

Although not a new issue, increasing attention is being given to the use of psychotropic medications in children and youth in foster care. Recent legislative policies in this area have been put forward by the state legislature citing concerns with the use of psychotropic drugs in children. The SCD will continue to monitor concerns in this area.

The SCD administers the HCPCFC in coordination with local program representatives in the development of related policy guidance and provide technical assistance and consultation to the foster care PHNs in this area as necessary.

HIGH RISK INFANT FOLLOW-UP (HRIF)

Infants discharged from CCS-approved NICUs are followed in NICU HRIF clinics. Three multidisciplinary outpatient visits are authorized by CCS up to age three to identify problems, provide and complete referrals, and monitor outcomes.

HIGH-RISK INFANT FOLLOW UP (HRIF) PROGRAM

The CCS Program redesigned the High Risk Infant Follow Up (HRIF) Program and started the Quality of Care Initiative (QCI) with the CPQCC. The QCI developed a web-based HRIF reporting system in 2009 to collect data for the CCS HRIF Program. The goal is to identify QI opportunities for NICUs in the reduction of long-term morbidity, allow programs to compare their activities with all sites throughout the state, allows the state to assess site-specific successes, and supports real-time case management. The system collects data on high-risk infants up to their third birthday and is linked with the CPQCC database to identify maternal and perinatal factors with child outcomes.
The HRIF summary reports provide information on the follow-up status of enrollees, demographic/social risk information; status of medical and special service needs, neurological examination outcomes and developmental outcomes.

INFORMATION & EDUCATION (I&E) PROGRAM

The I&E Program funds local agencies to implement sexual and reproductive health education programs that equip teens at high risk for pregnancy with the knowledge, and skills in partner communication, sexual negotiation and refusal skills to make responsible decisions regarding risky sexual behaviors, and to access reproductive health services.

LOCAL HEALTH JURISDICTION (LHJ) MATERNAL CHILD AND ADOLESCENT HEALTH PROGRAMS (LHDMP)

61 LHJs receive Title V allocations that support local infrastructure, including staff, to conduct culturally sensitive collaborative and outreach activities to improve services for women and children, refer them to needed care, and address state and local priorities for improving the health of the MCAH population.

LOS ANGELES PARTNERSHIP FOR SPECIAL NEEDS CHILDREN/CCS WORKGROUP

The Los Angeles Partnership for Special Needs Children is the oversight entity for the CCS Workgroup in Los Angeles County. The Workgroup is a group of key stakeholders from throughout the county whose goal is to improve the system of care for children with special health care needs. Members include health plans, hospitals, regional centers, providers and parents, including participant members from family resource centers and the Family Centered Care Committee.

Maternal and Infant Health Assessment (MIHA)

MIHA is an annual, statewide-representative survey of women with a recent live birth in California which collects self-reported information about maternal and infant experiences and about maternal attitudes and behaviors before, during and shortly after pregnancy. Due to a collaboration with WIC, local level MIHA data are available to the 20 largest counties, which comprise 90% of all births in California. The MIHA team is currently providing support to a variety of state level partners, such as the Immunization Branch, State WIC program, GDSP, Tobacco Control Section and the Office of Oral Health.

MATERNAL QUALITY INDICATOR (MQI) WORKGROUP

The MQI workgroup conducts trend analysis of maternal morbidity rates, chronic conditions that compromise maternal health, analyzes composite healthcare costs maternal morbidities, and suggests strategies for monitoring quality benchmarks for obstetric hospitals.

MCAH TOLL-FREE HOTLINE

MCAH staff responds to calls and refer callers to local MCAH programs. LHJs also have local toll-free numbers that provide information and referrals to clients. Local MCAH contact information is made available online.

MEDICAL THERAPY PROGRAM (MTP)

MTP provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. MTP conducts multidisciplinary team conferences to support case management and care coordination.

MEDICAL THERAPY PROGRAM

The Medical Therapy Program (MTP) provides physical therapy (PT) and occupational therapy (OT) services to children with CCS MTP eligible conditions in school-based medical therapy units. There is no financial eligibility requirement. The MTP conducts multidisciplinary team conferences to support case management and care coordination. The MTP delivers services in two ways, the traditional model in which PT is given by the physical therapist throughout the year, and the other model, a participatory model in which intensive PT is for three non-consecutive months and the parent is trained to do exercises with the child during the remaining months.

NEWBORN HEARING SCREENING PROGRAM (NHSP)

NHSP helps identify hearing loss in infants and guide families to the appropriate services needed to develop communication skills.

NICU QI/CPQCC

The CCS Program works closely with the California Perinatal Quality Care Collaborative (CPCQQ) in both Neonatal Intensive Care Unit (NICU) performance evaluation and improvement. All 116 CCS Program approved NICUs report annual data describing patient case-mix, resource use and processes of care, and clinical outcomes to CPQCC which then provides an aggregate dataset to the CCS Program along with individual NICU level reports in pdf format. An active partnership function of the two organizations includes activities such as CPQCC investigators and CCS Program investigators co-authoring peer-reviewed publications. Associated with the CCS/CPQCC collaboration, central line associated bloodstream infection (CLABSI) rates have declined and remained at ~1 CLABSI/1000 CL-days. In addition, beginning in 2013, the CCS Program required all NICUs to report antibiotic use patient days. Extremely wide practice variation was found, based on 126 NICUs and 750,000 patient days (done), described in an article published in Pediatrics in May, 2015. NICU antibiotic stewardship efforts will be informed by ongoing review of NICU antibiotic prescribing practice.

NUTRITION AND PHYSICAL ACTIVITY TECHNICAL ASSISTANCE INITIATIVE

This integrates healthy eating and physical activity promotion within MCAH and its local programs. Strategies include providing technical assistance, development of healthcare policies, training and guidelines; supporting partners in coalition building; and using epidemiological information to design, implement, and evaluate nutrition and physical activity initiatives.

ORAL HEALTH

The SCD places a high priority on oral health and has been working to initiate a mandatory age one dental referral (currently mandated beginning at age three in California) for the CHDP Program. For FY 2015-2016, the Governor has added the cost of an age one dental referral into the 2015-16 proposed State Budget. The SCD has been working with the Medi-Cal Dental Services Division (MDSD) and the MMCD to encourage providers to incorporate an age one dental referral, following national guidelines and AAP, American Dental Association and American Academy of Pediatric Dentistry (AAPD) policy. The DHCS has also been working to increase access to care for dental services for low income children. The CHDP Program's Fluoride Varnish (FV)

trainings have begun to be used by local CHDP programs to train local medical providers. There has been good feedback regarding the ease and usefulness of this training.

The SCD has developed dental trainings for providers, and updated dental brochures for families and oral health education provider guides which include links to brochures on many oral health topics and can be used to download brochures for families. The SCD will also develop an electronic provider reporting form (to coincide with the electronic billing form) to include more information on dental findings and services, including a box to be checked when a FV has been applied by the provider and a place to indicate clearly the classification/urgency of dental treatment needs.

The CHDP Program's oral health subcommittee (OHS) collaborates with many representatives from professional organizations: California Dental Association (CDA), California Dental Hygienists Association, California Society of Pediatric Dentistry, Center for Oral Health, Children Now, Oral Health Access Council (OHAC), California Primary Care Association (CPCA), as well as State partners, the SCD Dental Hygienist Consultant, Maternal, Child and Adolescent Health (MCAH), Women, Infants and Children (WIC), and Medi-Cal Dental Services Division (MDSD). The CHDP, OHS and MDSD, plan to promote dental sealants for all Medi-Cal eligible children.

PEDIATRIC PALLIATIVE CARE WAIVER PROGRAM

This program allows for the provision of expanded hospice type services and curative care concurrently. This program is designed to improve the quality of life for children with life limiting or life threatening conditions, and their family members. It is anticipated that cost neutrality will be achieved by reduced hospital stays, medical transports, and emergency room visits in addition to other costs avoided while the child is enrolled in the program.

PEDIATRIC INTENSIVE CARE UNIT (PICU)

California's 26 CCS Program approved pediatric intensive care units (PICU) all participate in the Virtual PICU Performance System (VPS), the largest collaborative for pediatric critical care using clinical data, and all PICUs submitted data to VPS and to the state in 2014. The plan for 2016 is to develop a single California CCS Program PICU Database with VPS for all 26 CCS Program Approved PICUs. This will permit the ability to benchmark against Unites States (US) PICUs and identify areas for QI. The PICU QI efforts align most closely with NOM 17.3, Percent of CSHCN receiving care in a well-functioning system.

PEDIATRIC PALLIATIVE CARE

Palliative care has been recognized in the DHCS strategic plan. Palliative care options for clients under 21 with life threatening conditions are palliative care services through condition-based special care centers, hospice with concurrent care (the right to continue to receive non-hospice services while enrolled in hospice), and the PPCW.

PRECONCEPTION HEALTH AND HEALTHCARE

MCAH is partnering with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health practice, develop policy strategies to support preconception care, and promote preconception health messages to women of reproductive age.

PRENATAL SUBSTANCE USE PREVENTION

MCAH's efforts related to perinatal substance use prevention are conducted through partnerships and collaboration. MCAH representatives participate in the California Fetal Alcohol Spectrum Disorders (FASD) Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. MCAH also participates in the State Interagency Team FASD workgroup, composed of members from the MCAH, (DSS, Department of Mental Health (DMH),

CDE, Department of Developmental Services (DDS) and ADP acting as lead. The goal of the workgroup is to identify interagency and systems issues that

PRECONCEPTION HEALTH COUNCIL OF CA (PHCC)

One of the key ways that MCAH partners with other entities is through PHCC which was established in 2006 by MCAH and MOD, California Chapter. In May 2009 the PHCC launched its official website: www.everywomancalifornia.org, which is supported by Title V funds. The website contains information for both consumers and providers and includes an interactive section for health professionals featuring discussion forums, opportunities for networking and resource-sharing, and an event calendar. MCAH also received a First Time Motherhood grant from HRSA/MCHB to develop a preconception health social marketing campaign reaching women at increased risk for poor pregnancy outcomes.

CMS formed a statewide Transition Workgroup comprised of healthcare professionals, experts in transition care, former CCS clients, and family representatives who worked together on the Branch's Transition Health Care Planning Guidelines for CCS programs. The Guidelines were released in 2009, as a CCS Information Notice.

REGIONAL PERINATAL PROGRAMS OF CALIFORNIA (RPPC)

RPPC promote access to risk-appropriate perinatal care to pregnant women and their infants through regional QI activities. RPPC facilitate local perinatal advisory councils to provide regional planning, coordination, and recommendations to assure appropriate levels of care. In addition, the local perinatal advisory councils perform hospital surveys and perinatal assessments of regional and statewide significance; develop communication networks locally; disseminate educational materials and produce a statewide newsletter; provide resource directories, referral services, and hospital linkages to the Northern and Southern CPeTS; and assist hospitals with QI activities, data collection protocols, and quality assurance policies and procedures.

management issues.

SUDDEN INFANT DEATH SYNDROME (SIDS) PROGRAM

SIDS is funded in all 61 LHJs to provide support to families that experience a SIDS death, conduct prevention activities, and enable staff to attend annual training. The SIDS Program provides statewide technical assistance and support to healthcare and public safety personnel and parents including education about SIDS, grief counseling, and information on prevention to reduce the risk of SIDS.

THE CALIFORNIA ADOLESCENT HEALTH COLLABORATIVE (CAHC)

MCAH has a contract with CAHC to provide adolescent health expertise, address current adolescent health concerns through technical assistance to the local MCAH programs and other partners. CAHC also supports core activities of ASHWG.

TECHNICAL ASSISTANCE

MCAH places high priority on providing stakeholders and partners with quality assistance where necessary to improve MCAH program performance. The following programs were created to address the developmental assistance needs in the state:

Attachment 3 - Programs and Partnerships

Attachment 3, Programs by Population Health Domains

Title-V Programs	**Population Health Domain**					
	Women/ Maternal	**Perinatal/ Infant**	**Child**	**CSHCN**	**Adolescent**	**Cross-cutting**
Adolescent Family Life Program (AFLP)	x	x		x	x	x
Black Infant Health (BIH)	x	x				x
Breastfeeding Program	x	x	x		x	x
California Birth Defects Monitoring Program (CBDMP)	x	x		x	x	x
California Children's Services (CCS) Program		x	x	x	x	
California Diabetes and Pregnancy Program (CDAPP) Resource Center	x					
California Early Childhood Comprehensive Systems		x	x	x		
California Perinatal Transport System (CPeTS)		x				
California Personal Responsibility Education Program (CA PREP)					x	
Child Health and Disability Prevention Program (CHDP)		x	x	x	x	
Comprehensive Perinatal Services Program (CPSP)	x	x			x	
Family-Centered Care	x	x	x	x	x	x
Fetal Infant Mortality Review Program (FIMR) and BIH FIMR		x		x		x
Genetically Handicapped Persons Program (GHPP)						
Hearing Conservation Program						

Health Care Program for Children in Foster Care (HCPCFC)		x	x	x	x	
High Risk Infant Follow-up (HRIF)		x	x	x		
Home Visiting Program	x	x	x	x	x	x
Human Stem Cell Research Program						
Information and Education (I&E)					x	
Local Health Department Maternal Child and Adolescent Health Program (LHDMP)	x	x	x	x	x	x
MCAH Toll Free Hotline	x	x	x	x	x	
Medical Therapy Program (MTP)		x	x	x	x	
Newborn Hearing Screening Program (NHSP)		x				
Oral Health Program	x	x	x	x	x	x
Pediatric Palliative Care Waiver Program		x	x	x	x	
Preconception Health and Health Care	x				x	x
Regional Perinatal Programs of California (RPPC)	x	x				
Sudden Infant Death Syndrome (SIDS) Program		x				x

Major Title-V Collaboratives, Task Forces and Advisory/Work Groups	**Population Health Domain**					
	Women/ Maternal	**Perinatal/ Infant**	**Child**	**CSHCN**	**Adolescent**	**Cross-cutting**
Adolescent Sexual Health Work Group (ASHWG)				x	x	
California Maternal Quality Care Collaborative (CMQCC)	x					x

California Perinatal Quality Care Collaborative (CPQCC)		x				x
Children's Regional Integrated Services Systems (CRISS)						
Maternal Quality Indicator Workgroup	x					
Neonatal Quality Improvement						
Perinatal Substance Use Prevention	x	x			x	x
Preconception Health Council of California (PHCC)	x	x			x	x
Transition Workgroup						

Capacity Building Partners	**Population Health Domain**					
	Women/	**Perinatal/ Infant**	**Child**	**CSHCN**	**Adolescent**	**Cross-cutting**
Branagh Information Group					x	
California Adolescent Health Collaborative					x	
California State University, Sacramento	x	x				
Childhood Injury Prevention Program		x	x	x	x	x
Family Health Outcomes Project at UCSF	x	x	x	x	x	x
Maternal and Infant Health Assessment Survey with UCSF	x	x	x	x	x	x

Attachment 4 - MCAH Local Scope of Work

DRAFT California Department of Public Health (CDPH)
Maternal, Child and Adolescent Health (MCAH) Program
Scope of Work (SOW)

BACKGROUND:

In an effort to increase efficiency, simplify and allow for local flexibility, MCAH has consolidated four Title V programs into one scope of work (SOW). All Local Health Jurisdictions (LHJs) will be accountable for Part I, the Local MCAH SOW. Only those LHJs with the Fetal Infant Mortality Review (FIMR) Program funding are accountable for Objectives 3.5-3.7 and 3.8 within Part I of the Local MCAH SOW.

LHJs that receive funding for the Adolescent Family Life Program (AFLP) and/or the Black Infant Health (BIH) Program must adhere to their respective SOWs.

The Local MCAH SOW has one part:

Part I. Local MCAH, which includes Title V and State required activities, the Comprehensive Perinatal Services Program (CPSP), the Sudden Infant Death Syndrome (SIDS) Program, and FIMR for those LHJs with FIMR funding.

It is the responsibility of the LHJ to meet the goals and objectives of this SOW. The LHJ shall strive to develop systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents, and their families.

The goals in this SOW incorporate local problems identified by LHJs 5-Year Needs Assessments and reflect the Title V priorities of the MCAH Division.

The development of this SOW was guided by several public health frameworks including the Ten Essential Services of Public Health and the three core functions of assessment, policy development and assurance; the Spectrum of Prevention; the Life Course Perspective; the Social-Ecological Model, and the Social Determinants of Health. Please consider integrating these approaches when conceptualizing and organizing local program, policy, and evaluation efforts.

- The Ten Essential Services of Public Health: http://www.cdc.gov/nphpsp/essentialServices.html; http://www.publichealth.lacounty.gov/qi/corefcns.htm
- The Spectrum of Prevention: http://www.preventioninstitute.org/component/taxonomy/term/list/94/127.html
- Life Course Perspective: http://mchb.hrsa.gov/lifecourseresources.htm
- The Social-Ecological Model: http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html
- Social Determinants of Health: http://www.cdc.gov/socialdeterminants/
- Strengthening Families: http://www.cssp.org/reform/strengthening-families

BUDGET:

All Title V programs must comply with the MCAH Fiscal Policies and Procedures Manual which is found on the CDPH/MCAH website at:
http://www.cdph.ca.gov/services/funding/mcah/Pages/FiscalDocuments.aspx

ACTION REQUIRED:

Part I. Local MCAH

All LHJs must perform the activities in the shaded areas in Goals 1-3 and monitor and report on the corresponding evaluation/performance measures. In addition, each LHJ is required to develop objectives to address one problem in each of Goals 1 and 2. LHJs are required to develop 2 objectives for Goal 3, a SIDS objective to promote infant safe sleep and risk reduction community health education and an objective to improve infant health outcomes. If resources allow, LHJs should also develop additional objectives, which they may place under any of the Goals 1-6. All activities in this SOW must take place within the fiscal year. Please see the MCAH Policies and Procedures Manual for further instructions on completing the SOW.
http://www.cdph.ca.gov/services/funding/mcah/Pages/LocalMCAHProgramDocuments.aspx

For LHJs that receive FIMR funding, perform the activities in the shaded area in Goal 3, Objectives 3.5-3.7 and 3.8. In the second shaded column, Intervention Activities to Meet Objectives, insert the number and percent of cases you will review for the fiscal year.

CDPH/MCAH Division expects each LHJ to make progress towards Title V State Performance Measures and Healthy People 2020 goals. These goals involve complex issues and are difficult to achieve, particularly in the short term. As such, in addition to the required activities to address Title V State Priorities, and Title V and State requirements, the MCAH SOW provides LHJs with the opportunity to develop locally determined objectives and activities that can be realistically achieved given the scope and resources of local MCAH programs.

Please review your data with key health department leadership at least annually.

LHJs are required to comply with requirements as stated in the MCAH Program Policies and Procedures Manual, such as attending statewide meetings, conducting a Needs Assessment every five years, submitting Agreement Funding Applications, and completing Annual Reports.

FIMR LHJs are required to comply with requirements as stated in the FIMR Policies and Procedures Manual:
http://www.cdph.ca.gov/services/funding/mcah/Pages/FIMRDocuments.aspx

Goal 1: Increase access and utilization of health and social services (cross-cutting)

- **Increase access to oral health services[1]**
- **Increase screening and referral for mental health and substance use services[1]**
- **Increase utilization of preventive health services[1]**
- **Outreach services will be targeted to identify pregnant women, women of reproductive age, infants, children and adolescents and their families who are eligible for Medi-Cal assistance or other publicly provided health care programs and assist them in applying for these benefits [2].**

The shaded area represents required activities. Nothing is entered in the shaded areas.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
1.1-1.6 **All women, infants and children, including Children with Special Health Care Needs (CSHCN) will have access to:** • Medical, mental, dental care and available social support services • Early and comprehensive perinatal care and maternal medical, dental, and mental health care • An environment that maximizes their health	**Assessment** **1.1** Identify and monitor trends, geographic areas and/or population groups, including disparities, social determinants and barriers to the provision of: 1. Health and human services to the MCAH population 2. Early and comprehensive perinatal care 3. Maternal medical, dental and mental health care 4. Fetal and infant health care Annually, share your data with your key health department leadership.	**Assessment** **1.1** Briefly describe the health status of women of reproductive age, pregnant women, infants, children, adolescents, and CSHCN, including the social determinants of health and access/barriers to health care and health and human services (includes medical, dental, and mental health services). Please highlight statistics on: trends over time, geographic areas and population group disparities. Date data shared with the key health department leadership. Briefly describe their response, if significant.	**Assessment**

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
	1.2 Participate in collaboratives, coalitions, community organizations, etc., to review data and develop policies and products to address social determinants of health and disparities.	**1.2** Report the total number of collaboratives with MCAH staff participation. Submit up to three Collaborative Surveys that document participation, objectives, activities and accomplishments of MCAH – related collaboratives.	**1.2** List policies or products developed to improve infrastructure and address MCAH priorities.
	Policy Development **1.3** Review, revise and enact policies that facilitate access to Medi-Cal, California Children's Services (CCS), Covered CA, Child Health and Disability Prevention Program (CHDP), Women, Infants, and Children (WIC), Family Planning, Access, Care, and Treatment (Family PACT), and other relevant programs.	**Policy Development** **1.3** Describe efforts to develop policy and systems changes that facilitate access to Medi-Cal, Covered CA, CHDP, WIC, CCS, Family PACT, and other relevant programs. List formal and informal agreements, including Memoranda of Understanding with Medi-Cal Managed Care (MCMC) plans or other organizations that address the needs of mothers and infants.	**Policy Development** **1.3** Describe the impact of policy and systems changes that facilitate access to Medi-Cal, Covered CA, CHDP, WIC, CCS, Family PACT, and other relevant programs.
	Assurance **1.4** Participate in and/or deliver trainings in MCAH and public health competencies and workforce development as resources allow.	**Assurance** **1.4** List trainings attended or provided and numbers attending.	**Assurance** **1.4** Describe outcomes of workforce development trainings in MCAH and public health competencies, including but not limited to, knowledge or skills gained, practice changes or partnerships developed.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	1.5 Conduct activities to facilitate referrals to Covered CA, Medi-Cal, CCS, and other low cost/no-cost health insurance programs for health care coverage and local MCAH programs, CHDP, WIC, and other relevant programs[2], such as Text4baby.	**1.5** Describe activities to facilitate referrals to health insurance and programs.	**1.5** Report the number of referrals to Medi-Cal, CCS, CHDP, WIC, FamilyPACT, Text4Baby, or other low/no-cost health insurance or programs.
	1.6 Provide a toll-free or "no-cost to the calling party" telephone information service and other appropriate methods of communication, e.g. local MCAH Program web page to the local community[2] to facilitate linkage of MCAH population to services.	**1.6** Describe the methods of communication, including the, cultural and linguistic challenges and solutions to linking the MCAH population to services.	**1.6** Report the following: 1. Number of calls to the toll-free or "no-cost to the calling party" telephone information service 2. The number of web hits to the appropriate local MCAH Program webpage

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	1.7 Conduct activities to promote the community-based system of services mandated for all CSHCN[2] 1. Families of children and youth with special health care needs partner in decision making at all levels and are satisfied with the services they receive 2. Children and youth with special health care needs receive coordinated ongoing comprehensive care within a medical home 3. Families of CSHCN have adequate private and/or public insurance to pay for the services they need 4. Children are screened early and continuously for special health care needs 5. Community-based services for children and youth with special health care needs are organized so families can use them easily 6. Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (insert link to suggested activities listed in MCAH P&P)	**1.7** Describe activities conducted to promote the community-based system of services for CSHCN	**1.7** Describe outcomes of activities conducted to promote the community-based system of services for CSHCN
Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below.			

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
1.8 **At least one specific short and/or intermediate SMART outcome objective(s) to address access and utilization of health and social services** Consider addressing problems related to: • Access to health care • Access to dental care • Access to mental health care	**1.8** List activities to address health disparities, social determinants and barriers to increased access to health and human services here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance. http://www.publichealth.lacounty.gov/qi/corefcns.htm	**1.8** Develop process measures for applicable intervention activities here.	**1.8** Develop short and/or intermediate outcome related performance measures for the objectives and activities here.

Goal 2: <u>Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age</u>

- **Decrease unintended pregnancies[1]**
- **Decrease the burden of chronic disease[1]**
- **Decrease intimate partner violence[1]**
- **Assure that all pregnant women will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women [2]**

The shaded area represents required activities. Nothing is entered in the shaded areas.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
2.1-2.3 **All women will have access to quality maternal and early perinatal care, including CPSP services for Medi-Cal eligible women.**	**Assurance** **2.1** Develop MCAH staff knowledge of the system of maternal and perinatal care. Conduct activities to increase access and improve quality of perinatal care	**Assurance** **2.1** Report the following: 1. List of trainings received by staff on perinatal care. 2. List activities implemented to increase access to quality maternal and early perinatal care to vulnerable, at-risk women. 3. Barriers and opportunities to improve access to quality maternal and perinatal care	**Assurance** **2.1** Describe outcomes from the following: • Activities implemented to increase access and improve quality of perinatal care • Successfully addressing the barriers to increase and improve quality maternal and perinatal care
	2.2 Provide technical assistance to perinatal providers and collaborate with MCMC Plans regarding perinatal service delivery, including CPSP.	**2.2** List technical assistance activities provided to perinatal and CPSP providers, and collaborative activities performed with local Medi-Cal Managed Care (MCMC) plans	**2.2** Describe outcomes of provider technical assistance and collaborative efforts performed with MCMC plans.
	2.3 At a minimum, conduct annual quality improvement quality assurance (QI/QA) activities, reviewing CPSP prenatal and postpartum services, for enrolled CPSP providers through site visits.	**2.3** List the types of CPSP provider QI/QA activities conducted during site visits. Report the number of actual site visits conducted with enrolled CPSP providers	**2.3** Describe the results of QI/QA activities that were conducted.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below.			
2.4 **At least one specific short and/or intermediate SMART outcome objective(s) to address the health of mothers/women is required here.** Consider addressing local problems related to: • Late initiation of prenatal care and/or inadequate prenatal care • Perinatal mood and anxiety disorders • Partner/family violence	**2.4** List activities to improve access to early, adequate and high quality perinatal care and maternal health here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance. http://www.publichealth.lacounty.gov/qi/corefcns.htm	**2.4** Develop process measures for applicable intervention activities here.	**2.4** Develop short and/or intermediate outcome related performance measures for the objectives and activities here.

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Goal 3: <u>Reduce infant morbidity and mortality[1]</u>

- **Reduce pre-term births[1]**
- **Increase safe sleep practices[1]**
- **Improve access to enhanced periatal (neonatal) services (NICU, CPets, etc.)[1]**

The shaded area represents required activities. Nothing is entered in the shaded areas, except for FIMR LHJs.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
3.1-3.2 **All infants are provided a safe sleep environment.**	**Assurance** **3.1** Establish contact with parents/caregivers of infants with presumed SIDS death to provide grief and bereavement support services[3].	**Assurance** **3.1** (Insert number) of parents/caregivers who experience a presumed SIDS death and the number who are contacted for grief and bereavement support services.	
	3.2 Attend the SIDS Annual Conference/ SIDS training(s) and other conferences/trainings related to infant health[3].	**3.2** Provide staff member name and date of attendance at SIDS Annual Conference/training(s) and other conferences/trainings related to infant health.	**3.2** Describe results of staff trainings related to infant health.
Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below.			
3.3	**3.3**	**3.3**	**3.3**

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
At least one specific objective(s) addressing infant safe sleep practices and SIDS risk reduction community health education is required here.	List activities to promote infant safe sleep and SIDS risk reduction education activities to the community here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance. http://www.publichealth.lacounty.gov/qi/corefcns.htm	Develop process measures for applicable intervention activities here.	Develop short and/or intermediate outcome related performance measures for the objectives and activities here.
3.4 **At least one specific short and/or intermediate SMART outcome objective(s) to address perinatal/infant health is required here.** Objectives that improve infant health may address local problems related to: • Prematurity/Low birth weight • Perinatal substance use	**3.4** List activities to improve infant health here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance. http://www.publichealth.lacounty.gov/qi/corefcns.htm	**3.4** Develop process measures for applicable intervention activities here.	**3.4** Develop short and/or intermediate outcome related performance measures for the objectives and activities here.
For FIMR LHJs Only: **3.5-3.7** **Preventable fetal, neonatal and postneonatal deaths will be reduced.**	**For FIMR LHJs Only:** **Assessment** **3.5** Complete the review of at least __ cases, which is approximately __% of all fetal, neonatal, and postneonatal deaths.	**For FIMR LHJs Only:** **Assessment** **3.5** Submit number of cases reviewed as specified in the Annual Report table.	**For FIMR LHJs Only:** **Assessment** **3.5** Submit periodic local summary report of findings and recommendations (periodicity to be determined by consulting with MCAH).
	Assurance **3.6** Establish, facilitate, and maintain a Case Review Team (CRT) to	**Assurance** **3.6-3.7** Submit FIMR Tracking Log and	

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
	review selected cases, identify contributing factors to fetal, neonatal, and postneonatal deaths, and make recommendations to address these factors.	FIMR Committee Membership forms for CRT and CAT with the Annual Report.	
	3.7 Establish, facilitate, and maintain a Community Action Team (CAT) to recommend and implement community, policy, and/or systems changes that address review findings.		
Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below.			
For FIMR LHJs Only: **3.8** **One objective addressing the development of interventions to prevent fetal, neonatal, and postneonatal deaths is required here.**	**For FIMR LHJs Only:** **3.8** Based on CRT recommendations, identify and implement at least one intervention involving policy, systems, or community norm changes here.	**For FIMR LHJs Only:** **3.8** Develop process measures for applicable intervention activities here.	**For FIMR LHJs Only:** **3.8** Develop short and/or intermediate outcome- related performance measures for the objectives and activities here.

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Goal 4: <u>Increase the proportion of children, adolescents and women of reproductive age who maintain an healthy weight[1]</u>

- **Increase exclusive breastfeeding initiation and duration[1]**
- **Increase consumption of a healthy diet[1]**
- **Increase physical activity[1]**

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
4.1 **Add specific short and/or intermediate SMART outcome objective(s) here.** Consider addressing local problems related to: • Exclusive breastfeeding initiation and duration. • Overweight/obesity – children, adolescents, or women.	**4.1** List activities to meet the Outcome Objective(s) here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development and Assurance. http://www.publichealth.lacounty.gov/qi/corefcns.htm	**4.1** Develop process measures for applicable intervention activities here.	**4.1** Develop short and/or intermediate outcome related performance measures for the objectives and activities here.

Goal 5: Improve the cognitive, physical, and emotional development of all children[1]

- **Reduce unintentional injuries[1]**
- **Reduce child abuse and neglect[1]**

Provide developmental monitoring and screening for all children[1]

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
5.1 **Add specific short and/or intermediate SMART outcome objective(s) here.** Consider addressing local problems related to: • Childhood injury • Child abuse • CSHCN	**5.1** List activities to meet the Outcome Objective(s) here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development, and Assurance. http://www.publichealth.lacounty.gov/qi/corefcns.htm	**5.1** Develop process measures for applicable intervention activities here.	**5.1** Develop short and/or intermediate outcome related performance measures for the objectives and activities here.

Goal 6 Increase conditions in adolescents that lead to the improved adolescent health[1]

- **Decrease teen pregnancies[1]**
- **Reduce teen dating violence/abuse[1]**

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
6.1 **Add specific short and/or intermediate SMART outcome objective(s) here.** Consider addressing local problems related to: • Adolescent sexual health • Adolescent pregnancy • Adolescent injuries • Adolescent violence • Adolescent mental health	**6.1** List activities to meet the Outcome Objective(s) here. Organize intervention activities and performance measures using the three core functions of public health: Assessment, Policy Development, and Assurance. http://www.publichealth.lacounty.gov/qi/corefcns.htm	**6.1** Develop process measures for applicable intervention activities here.	**6.1** Develop short and/or intermediate outcome related performance measures for the objectives and activities here.

Attachment 5 – Collaborations

Ongoing Program Partnerships and Collaborations

Title	Partners Involved	MCAH Role and Contributions
State-level Multi-Party Partnerships		
Adolescent Family Life Program Regional Representatives	Children's Hospital Los Angeles; Sutter Teen Programs (Sacramento); Brighter Beginnings (Alameda & Contra Costa); Clinica Sierra Vista (Kern); Placer County Health & Human Services; San Joaquin County Public Health Dept.; Ventura County Dept. of Public Health; Branagh Information Group; UCSF; CA Dept. of Social Services, CalLEARN	Program administrator Coordinate input on policies and procedures Facilitate communication Coordinate statewide meetings Provide technical support and epidemiology and data support
Adolescent Sexual Health Workgroup	CDPH Office of Family Planning; CDPH Office of Aids; CDPH Sexually Transmitted Diseases Control; CDPH Immunization; CA Dept. of Education; CA Adolescent Health Collaborative; CA Family Health Council; ETR Associates; CA School Boards Association; Youth Technology Health; Public Health Institute; Center for Health Training Cardea Services; Dibble Institute	Steering committee and leadership group member Provide expertise and financial support through the California Adolescent Health Collaborative contract
Audits and Investigations/Medical Review Branch	CDPH/MCAH Division Program staff; local Perinatal Services Coordinators	Participant; liaison for the Medical Review Branch for collaboration, education or questions about appropriateness of referrals Address questions about the integrity of the Comprehensive Perinatal Services Program (CPSP) Provide education regarding audit findings as applicable
Black Infant Health Program Advisory	Former and current local BIH Coordinators; national and local MCH experts	Convener Provide administrative and financial support

Title	Partners Involved	MCAH Role and Contributions
Committee		Develop revised BIH model
CA Adolescent Health Collaborative	National Center for Youth Law; Adolescent Sexual Health Working Group; National Adolescent Health Information Center; Los Angeles County Dept. of Public Health, MCAH; Children's Hospital Los Angeles; Family Violence Prevention Fund	Provide funding to the collaborative to support technical assistance to LHJs
CA Behavioral Risk Factor Surveillance System Workgroup	CDC; CDPH Cancer Surveillance and Research Branch; CDPH Chronic Disease and Injury Control; CDPH Division of Environmental and Occupational Disease Control; CDPH Center for Infectious Diseases; CDPH WIC Program; CDPH Office of Health Equity; CDPH Genetic Disease Screening Program; DHCS Cancer Detection and Treatment Branch; DHCS Office of Family Planning; DHCS Substance Use Disorders Prevention, Treatment, and Recovery Services Division	Participant
CA Breastfeeding Coalition	Local breastfeeding Coalitions, CWA, WIC, California Obesity Program	Collaborate to put on annual breastfeeding summit, monitor Baby Friendly hospitals in California and partner on baby friendly clinic project with California Obesity Program.
CA Statewide Screening Collaborative	CA Dept. of Developmental Services; CA Dept. of Education; California First 5; DHCS; CA Dept. of Managed Health Care Services; CA Dept. of Mental Health; CA Dept. of Social Services; Academy of Family Physicians; AAP; CA Association of Health Plans; First 5 Association and county commissions; Lucile Packard Hospital; UC Davis MIND Institute; UCLA, Children NOW	Participant Collaborative member Provide expertise

Title	Partners Involved	MCAH Role and Contributions
CA WIC Association	WIC directors, service providers, businesses, vendors, and the general public	Provides data and expertise to promote nutrition, physical activity and breastfeeding education and services to strengthen health and well-being of MCAH and WIC target population. Strengthens the reproductive life course as it serves as a framework for MCAH activities. Aims to reach “collective impact” by collaborating, communicating, building and sustaining relationships at the State and local level.
California Maternal Quality Care Collaborative	American College of Obstetrics and Gynecology (ACOG); Amniotic Fluid Embolism (AFE) Foundation; American College of Nurse Midwives; Association of Women's Health; Obstetric and Neonatal Nurses (AWHONN); California Health Care Foundation; California Healthcare Services - Medi-Cal Benefits Branch; CDPH Center for Health Statistics and Informatics - Vital Records Registration Branch; California Pacific Medical Center; CA Perinatal Quality Care Collaborative (CPQCC); Childbirth Research Associates; Community Perinatal Network; Doctors Medical Center Modesto; Hospital Quality Institute (HQI); Kaiser Family Foundation; Los Angeles County MCAH; March of Dimes (MOD); Office of Statewide Health Planning and Development (OSHPD); Permanente Medical Group in Northern and Southern CA; RPPC; Santa Clara Valley Medical Center; Society of Maternal Fetal Medicine; Stanford University; Sutter Health	Participant Provide technical assistance, oversight, expertise, funding and data Conduct process/progress evaluations

Title	Partners Involved	MCAH Role and Contributions
	System; UC Health System at Irvine and San Francisco; and University of Southern CA.	
California Maternal Mental Health Collaborative; 2020 Mom Project	MCAH Directors, Perinatal Services Coordinators, ACOG, providers, mental health providers, Regional Perinatal Programs leaders of CA	Participant
California Perinatal Quality Care Collaborative	California Association of Neonatologists; DHCS California Children's Services; CPeTS; CDPH Office of Vital Records; OSHPD; RPPC; ACOG; Pacific Business Group on Health; Stanford University; Vermont Oxford Network	Participant Executive Committee member Perinatal Quality Improvement Program (PQIP) Committee member PQIP QI Infrastructure Committee Chair Consultant to CPQCC data system Provide contract funding Provide expertise on project development
CDPH/DHCS Nutrition Services Coordinating Group	CDPH WIC; CDPH Genetic Disease Screening Program; DHCS Children's Medical Services	Collaborator Provide expertise in coordinating services and nutrition/physical activity messages Continue to meet regularly for consistent science-based messaging
Center for Social Emotional Foundations for Early Learning Workgroup	State Agencies; early child care and education staff; university early childhood development staff; technical assistance consultants	Participant Provide expertise

Title	Partners Involved	MCAH Role and Contributions
CityMatCH/AMCHP/NHSA Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative	Los Angeles County Dept. of Public Health, MCAH; LA BioMed; March of Dimes CA Chapter; Shields for Families; Los Angeles County Dept. of Public Health, BIH Program; University of Southern CA School of Social Work; Healthy African American Families II	Co-lead (Title V representative) Provide expertise Currently ongoing at local county level
CityMatCH Prevention of Substance-Exposed Pregnancies Collaborative	Sonoma County Department of Health Services; First 5 Sonoma; Sonoma County Mental Health Community Intervention Project; Center for Applied Research Solutions; Santa Rosa Kaiser Permanente; Santa Rosa Family Medicine Program; Santa Rosa Community Health Center; Drug Abuse Alternatives Center	Title V representative Provide expertise Currently ongoing at local county level
Comprehensive Perinatal Services Program Executive Committee	Perinatal Services Coordinators representing four regions of the state: Northern, Central, Southern and Bay Area	Provide technical assistance, training and support Consult on provider enrollment
Comprehensive Perinatal Services Program Curriculum Advisory Committee	Perinatal Services Coordinators, CPSP Providers, DHCS staff, CSUS staff	Provide input on new CPSP program orientation curriculum and materials.
Coordinated Chronic Disease Prevention program	Chronic Disease Programs, including obesity, diabetes, stroke, heart and more.	Participated in development of new “Wellness” plan (2014) for coordinating chronic disease strategic planning.
Department of Developmental Services	State Departments, parents, advocacy group, health professionals and family support groups	Participant Provide expertise and data
Department of Health	CDPH/MCAH Division staff; Perinatal Services	Participant; provides information on the Comprehensive

Title	Partners Involved	MCAH Role and Contributions
Care Services	Coordinators; local MCAH Directors	Perinatal Services Program (CPSP) provider reimbursement and program issues; collaborates to develop solutions to gaps and barriers
Fetal Alcohol Spectrum Disorders Task Force	The Arc of California (lead); CA Department of Public Health/MCAH; Department of Health Care Services; State Indian Health Program; Administrative Office of the Courts; MCAH Action; Arc of Riverside; Arc of Bakersfield; Family Empowerment Center; Violence Intervention Program Community Mental Health Center, Los Angeles; Lassen Fetal Alcohol Services Inc.; Fetal Alcohol Teamwork, Consultation & Training; People First of California, Inc.; Parents of FASD children; CalFAS; Dept. of Alcohol & Drug Services, Santa Clara Valley Health & Hospital System; Children & Family Futures; other community organizations that are corresponding members	Participant Provide expertise and data
California Home Visiting Program	MIECHV: American Academy of Pediatrics, California (AAPCA) , American Indian Infant Health Initiative (AIIHI) DHCS, CDE, California WIC, CA Department of Alcohol and Drug Programs, CA Department of Developmental Services, Early Start Program, CDSS, CA Domestic Violence Leadership Group, Center for the Study of Social Policy, CA Department of Housing & Community Development, Family Resource Center Network of California, MCAH Action Representatives, Safe and Active Communities – CDPH/State and Local Injuries Control, ECCS: California's Race to the Top-Early Learning Challenge (RTT-ELC) program, First 5 California, First 5 Association, and Office for Child Abuse and Prevention, , First 5 Association, California Project LAUNCH, Help Me	Lead on the California Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) Early Childhood Comprehensive Systems (ECCS) Grant implementing agency

Title	Partners Involved	MCAH Role and Contributions
	Grow, and Strengthening Families	
Human Stem Cell Research Advisory Committee	UC San Francisco; UCLA; Stanford University; UC Hastings College of Law; American Jewish University; Santa Clara University; Children's Hospital and Research Center Oakland; Salk Institute for Biological Studies; Signum Biosciences; California Institute for Regenerative Medicine	Committee founder Provide advice on research guidelines and revisions Provide administrative support and funding Organize and facilitate meetings Review and finalize committee recommendations Manage internal processes of publicly releasing documents Provide research/program updates
Indian Health Program	CDPH/MCAH Program staff, MCAH Directors	Participant; collaborate on the American Indian population health needs; share information with CDPH and MCAH Directors
Interagency Planning Autism Workgroup	UC Davis MIND Institute; State Agencies early care and education; regional centers; local education areas; UCED; diagnostic centers	Participant Provide expertise
March of Dimes Program Services Committee	Providers, hospital systems, community-based organizations, RPPC representatives, and state and local MCAH programs	Member
Medi-Cal Managed Care	CDPH/MCAH staff; input from the Perinatal Services Coordinators and local MCAH Directors	Participant; provides information on the Comprehensive Perinatal Services Program (CPSP) provider reimbursement and program issues; collaborates to develop solutions to gaps and barriers; provide technical assistance to local health jurisdictions to develop Memorandums of Understanding

Title	Partners Involved	MCAH Role and Contributions
Maternal Quality Indicator (MQI) Workgroup	UCLA; Cedars Sinai Medical Center; University of Southern California, AMF Consulting Inc., Kaiser Permanente West Los Angeles Medical Center; Saddleback Medical Center; White Memorial OB/GYN Medical Group; Loma Linda University; Health Information Solutions; OSHPD; March of Dimes; CMQCC	Participant Provide funding, oversight, and conduct progress reviews Provide technical assistance in developing measures, risk-adjusted maternal health indicators, data evaluation, and surveys, conducts process and progress evaluations, estimates costs of maternal morbidity Assist in forming collaborations
MCAH Action (Association of local health jurisdiction MCAH Directors)	MCAH Directors; Perinatal Services Coordinators; BIH Coordinators; AFLP Directors; MCAH Action Steering Committee	Provide program and policy expertise and technical support to MCAH Action Steering Committee Provide input to policy and program decisions; disseminate information
Obesity Bi-annual Conference Planning Committee	CDPH Programs	Participant Provide expertise
Oral Health Workgroup	Medi-Cal; DHCS Children's Medical Service; CDPH Office of Oral Health; CA Dental Association and Foundation; CA Dept. of Education; CA Rural Indian Health Bureau; First 5; UCSF CA Dental Hygienists' Association	Participant Collaborate on oral health issues Provide evaluation research and data support
Oral Health Access Council	CA Primary Care Association; CA Dental Association; CA Dental Hygienists' Association; DHCS; CDPH; Access Dental Plans, Delta Dental of CA, Western Dental, Children Now, UOP, Center for Oral Health, Children's Partnership, Liberty Dental Plans, UCSF, Maternal & Child Access, CA School Health Centers, CA Society of Pediatric Dentists, OSHPD	Participant Collaborate on oral health issues

Title	Partners Involved	MCAH Role and Contributions
Preconception Health Council of CA	California Department of Public Health • Maternal, Child and Adolescent Health Division • California Women, Infants and Children Nutrition Program • Genetic Disease Screening Program • Department of Alcohol and Drug Programs California Department of Health Care Services • Medi-Cal Policy Section • Office of Family Planning California Department of Developmental Services Maternal, Child and Adolescent Health Action • Alameda County Public Health Department • Los Angeles County Department of Public Health • Solano County Department of Health Services University of California, San Francisco, Program on Reproductive Health and the Environment Health Services Association of California Community Colleges March of Dimes Futures Without Violence Los Angeles Best Babies Network California Family Health Council Los Angeles Trust for Children's Health Kaiser Permanente Sutter Medical Center Miller Children's Hospital Good Samaritan Hospital Veterans Affairs Oral Health Access Council Pacific Business Group on Health Association of Women's Health Obstetric and Neonatal Nurses American Congress of Obstetricians and Gynecologists American Academy of Pediatrics	Executive Committee member; Liaison to Council Provide leadership, training, web and personnel resources, data, program updates, and governmental outreach and promotional collaboration

Title	Partners Involved	MCAH Role and Contributions
	American Academy of Family Physicians	
Regional Perinatal Programs of California (RPPC)	CA birthing hospitals and birthing centers; California Maternal Data Center (CMDC); California Maternal and Perinatal Quality Care Collaborative (CMQCC and CPQCC); California Perinatal Transport Systems (CPeTS); CDPH Center for Health Statistics and Informatics - Vital Records Registration Branch, Birth Marriage Registration Section; County MCAH and public health leaders; DHCS Children's Medical Services (CMS) Systems of Care Division (SCD); managed health care plans; Office of Statewide Health Planning and Development (OSHPD); perinatal professional groups and agencies; public and private health care providers and Women Infants and Children (WIC)	Develop and monitor RPPC activities Provide funding, expertise, consultation and technical assistance Assist in data evaluation
(RPPC)/Vital Records Birth Clerk Trainings	Automated Vital Statistics System (AVSS); county birth registrars; MCAH; CDPH Vital Records Registration Branch, Birth Marriage Registration Section ; administration and staff;; county registrars; birthing hospitals and birthing centers administration and staff; CDPH MCAH; county MCAH leaders; Paternity Opportunity Program; RPPC Leaders;	Participate in content development for trainings on improving data quality on birth certificates Provide logistical support for training sessions
MCAH Leadership Training Collaborative	UCLA School of Public Health, UCSF Learning and Education in Adolescent Health, Stanford University Developmental-Behavioral Pediatrics, USC/ CHLA Developmental-Behavioral Pediatrics, UC Davis Developmental-Behavioral Pediatrics, UC Berkeley School of Public Health , USC/CHLA Interdisciplinary Leadership Education in Neurodevelopmental and Related Disabilities Training Program CalLearn	Provide expertise and participate in collaborative development; steering committee member

Title	Partners Involved	MCAH Role and Contributions
Single-entity Partnerships		
CDPH/MCAH - WIC	MCAH Division and WIC staff	Convener and participant; provide expertise in nutrition and breastfeeding guidelines; Collaborate to support consistent messages, improve service delivery, and strengthen partnerships at the State and local level.
CDPH Genetic Disease Screening Program		Provide preconception messages on folic acid; Share newborn screening data on infant feeding choices after delivery; Gain contact information for MIHA survey; Provide information from MIHA for GDSP program evaluation and planning Collaborate on CDPH Breastfeeding and Healthy Living web page Collaborate on bill analysis as relates to both programs.
UCSF Center on Social Disparities in Health		Coordinate multiple research and evaluation projects related to MIHA survey and the Black Infant Health Program
Family Health Outcomes Project		Support state and local health jurisdictions by providing technical assistance, surveillance data and training in support of needs assessment and ongoing public health activities.
UC Davis School of Medicine MPH program		Preceptor for MPH students and guest lecturer

Title	Partners Involved	MCAH Role and Contributions
National / Federal Partnerships		
PRAMS/MIHA Survey Development	CDC Division of Reproductive Health, Applied Sciences Branch	Collaborate with CDC and coordinate the inclusion of similar questions on PRAMS and MIHA when possible; pilot test the MIHA survey and use the results to provide expertise and improve survey questions in PRAMS and MIHA
Association of State Public Health Nutritionists	MCAH Nutritionists, CDPH nutritionists, other states' public health nutritionists	MCAH participates in this Association. The current national President is from MCAH. MCAH has 5 members of this association and their sub group-the MCH Nutrition Council
Development of HP 2020 Indicators	CDC Division of Reproductive Health, Applied Sciences Branch	Collaborate with CDC to develop 7 proposed Healthy People 2020 measures, which will combine data from PRAMS and MIHA and will allow tracking of key MCAH indicators, including infant sleep position, substance use and weight gain during pregnancy, postpartum smoking, and preconception/interconception care, many of which are otherwise unavailable from other data sources, and will represent approximately 85% of all births in the US
March of Dimes	March of Dimes; CMQCC; CPQCC; MQI; Joint Commission; OSHPD; Florida Dept. of Health; Texas Dept. of State Health Services; New York State Dept. of Health; Illinois Dept. of Public Health (Big 5 States)	Provide technical assistance and participate in meetings Provide oversight to joint CMQCC, CDPH and March of Dimes quality improvement activities; Provide oversight to prematurity prevention campaigns/collaborations; Provide data, program and policy expertise; Facilitate multi-stakeholder collaborations

Title	Partners Involved	MCAH Role and Contributions
Association of State and Territorial Public Health Nutrition Directors MCH Nutrition Council	National MCH Directors; MCH Nutrition Professors; Title V nutrition and physical activity leads	Member and chairperson Provide leadership to achieve optimal well-being of MCAH population; Provide expertise on IOM recommendations
US Breastfeeding Committee	ASPHN; ADA; AAP; ACOG; MCHB; CDC, USDA	MCAH staff is a liaison of the ASPHN to the USBC. Promote workplace lactation support, emergency infant feeding, reduction of formula marketing, public relations and health equity
Association of State Public Health Nutritionists (ASPHN)	MCHB, State Public Health Nutritionists, CDC	MCAH staff is the state Designee and Past President of the ASPHN. ASPHN develops leaders in public health nutrition who strengthen policy, programs and environments making it possible for everyone to make healthy food choices and achieve healthy, active lifestyles.
National Preconception Health and Health Care Steering Committee	CDC; preconception health leaders from across the country	Participant Provide expertise
National Consumer Workgroup on Preconception Health	CDC; preconception health leaders from across the country	Participant Provide expertise
AMCHP	AMCHP staff; regional directors; family representatives	Participant Provide leadership and expertise in administering Title V programs and services; participate in conference calls to share data, issues, best practices, policies
National Birth Defects Prevention Network (NBDPN)	California Birth Defects Monitoring Program (CBDMP), CDC, birth defects surveillance programs throughout the United States	MCAH provides data for the NBDPN Annual Data Report MCAH staff are members of the NBDPN Data Committee MCAH staff chair the Abstractor/Technical Tool Workgroup

Title	Partners Involved	MCAH Role and Contributions
		MCAH staff received the NBDPN Distinguished Service Award for leadership with the Abstractors Workgroup and spearheading the NBDPN's efforts in preparing for ICD-10-CM.
MCAH-California Tobacco Control Program (CTCP)	MCAH staff, BIH Coordinators, CTCP staff	Increase community involvement and awareness by sharing program services, resources and health educational campaigns.

Attachment 6 - MCAH Local Staff Qualifications

Attachment 6, Local Program Staff Job Descriptions

MCAH Staff Requirements for MCAH Programs

Adolescent Family Life Program
AFLP Program Directors

Each agency will maintain an organizational structure that assures the operation and oversight of AFLP meets the SOW and Policies and Procedures for each program.

Introduction

Key positions in the AFLP are the AFLP Director, Coordinator and Case Manager Supervisor. Each position must meet specific education requirements. Academic knowledge and skills provide AFLP Directors, Coordinators and supervisory staff with the necessary skills and abilities to lead case managers as they support AFLP clientele in making positive life decisions. The complexity of AFLP clientele requires that providers possess an academic background to promote the personal, social, and academic development of a multi-cultural and linguistically diverse AFLP population.

The AFLP Director and/or AFLP Coordinator is responsible for:

1) Ensuring management capacity to support the AFLP program infrastructure and activities required in the AFLP and Fiscal P&P Manuals and SOW
2) Oversight for implementation of quality assurance and quality improvement processes to coordinate, manage, and monitor the efforts of staff to ensure high quality work and adherence to program requirements
3) Oversight and assessment of case management activities including intake, comprehensive baseline assessments, individual service plans, appropriate referrals, and other program activities
4) Incorporating the principles in the Core Competencies Human Resources Toolkit when hiring and recruiting program staff. The Core Competencies for Providers of Adolescent Sexual and Reproductive Health Programs/Services and associated tools can be accessed on line at http://www.californiateenhealth.org/wp-content/uploads/2011/07/CC-HR-Toolkit.pdf
5) Evaluating staff performance and assuring ongoing staff development utilizing the core competencies to enable staff to carry out their duties sufficiently
6) Attending required trainings and meetings
7) Representing the Program’s interest at local and state collaborative(s)
8) Assuring that the Program’s internal policies and procedures are followed and maintained at all times.

Black Infant Health Program Staff Qualifications

BIH Coordinators

Standards (education, experience, etc.):

1) Master's Degree from an accredited college or university program in Social Work, Public Health, Nursing, Education, Health Education, or other health related or social science field; or Bachelor's Degree from an accredited college or university program in Social Work, Public Health, Nursing, Education, Health Education, or other health related or social science field plus three years management experience in a health/public health or social service setting.
2) Fully embraces and supports the *BIH Governing Concepts* of culturally relevant, client-centered, strength-based, and cognitive skill-building approaches.
3) Possess strong leadership skills;
4) Demonstrates the organizational and interpersonal skills needed to communicate at different levels and work in complex situations;
5) Demonstrates knowledge of the following:
    a) Women's health, including prenatal and postpartum health
    b) Life course perspective
    c) Infant behavior and development
    d) Health education, including breastfeeding, nutrition and physical activity
    e) Local community and social services
6) Demonstrates cultural competence;
    a) Implement and maintain a culturally relevant BIH Program that recruits, trains, and retains staff who reflect and respond to the values of the African American community served by BIH.
    b) Knowledgeable about community organizations and community resources serving the African American community in their local jurisdiction;
    c) Demonstrates an understanding of the complex, interrelated issues and concerns contributing to health disparities affecting African Americans;
7) Reflect basic skills of the HRSA MCH Bureau *Leadership Competencies* (http://leadership.mchtraining.net/)

Duties:

1) Responsible for the management and coordination of local BIH program activities and staff;
2) Maintains confidentiality and adheres to Health Insurance Portability and Accountability Act (HIPAA) regulations;
3) Provides supervision and professional development for staff.

Family Health Advocate (FHA)

Standards (education, experience, etc.):

1) Possess a Bachelor's Degree from an accredited college or university program in Social Work, Public Health, Nursing, Education, Health Education, or other health related or social science field.
2) Has one year of community work experience providing direct services to target population, performing tasks related to the program;
3) Possess socio-cultural experiences comparable to the population served;
4) Possess knowledge, understanding and respect of the values and beliefs of African American women and the African American community;
5) Fully embraces and supports the *BIH Governing Concepts* of cultural competence, client-centered, strength-based, and utilization of cognitive skill building approaches (details above in the Governing Concepts section);
6) Possess knowledge of the following:
    a) Women's health, including prenatal and postpartum health;
    b) Life course perspective
    c) Infant behavior and development
    d) Health education, including breastfeeding, nutrition and physical activity
    e) Local community and social services
7) Demonstrates:
    a) Cultural competence and ability to operate in a culturally affirming manner;
    b) Sound communication and interpersonal skills;
    c) Basic counseling skills (i.e. reflecting, active listening, paraphrasing);
    d) Critical thinking and problem solving skills;
    e) Basic administrative skills (i.e. appointment scheduling, documentation, report writing, computer skills)
8) Is able to work collaboratively within a multidisciplinary team;
9) Possess a valid California driver's license.

Duties:

1) Responsible for providing social service case management to clients;
2) Maintain awareness and familiarity with local community and social services for client referrals;
3) Responsible for the development of a Life Plan that is on-going throughout the intervention;
4) Complete subsequent client assessment, Birth Outcome form, etc.;
5) Develop a Birth Plan;

6) Enter data related to case management, Life Planning, etc. in a timely and accurate manner;
7) Coordinate and consult with group facilitators to ensure that case management goals are linked to group sessions goals;
8) Attend CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;
9) Maintains confidentiality and adheres to HIPAA regulations
10) Develop a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8;*
11) Works under the supervision of the BIH Coordinator.

Group Facilitator

Standards (education, experience, etc.):

1) Possess a Bachelor's Degree from an accredited college or university program in Social Work, Public Health, Nursing, Education, Health Education, or other health related or social science field.
2) Has one year of community work experience providing direct services to target population, performing tasks related to the program;
3) Possess knowledge, understanding and respect of the values and beliefs of African American women and the African American community;
4) Fully embraces and supports the *BIH Governing Concepts* of cultural competence, client-centered, strength-based, and utilization of cognitive skill building approaches (details above in the Governing Concepts section);
5) Possess knowledge of the following:
    a) Women's health, including prenatal and postpartum health;
    b) Life course perspective
    c) Infant behavior and development
    d) Health education, including breastfeeding, nutrition and physical activity
    e) Local community and social services
6) Demonstrates:
    a) Strong group facilitation skills;
    b) Cultural competence and ability to operate in a culturally affirming manner;
    c) Sound communication and interpersonal skills;
    d) Basic counseling skills (i.e. reflecting, active listening, paraphrasing);
    e) Basic administrative skills (i.e. appointment scheduling, documentation, report writing, computer skills);
7) Is able to work with a co-facilitator and collaboratively within a multidisciplinary team.

Duties:

1) Responsible for the management, facilitation and organization of the group intervention with another group facilitator (each group session must have two trained facilitators conducting the session);
2) Enter data related to group sessions in a timely and accurate manner;
3) Coordinates and consults with FHAs to ensure that group sessions goals are linked to case management goals;
4) Attends CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;
5) Maintains confidentiality and adheres to HIPAA regulations;
6) Develop a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8;*
7) Works under the supervision of the BIH Coordinator.

Outreach Liaison

Standards (education, experience, etc.):

1) Possess a Bachelor's Degree from an accredited college or university program in Social Work, Public Health, Nursing, Education, Health Education, or other health related or social science field.
2) Possesses knowledge, understanding and respect of the values and beliefs of African American women and the African American community;
3) Fully embraces and supports the *BIH Governing Concepts* of cultural competence, client-centered, strength-based, and utilization of cognitive skill building approaches
4) Demonstrates:
    a) Cultural competence and ability to operate in a culturally affirming manner;
    b) Sound communication and interpersonal skills;
5) Basic administrative skills (i.e. appointment scheduling, documentation, report writing, computer skills, organizational skills)
6) Excellent communication skills
7) Experience working on a multidisciplinary team
8) 1-3 years' experience in community based organizations
9) Foundational knowledge of the community resources and programs of the Local Health Jurisdiction in which they will be working

Duties:

1) Develop and maintain a site-specific Recruitment Plan for BIH;
2) Establish a database of community agencies and create relationships to obtain BIH referrals

3) Maintain relationships with medical and community service providers who are the primary referral sources into BIH;
    a) Develop Partnership Agreements to assist in providing referrals to the BIH Program
    b) Conduct outreach activities on a regular basis; for example, conducting in-service trainings and BIH orientations for Partnership Organizations;
    c) Attend inter-agency and community meetings
4) Attends CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;
5) Maintains confidentiality and adheres to HIPAA regulations;
6) Develop a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8;*
7) Works under the supervision of the BIH Coordinator.

Data Entry

Standards (education, experience, etc.):

1) Possess a high School diploma or completion of General Education Development (GED)
2) Possess sound data entry skills;
3) Excellent communication skills (verbal and written);
4) Experience working on a multidisciplinary team.

Duties:

1) Enters BIH case management and program data in a timely and accurate manner into the State data system and download program information from the MCAH- BIH-MIS.
2) Oversees the maintenance of clean and complete participant and site-specific data.
3) Complies with or assists in the compilation of statistical information for special reports.
4) Assists in developing and maintaining filing system for the BIH Program.
5) Utilizes computerized data entry equipment and various word processing, spreadsheet and file maintenance programs to enter, store and/or retrieve information as requested or necessary, and summarizes data in preparation of standardized reports.
6) Provides support to Skilled Professional Medical Personnel working with the BIH Program.
7) Attends CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;

8) Maintains confidentiality and adheres to HIPAA regulations;
9) Develop a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8;*
10) Works under the supervision of the BIH Coordinator.

Mental Health Professional

Standards (education, experience, etc.):

1) Education and training
    a) Master's Degree in social work, psychology or counseling from an accredited college or university;
    b) One year of professional experience working as a mental health professional that included maternal, infant and child health.
2) Understands and respects the values and beliefs of African American women and the African American community;
3) Fully embrace and support the *BIH Governing Concepts* of cultural competence, client-centered, strength-based, and utilization of cognitive skill building approaches (details above in the Governing Concepts section);
4) Knowledge of the following:
    a) Women's health, including prenatal and postpartum mental health and psychosocial issues;
    b) Life course perspective;
    c) Impact of psychosocial, cultural and economic factors on the health of women, their infants and their families;
    d) Psychosocial risk status of client, including stress, health, social relationship, environment (housing), financial status, transportation that may impact her pregnancy or participation in the BIH Program;
    e) Prevailing trends and policies in mental health, public health and public welfare;
    f) Knowledge, understanding and location of community services, including, but not limited to: social services, mental health, substance abuse treatment programs, domestic violence programs, legal systems, housing and other resources for referral;
5) Demonstrates:
    a) Cultural competence and ability to operate in a culturally-affirming manner;
    b) Clinical experience in individual and group psychotherapies dealing with individuals in multiple systems of health and social systems;

b) The ability to identify behavioral tendencies that impact functioning, and recommend cognitive behavioral approaches that integrate client strengths into improving functioning;
c) The ability to conduct crisis intervention as needed or as resources allow;
d) Sound communication and interpersonal skills;
e) Critical thinking and problem solving skills;
f) Basic administrative skills (i.e. appointment scheduling, documentation, report writing, computer skills).

6) Ability to work collaboratively within a multidisciplinary team.

Duties:

1) Conduct the client enrollment which includes an orientation, informed consent, and the initial assessment, and refers participant to FHAs for on-going case management;
2) Responsible for conducting case conferencing with local BIH staff and any other members of a multidisciplinary team
3) Develop and maintain relationships with local mental health professionals for client referrals;
4) Participate in the group sessions that focus on mental health issues by being available to answer participant questions and provide support to the group facilitators.
5) Provide medical health education to clients when requested by the FHAs.
6) Conduct trainings on the basics of maternal and infant mental health;
7) Attends CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;
8) Maintains confidentiality and adheres to HIPAA regulations;
9) Develop a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8;*
10) Works under the supervision of the BIH Coordinator.

(Optional Staff Position)

Public Health Nurse (PHN)

Standards (education, experience, etc.):

1) Education and training:
   a) Bachelor of Science degree in nursing from an accredited college or university;
   b) Public Health Nurse Certificate and license issued by the State of California;
   c) Valid California driver's license; and
   d) Performs all duties within the legal scope of practice as described in the Nurse Practice Act and other laws, rules, regulations.

   e) One year of responsible, professional experience working as a PHN that included maternal, infant and child health.
2) Knowledge, understanding and respect of the values and beliefs of African American women and the African American community;
3) Fully embrace and support the *BIH Governing Concepts* of cultural competence, client-centered, strength-based, and utilization of cognitive skill building approaches (details above in the Governing Concepts section);
4) Knowledge of the following:
   a) Women's health, including prenatal and postpartum health;
   b) Life course perspective;
   c) Infant behavior and development;
   d) Health education, including breastfeeding, nutrition and physical activity;
   e) Local community and social services;
   f) Clinical and technical assistance of maternal, infant and child health nursing;
   g) Epidemiological methods of health promotion, disease prevention and control of communicable diseases;
5) Demonstrates:
   a) Cultural competence and ability to interact with clients and staff in a culturally affirming manner;
   b) Sound communication and interpersonal skills;
   c) Critical thinking and problem solving skills;
   d) Basic administrative skills (i.e. appointment scheduling, documentation, report writing, computer skills);
6) Ability to work collaboratively within a multidisciplinary team.

<u>Duties:</u>

1) Participate in all formal Case Consultations.
2) Provide informal case consultation with FHAs on clients who require more immediate medical attention.
3) Conduct Edinburgh Postpartum Depression Screen and home safety check list;
4) Participate in the group sessions that focus on medical issues by being available to answer participant questions and provide support to the group facilitators.
5) Provide medical health education to clients when requested by the FHAs.
6) Conduct staff trainings on relevant medical topics.
7) Provide limited nurse case management as needed.
8) Attends CDPH/MCAH-sponsored BIH Basic Training, as well as subsequent BIH Advanced Trainings;
9) Maintains confidentiality and adheres to HIPAA regulations;
10) Develop a Professional Development Plan in conjunction with the BIH Coordinator and reflects basic skills of the HRSA MCH Bureau *Leadership Competencies 1-8;*
11) Works under the supervision of the BIH Coordinator.

Attachment 7 -

A) Public Input to the Draft Abridged Application/ Report and Response

B) Response to the Title V 2013 Report/ 2015 Application (Previous Year's) Review Recommendations

C) Public Input and Commentaries related to MCAH-related News Articles

A. Public Input to the Draft Abridged Application/ Report and Response

Comment 01 (recommended collaboration with the California Department of Education programs):

As a state partner serving infants, children, and adolescents, the California Department of Education Nutrition Services Division (NSD) commends MCH in your development of the 2016-2020 Title V priorities and encourages MCH to expand your current state collaboration and coordination to include the CDE NSD and members from the State Superintendent of Public Instruction's Team California for Healthy Kids (TCHK) Initiative. The following priorities are areas that the CDE NSD can partner with MCH:

Priority 4 (page 40): Providing a whole-child approach to serve children with special health care needs. Objective 1: increase systems that support children with special health care needs. We encourage MCH to expand the scope to include the school, preschools, and child-care settings and school-based health clinics.

Priority 8 (page 42): Increase the proportion of children, adolescents, and women of reproductive age who maintain a healthy weight. Objective 1: increase consumption of a healthy diet and Objective 2: increase physical activity. We encourage MCH to include the CDE as a state partner and expand the scope to include schools.

For the Five-Year State Action Plan, the CDE recommends the following partnerships:

Perinatal/Infant Health Domain, Priority 2 (page 46): include Child and Adult Care Food Program (CACFP) providers as a target group under the key strategies.

Child Health Domain, Priority 3 (page 48): include CACFP providers as a target group.

Adolescent Health Domain, Priority 6 (page 58): include the CDE as a state partner.

Cross-cutting/Life Course Domain, Priority 7 (page 60): include the CDE as a state partner to increase cross-system collaboration and coordination.

Response to Comment 01:

Thank you for your comment and interest in collaborating with Systems of Care (DHCS) and the Maternal, Child and Adolescent Health Division (CDPH)! The list of activities and partnerships in this document was not meant to be exhaustive and continues to be developed. As an example of related work, the MCAH Nutrition and Physical Activity Coordinator has been working with Emergency Medical Services Authority and CDE to implement AB 290, a bill that was signed into law and requires the state to develop a one hour nutrition class for childcare providers to be eligible for a license. In addition to helping develop the requirements for the curriculum, she is also on workgroup developing an emergency feeding plan for childcare centers. Previously, she was on the nutrition panel that wrote Caring for Our Children: National Health and Safety

Performance Standards - Guidelines for Early Care and Education Programs (3rd ed.) so has been able to share expert assistance.

The Five-Year Action Plans are living documents and will be revised, refined and updated as we move forward. We will communicate your desire to collaborate with our management and program leads and look forward to working together to improve the health of California's families.

Comment 02 (Breastfeeding promotion activities)

I am very excited to see the following goal as a major emphasis for our next 5 years: Breastfeeding, Nutrition and Physical Activity: The overall emphasis for the breastfeeding, nutrition, and physical activity plans for the next year is to target racial and ethnic disparities. Rather than targeting all women, the goal is to tailor limited resources to address persistent health inequity.

CDPH could greatly accelerate efforts by helping to create linkages between different efforts in the State. For example:

- *Support the implementation of the "Nine Steps to Breastfeeding-Friendly for Community Health Care Centers."*
    - *PSC's and MCAH staff can support local Federally Qualified Health Centers in implementing the 9 steps*

- *Leverage the learnings and network of the recent grant awardees working on this topic by Create an on-line learning community and information sharing forum on a platform such as Hoopla; including agencies who received the following grants:*
    - *Collaborative Improvement and Innovation Network (COIN) Grant to improve lactation support*
    - *NACCHO Reducing Breastfeeding Disparities Peer and Professional Lactation Support Grant*
    - *Center for Disease Control Community Transformation Grants to implement Baby-Friendly*

- *Advocate that Medi-Cal, Medi-Cal HMO's, and other insurance fully implement the ACA provisions to support payment for breastfeeding-related medical services. Update MCAH teams across the state about improvements in access to service. FQHC's would offer more breastfeeding support services if they could bill beyond CPSP (including clients not participating in CPSP and clients needing services after the immediate post-partum period) for such services.*

- *Identify further funds to help support MCAH staff in implementing these efforts. This is a topic on the National Agenda – both federal and private funds may be available to support our efforts.*

Response to Comment 02:

Thank you for the comment. CDPH is very interested in creating linkages between different efforts in the State. For example, MCAH has been working with

- The State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health CDC-RFA-DP13-1305," referred to as "Prevention First" in California to support the implementation of the "Nine Steps to Breastfeeding-Friendly for Community Health Care Centers," and improve CDPH and DHCS lactation accommodation.
- The Local Health Jurisdiction Coordinators by providing informative email distributions and inviting them to come together at the annual California Breastfeeding Summits. Investigating new technologies such as Hoopla is always a good idea.
- the LHJs in applying for grants on lactation by sharing information on such grants, sending information as emails to MCAH contacts, and being part of related learning collaboratives. We will continue to review and consider participating in future opportunities.
- WIC, Systems of Care, California WIC Association, the Attorney General's Office, and the California Breastfeeding Coalition to improve lactation accommodation for the low wage worker.

MCAH has been a leader advocating for lactation services as part of the ACA. MCAH is available to DHCS to discuss that Medi-Cal, Medi-Cal HMO's, and other insurance fully implement the ACA provisions to support payment for breastfeeding-related medical services.

As recommended, MCAH management will consider additional initiatives and allocation of funds to support lactation promotion

Comment 03: (Regional Hospital Activities)

Excellent report. Very encouraging. But we still have a lot of work to do. At Community Regional Medical Center, we deliver approximately 500 infants each month. We are a very diverse population with a high rate of poverty and high risk mothers and babies. We are currently on the path to becoming a Baby Friendly Hospital. Thank you for this very important report.

Response to Comment 03:

MCAH is glad that the Community Regional Medical Center is on the path to become a Baby-Friendly Hospital. As you are aware, MCAH is supportive of the law that requires all general acute care hospitals and special hospitals that have a perinatal unit shall, by January 1, 2025, adopt the "Ten Steps to Successful Breastfeeding," as adopted by Baby-Friendly USA, per the Baby-Friendly Hospital Initiative, or an alternate process adopted by a health care service plan

that includes evidenced-based policies and practices and targeted outcomes, or the Model Hospital Policy Recommendation.

We encourage you to work with your regional coordinator for the MCAH Regional Perinatal Program of California (RPPC). These 9 regional coordinators provide expert quality improvement support for the maternity hospitals, facilitate local perinatal advisory councils and maintain communication networks. They provide resources and technical assistance to hospitals and health care providers, including assistance on implementing laws related to hospitals and breastfeeding.

MCAH maintains CDPH's breastfeeding webpage *http://www.cdph.ca.gov/HealthInfo/healthyliving/childfamily/Pages/MO-BFP-BreastfeedingHealthyLiving.aspx* which includes information and resources from WIC, MCAH and Chronic Disease on:

- Hospital and Clinic Resources-including those to meet the requirements of state breastfeeding-related laws.
    - Recommended Hospital Breastfeeding Policies.
    - On-Line Toolkit to Implement the Recommended Hospital Breastfeeding Policies:
- Useful hospital related data, including:
    - In-Hospital Breastfeeding Initiation Data is monitored using data collected by the Genetic Disease Screening Program, Newborn Screening (NBS) Program. These data provide hospital level breastfeeding initiation rates overall and by the race/ethnic breakdown of the patient population. Hospitals routinely use these data to examine the percentage of women who initiate breastfeeding at their hospital in comparison to similar hospitals and the state rates.
    - California MIHA Data is from an annual, statewide-representative survey of women with a recent live birth in California. MIHA collects self-reported information on maternity care practices known to support breastfeeding, including: skin-to-skin contact, early breastfeeding initiation, rooming-in, formula supplementation, pacifier use, and receipt of gift packs containing formula, as well as infant feeding practices, including breastfeeding initiation, duration and exclusivity.
    - The Maternity Practices in Infant Nutrition and Care (mPINC) is a national survey of maternity care practices and policies that is conducted by the Centers for Disease Control and Prevention (CDC) every 2 years. The CDPH develops county and regional mPINC Benchmark Reports to provide Breastfeeding Coalitions, Regional Perinatal Programs of California (RPPC) Coordinators, WIC Regional Breastfeeding Liaisons (RBLs), and other stakeholders with local data to facilitate their work with hospitals and birth centers in improving maternity care practices that support breastfeeding.

Comment 04: (Women/ Maternal Health Domain Action Plan)

*Thank you for an **excellent** report. Sorry for the delay in getting comments to you. Here are my thoughts:*

- *I'm especially pleased with the focus on unintended pregnancy in Priority One and the mention of One Key Question as this will be a big focus for the Preconception Health Council over the next few years, as will the issue of chronic disease. Nice alignment. The action plan strategies for the Women's/Maternal Health Domain are excellent!*
- *We are very focused in our county on incorporating the ASQ into all of our home visiting programs so the prioritization of developmental screening is something we are already doing. Helpful to have this emphasis in the State plan.*
- *I wanted to see much more in the cross-cutting/life course domain, What about other social determinants of health like poverty and lack of decent affordable housing? You do address the SDOH in one of the strategies under women's /maternal health, and I think it is really good but almost missed it since I was looking for that kind of strategy in the last domain. Is there another way to highlight it?*
- *What about binge drinking as a focus for the next five years? You mention what has been done in past years but then it seems to be dropped from the five year plan, as does perinatal substance use in general. Or did I miss it?*
- *A general comment: it's odd that the annual report info is mixed in with the narrative about the next five year's activities at the end of the document. I guess you don't have much say in that formatting…is that right?*
- *Thanks for the opportunity to comment!*

Response to Comment 04:

Qualitative and quantitative data from the 2016 -2020 Title V Needs Assessment pointed MCAH in the direction of unintended pregnancies and developmental screening. As you know, these two areas have been of concern for MCAH, with developmental screening gaining additional interest as the early intervention efforts have generated positive results.

The life course domain and its intersection with social determinants of health is a critical concern to MCAH work. As a result of this comment, MCAH has strengthened the introduction to *Cross-Cutting/Life Course* health domain by further describing the relationship of social determinants to our work, yet more could have been said had the document word limit been longer. The brief mention of social determinants is not representative of its emphasis in MCAH's work.

Priority 7, Increase access and utilization of health and social services can address binge drinking and other substance use concerns. *After the 2016 -2020 Title V Needs Assessment* has been completed, MCAH will begin to develop thorough Action Plans that will consider all areas of substance use.

The most current version of the Guidance and Forms for the Title V Application/ Annual Report(7th edition) requires that for each of the six population domains, grantees should describe the previous year's activities, accomplishments, challenges and revisions as well as a plan for the coming year. We made the effort to present both previous year's activities and the coming year's plan in a manner consistent with the Guidance.

Response to the Title V 2013 Report/ 2015 Application (Previous Year's) Review Recommendations

There were strengths, weaknesses and recommendations made in the review of California's Title V Application for 2013 Report/ 2015 Application. The following weaknesses and recommendations were noted:

Weakness 1: Previous applications/reports have indicated that an ongoing evaluation/ implementation plan was being implemented for the CCS pilots, yet little information is included in the current submission. For example, the application recognizes the challenge of assuring access to pediatric subspecialty care, yet little information is provided to indicate whether such access has improved, remained the same, or worsened. Having updated data will be essential for monitoring the implementation of this and other models for CCS, as well as for non-CCS CYSHCN.

California Response:
The evaluation of the one active pilot, managed care through health plan of San Mateo, is currently in progress.

Weakness 2: It is sometimes difficult to distinguish whether and/or when the CCS program is considered synonymous with the CSHCN program. The narrative uses the terms CCS and CSHCN program interchangeably in many sections. A clearer articulation of the CSHCN program, with CCS as one component would be helpful.

California Response:
CCS impacts CSHCN through facility and provider standards and site reviews. CCS data is collected on CSHCN who meet CCS eligibility criteria, including CCS-eligible medical condition and financial eligibility.

Recommendation 1: The Systems of Care Division (SCD) program is encouraged to better articulate its vision and mission in the next application, in a manner that complements or is directly aligned with the MCAH vision and mission. The two divisions may consider a single Title V vision and mission that embraces all aspects of the MCH/CSHCN efforts in the state.

California Response:
MCAH develops systems with the goal to help protect and improve the health of California's reproductive age women, infants, children, adolescents, and their families. This is complemented by SCD's mission to promote integrated systems of care that provides the

population of children and adults with special health care needs the opportunity to achieve the healthiest life possible and to develop to their highest potential.

Recommendation 2: The divisions may also want to consider working closely on a comprehensive needs assessment that reflects the continuum of needs of children and families, the life course approach the state has already embraced, and the myriad connections these programs have with partner entities and constituents.

California Response:

MCAH began coordinating with SCD on the 2016 – 2020 Title V Needs Assessment in fall 2013. Collaborations began with high-level management meetings to discuss local and state needs assessment processes. Once a strategy and a timeline was agreed upon, MCAH and SCD staff agreed to meet monthly as the needs assessments were developed, conducted, and finalized. To support Recommendation 2, both MCAH and SCD have assigned dedicated staff to assure the integration of CSHCN within programs. A work plan detailing the needs of the CSHCN population will be developing during FFY 2015 – 2016.

Recommendation 3: The applicant organization may want to consider developing and providing in the 2014 Application a chart/table, listing major MCAH programs in each of the State priority areas, with an indication of how long programs have been in place, whether evaluation activities are in place for those programs, whether impact data are available, and the nature of impact.

California Response:

In the past five annual reports/ applications, an appendix was included to list all California Title V programs and the primary target population(s) they serve. With the release of the 7th edition of the Title V Guidance and Forms, annual reporting has been extensively revised with the goal of reducing the reporting burden for grantees. Thus, for this and succeeding annual reports/ applications, we will not be including information that is beyond what the Guidance and help fulfill the goal of reducing the reporting burden. However, these tables can be made available to MCHB upon request.

Recommendation 4: For the FY 2016 application submission, the applicant organization should consider clearly articulating how the broad population (beyond the 25% served by CCS) are defined, identified, and served by the multitude of MCAH/SCD/CCS programs. It could be helpful to describe how the broad population of CSHCN is reflected in the vision, mission, and design of the MCH/CSHCN population.

California Response:

Dr. Connie Mitchell, Chief of the Center of Family Health (CFH), directed MCAH and other CFH partners to assess CDPH's programs' commitments to the broad population of CSHCN. MCAH staff reviewed internal documents that included a survey to MCAH directors about their

work with the CSHCN population, and held a conference call with HRSA to understand further its responsibility to this population. Monthly meetings sought to fact-find and establish a system of accountability. Both MCAH and SCD have hired nurses who will assist MCAH and SCD in its collaboration. The MCAH nurse will be responsible for monitoring MCAH's effort which includes changes to the Local MCAH scope of work that will require local health jurisdictions to address the broader CSHCN population. The SOW is in Attachment 4. MCAH is currently developing a work plan that strives to address outcomes related to CSHCN, as described in the 2016 – 2020 Title V Action Plan.

Recommendation 5: *California should evaluate and report on the implementation of the CCS waiver Medicare Managed Care (MCMC) Health Plan model implemented in San Mateo County in 2013.*

California Response:

The evaluation of the one active pilot, managed care through health plan of San Mateo, is currently in progress.

Recommendation 6: It is recommended that the State refine the measurement strategy for CCS performance measures, SPM#1, #3 and #10, for the FY2016 application, especially if they continue under the new block grant guidance. The focus of the measures (continuity of care; family satisfaction; medical home) is appropriate but the measures themselves do not measure the constructs. For example, family satisfaction should not be solely defined by the percentage of CCS families who complete an annual survey. The content of the response should also be considered. Also, California may want to consider reporting on the expanded sample of families with CCS eligible children who do not reside in waiver counties.

California Response:

For the 2015 Needs Assessment, CCS conducted a statewide family survey which extended beyond waiver counties. The comments about the measures are noted and measures developed for the next five-year cycle will more accurately reflect the construct to be measured.

Recommendation 7: The applicant is encouraged to secure its position as a national leader by publishing its studies, evaluations, toolkits, methods, etc. so that other states and jurisdictions may benefit from these experiences. In particular, the MCH/CSHCN experience with full implementation of the ACA is a story that could be shared.

California Response:

California's Title V had previously published evaluation reports, including the Title V Annual Report/ Application by working with the California Office of State Publishing to create hardcopies of these reports. With the greater use of electronic media, we have used electronic media to publish our reports. The Annual Reports/Applications, Evaluation Reports, toolkits,

etc. are available for download in the MCAH website at http://www.cdph.ca.gov/programs/mcah/Pages/default.aspx . The website includes news, hot topics and updates; publications and reports; data and statistics; programmatic materials and toolkits, and links to additional resources and publications. This is supplemented by a contract with the Family Health Outcomes Project of the University of California at San Francisco to make available county health data and statistics in a password protected site; needs assessment resources and toolkits; archived training and technical assistance webinars; and program intervention, evaluation and assessment tools available on their website. The Family Health Outcomes Project can be accessed at http://fhop.ucsf.edu/ .

B. Public Input and Commentaries related to MCAH-related News Articles

In the past, MCAH and its partners have developed press releases directed at members of the news media for the purpose of announcing newsworthy benchmarks or to highlight health issues related to MCAH's state priorities. These press releases are picked up by some of the major California dailies and published online as originally released or with modifications. With improved technology, these news articles, published in digital newspapers, allow the public to provide ad-hoc comments. Relevant public input gathered from select online news articles were reviewed. The number of comments received, the article's author, the news article title, the date of publication and a hyperlink to the webpage where the article can be found are included below. Note that articles and their comments are archived and inaccessible online after a period of time as determined by each of the news sites or news agencies.

1. Two (2) comments reviewed from:
   Peak, C. (2015, April 14). The Common Sense Move That Reduced California's Teen Pregnancy Rate by 60 Percent. Nationswell, New York, New York. Retreived from http://nationswell.com/california-reduction-teen-pregnancy-rate/ . Last accessed on June 1, 2015.

2. One (1) comment reviewed from:
   Harvey, A. (2015, May 22). Black Infant Health Aims to Improve Health Among African American Mothers. The Sacramento Observer, Sacramento. CA. Retreived from http://sacobserver.com/2015/05/black-infant-health-aims-2-improve-health-among-african-american-mother/#comments . Last accessed on June 1, 2015.

3. Six (6) comments reviewed from :
   Graff, A. (2014, December 1). More than half of kids sleep with soft bedding despite SIDS risk. San Francisco Chronicle, San Francisco, CA. Retrieved from: http://blog.sfgate.com/sfmoms/2014/12/01/more-than-half-of-kids-sleep-with-soft-bedding-despite-sids-risk/. Last accessed on January 16, 2015.

4. Fifty-nine (59) comments reviewed from:

Kaplan, K. (2014, August 20). Contraception, abstinence push U.S. teen birthrates to historic lows. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-teen-birth-rate-historic-low-20140820-story.html. Last accessed on January 16, 2015.

5. Ten (10) comments reviewed from:
   Kaplan, K. (2014, October 1). Study: Good access to birth control prevents teen pregnancy, abortion. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-teen-pregnancy-contraception-choices-project-20141001-story.html. Last accessed on January 16, 2015.

6. Fifteen (15) comments reviewed from:
   Perry, T. (2014, July 11). Woman wasn't urged to leave 'pit' because of breast-feeding, police say. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/local/lanow/la-me-ln-concert-breastfeeding-20140711-story.html. Last accessed on January 16, 2015.

7. Twenty-four (24) comments reviewed from:
   Rohwer, S. (2014, August 7). Why Olivia Wilde's Glamour breastfeeding photo is a slap in the face. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/opinion/opinion-la/la-ol-olivia-wilde-breast-feeding-glamour-20140807-story.html. Last accessed on January 14, 2015.

8. Twenty-one (21) comments reviewed from:
   Author unknown. (2014, August 11). Should women breastfeed in public? Speakout. Opinion, Long Beach Press Telegram, Long Beach, CA. Retrieved from: http://www.presstelegram.com/opinion/20140811/should-women-breastfeed-in-public-speakout#disqus_thread. Last accessed on January 14, 2015.

9. Two (2) comments reviewed from:
   Ross M. (2014, August 19.) Olivia Wilde breast-feeding photo sparks new round of the Mommy Wars. San Jose Mercury News, San Jose , CA. Retrieved from: http://www.mercurynews.com/bay-area-living/ci_26359831/olivia-wilde-breast-feeding-photo-sparks-new-round. Last accessed on January 14, 2015.

10. One (1) comment reviewed from:
    Gonzales, C. (2014, August 20). Breastfeeding Mothers Hold A Nurse-In Protest In Beverly Hills. Fox Television Stations, Inc, Los Angeles, CA. Retrieved from: http://www.myfoxla.com/story/26332971/breastfeeding-mothers-hold-a-nurse-in-protest-in-beverly-hills. Last accessed on January 14, 2015.

11. One hundred seventy-four (174) comments reviewed from:
Author Unknown. (2014, August 20). Breastfeeding Moms Stage 'Nurse-In' At Anthropologie In Beverly Hills. CBS Local Media, Los Angeles, CA. Retrieved from: http://losangeles.cbslocal.com/2014/08/20/breastfeeding-moms-stage-nurse-in-at-anthropologie-in-beverly-hills/. Last accessed on January 14, 2015.

12. One hundred thirty-one (131) comments reviewed from:
Stallworth, L. (2014, August 21). Breastfeeding mothers hold 'nurse-in' at Beverly Hills Anthropologie store. KABC-TV Los Angeles, CA.
Retrieved from: http://abc7.com/news/breastfeeding-moms-hold-nurse-in-at-beverly-hills-store/274005/. Last accessed on January 14, 2015.

13. Twenty-one (21) comments reviewed from:
Netburn, D. (2014, July 8). Obesity: We're not overeating, we're under-exercising, study suggests. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-lack-of-exercise-linked-to-rise-in-obesity-20140707-story.html. Last accessed on January 15, 2015.

14. Nine (9) comments reviewed from:
Kaplan, K. (2014, July 24). Overweight and obese kids are in denial about their weight, CDC says. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-weight-status-misperception-kids-20140724-story.html. Last accessed on January 16, 2015.

15. Two (2) comments reviewed from:
Healy, M. (2014, July 31). Study says early DDT exposure may set up females for obesity, diabetes. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/la-sci-sn-ddt-pesticide-obesity-diabetes-20140730-story.html. Last accessed on January 16, 2015.

16. Nine (9) comments reviewed from:
Huffman, J. (2014, August 2). Struggling with morbid obesity, some turn to surgery. Napa Valley Register, Napa, CA. Retrieved from: http://napavalleyregister.com/news/local/struggling-with-morbid-obesity-some-turn-to-surgery/article_4de1081e-1886-5309-a45c-45ace87c6aa7.html. Last accessed on January 16, 2015.

17. Eleven (11) comments reviewed from:
Kurata, E. (2014, August 7). Energy drinks, sports drinks not as healthy as advertised, campus researchers say. The Daily Californian, Berkeley, CA. Retrieved from:

http://www.dailycal.org/2014/08/07/energy-drinks-sports-drinks-healthy-advertised-campus-researchers-say/. Last accessed on January 16, 2015.

18. Twenty-one (21) comments reviewed from:
Karlamangla, S. mailto:soumya.karlamangla@latimes.com?subject=Regarding%20One%20man%27s%20uphill%20fight%20to%20stem%20childhood%20obesity(2014, August 8). Great Read One Man's Uphill Fight to stem Childhood Obesity. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/local/education/la-me-c1-kindergarten-obesity-20140808-story.html#page=1. Last accessed on January 16, 2015.

19. Eighteen (18) comments reviewed from:
Kaplan, K. (2014, August 25). As kids get fatter, fewer parents can tell their children are obese. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-childhood-obesity-parents-clueless-20140825-story.html. Last accessed on January 16, 2015.

20. One (1) comment reviewed from:
Kaplan, K. (2014, August 26). Lose weight to gain brain power? Study says it may work. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/la-sci-sn-weight-loss-surgery-dementia-20140826-story.html. Last accessed on January 16, 2015.

21. Two (2) comments reviewed from:
Kaplan, K. (2014, September 4). Report: U.S. obesity crisis may be stabilizing, especially in kids. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-american-obesity-crisis-stabilizing-20140904-story.html. Last accessed on January 16, 2015.

22. Seven (7) comments reviewed from:
Kaplan, K. (2014, September 16). Obesity rates have stabilized, but our waistlines are still growing. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-obesity-waist-circumference-20140916-story.html. Last accessed on January 16, 2015.

23. Two (2) comments reviewed from:
Author unknown. (2014, September 26). Los Angeles gets $14M federal grant to fight obesity. LA Daily News, Woodland Hills, CA. Retrieved from: http://www.dailynews.com/health/20140926/los-angeles-gets-14m-federal-grant-to-fight-obesity#disqus_thread. Last accessed on January 16, 2015.

24. Eight (8) comments reviewed from:

Healy, M. (2014, September 29). Early, frequent antibiotic use linked to childhood obesity. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/la-sci-sn-childhood-antibiotics-obesity-20140929-story.html. Last accessed on January 16, 2015.

25. Six (6) comments reviewed from:
Kaplan, K. (2014, October 16). Losing weight quickly is just as good (or bad) as losing it gradually. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-rapid-vs-gradual-weight-loss-20141016-story.html. Last accessed on January 16, 2015.

26. Two (2) comments reviewed from:
Healy, M. (2014, November 6). When obesity is an inherited trait, maybe gut bacteria is the link. Los Angeles Times, Los Angeles, CA.

Retrieved from:http://www.latimes.com/science/sciencenow/la-sci-sn-obesity-genes-gut-bacteria-20141106-story.html. Last accessed on January 16, 2015.

27. Three (3) comments reviewed from:
Kaplan, K. (2014, November 25). Study: Being overweight or obese led to 481,000 cancers in one year. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-cancer-risk-bmi-overweight-obese-20141125-story.html. Last accessed on January 16, 2015.

28. Four (4) Comments reviewed from:
Ross, A. (2014, November 26). Obesity costs U.S. health system $150 billion a year. SFGate, a sister-site of the San Francisco Chronicle, San Francisco Bay Area, CA.

Retrieved from: http://www.sfgate.com/business/bottomline/article/Obesity-costs-U-S-health-system-150-billion-a-5920702.php. Last accessed on January 16, 2015.

29. Eight (8) Comments reviewed from:
Healy, M. (2014, December 3). To prevent or reverse obesity and its ills, timing may be everything. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-prevent-reverse-obesity-fasting-20141203-story.html. Last accessed on January 16, 2015.

30. Eight (8) Comments reviewed from:
Lazarus, D. (2014, December 8). A national soda tax is needed to reduce obesity and save lives. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/business/la-fi-lazarus-20141209-column.html. Last accessed on January 16, 2015.

31. Four (4) Comments reviewed from:
Dayton, L. (2014, December 19). BMI may not be the last word on health risks, some experts say. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/health/la-he-bmi-20141220-story.html. Last accessed on January 16, 2015.

32. Ten (10) Comments reviewed from:
Mantle, L. (2014, December 24). Should obesity be considered a disability? 89.3 KPCC, Southern California Public Radio, Pasadena, CA. Retrieved from: http://www.scpr.org/programs/airtalk/2014/12/24/40887/should-obesity-be-considered-a-disability/. Last accessed on January 16, 2015.

33. Thirty-two (32) comments reviewed from:
Kaplan, K. (2014, December 4) U.S. birthrate hit new low in 2013 as women delayed having kids. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-us-birth-rate-historic-low-20141203-story.html. Last accessed on January 16, 2015.

34. Thirteen (13) comments reviewed from:
Kaplan. K. (2014, September 24). Premature births a big factor in high U.S. infant mortality rate. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-infant-mortality-us-ranks-26th-20140924-story.htmlL. Last accessed on January 29, 2015.

35. Seven (7) comments reviewed from:
Klein, K. (2014, December 30). Opinion - FDA has its reasons for being the fetal-ultrasound party pooper. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/opinion/opinion-la/la-ol-fda-fetal-ultrasound-party-20141230-story.html. Last accessed on January 29, 2015.

36. Two (2) comments reviewed from:
Demarco/Fronteras, M. (2014, September 23). Mothers Fight Stigma Of Drug Addiction. KPBS Public Broadcasting, San Diego, CA. Retrieved from: http://www.kpbs.org/news/2014/sep/23/mothers-fight-stigma-drug-addiction/. Last accessed on January 29, 2015.

37. Ten (10) Comments reviewed from:
Murray, D. (2014, September 25). Why pregnancy and pot don't - and shouldn't – mix. The San Diego Union-Tribune, LLC, San Diego, CA. Retrieved from: http://www.utsandiego.com/news/2014/sep/25/pregnancy-marijuana/2/?#article-copy. Last accessed on January 29, 2015.

38. Eleven (11) comments reviewed from:
Romney, L. (2014, July 6). San Francisco is likely to approve Laura's Law mental health program. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/local/crime/la-me-lauras-law-20140707-story.html. Last accessed on January 29, 2015.

39. Two (2) comments reviewed from:
Sewell, A. (2014, July 13). L.A. County board to vote on court-ordered mental health treatment law. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/local/countygovernment/la-me-lauras-law-20140714-story.html. Last accessed on January 29, 2015.

40. Four (4) comments reviewed from:
Lopez, S. (2014, September 6). Behind a senator's mental health advocacy, a private family battle. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/local/la-me-lopez-jordie-20140907-column.html. Last accessed on January 30, 2015.

41. One (1) comment reviewed from:
Lee, J. (2014, September 18). Evidence of increased demand for mental health services presented to UC Board of Regents. The Daily Californian, Berkeley, CA. Retrieved from: http://www.dailycal.org/2014/09/18/increased-demand-mental-health-services-presented-uc-regents/. Last accessed on January 30, 2015.

42. Thirty-four (34) comments reviewed from:
Espinoza, M. (2014, September 23). Mental health patients forced to seek treatment outside Sonoma County. The Press Democrat, Santa Rosa, CA. Retrieved from: http://www.pressdemocrat.com/news/2853924-181/mental-health-patients-forced-to?page=0. Last accessed on January 30, 2015.

43. Two (2) comments reviewed from:
Sisson, P. (2014, September 29). Mental health treatment in high demand. The San Diego Union-Tribune, LLC. San Diego, CA. Retrieved from: http://www.utsandiego.com/news/2014/sep/29/mental-health-san-diego-beds/#comments-module. Last accessed on January 30, 2015.

44. Two (2) comments reviewed from:
Evans, E. (2014, October 9). Faculty Senate addresses Stanford's mental health services. The Stanford Daily, Stanford, CA. Retrieved from: http://www.stanforddaily.com/2014/10/09/faculty-senate-addresses-stanfords-mental-health-services/. Last accessed on January 30, 2015.

45. One (1) comment reviewed from:
Minneapolis Star Tribune. (2014, October 14). Clinic offers mental health treatment on the spot. SFGate, a sister-site of the San Francisco Chronicle, San Francisco Bay Area, CA. Retrieved from: http://www.sfgate.com/health/article/Clinic-offers-mental-health-treatment-on-the-spot-5822347.php. Last accessed on January 30, 2015.

46. Two (2) comments reviewed from:
Roberts, E. (2014, October 20). Mental Health: 'Before it's too late'. Local Media Group, Inc. Local Media Group Publications, Stockton, CA. Retrieved from: http://www.recordnet.com/article/20141020/News/141029998. Last accessed on January 30, 2015.

47. One (1) comment reviewed from:
Haagenson, G. (2014, November 4). Fresno County Allocates Funds for Children's Mental Health Services Building. ABC Inc., KFSN-TV, Fresno, CA. Retrieved from: http://abc30.com/politics/fresno-county-allocates-funds-for-childrens-mental-health-services-building/380940/. Last accessed on January 30, 2015.

48. One (1) comment reviewed from:
Karasik, C. (2014, November 5). "Taking care of each other" and mental health. The Stanford Daily, Stanford, CA. Retrieved from: http://www.stanforddaily.com/2014/11/05/taking-care-of-each-other-and-mental-health/. Last accessed on January 30, 2015.

49. One (1) comment reviewed from:
Plevin, R. (2014, November 30). Mental health agency says holidays bring more child depression. 89.3 KPCC, Southern California Public Radio, Pasadena, CA. Retrieved from: http://www.scpr.org/news/2014/11/30/48300/didi-hirsch-mental-health-agency-holidays-bring-mo/. Last accessed on January 30, 2015.

50. Seven (7) comments reviewed from:
Kaplan, K. (2014, December 3). 7.6% of Americans are depressed, but few seek mental health treatment. Los Angeles Times, Los Angeles, CA. Retrieved from: http://www.latimes.com/science/sciencenow/la-sci-sn-depression-in-america-20141203-story.html. Last accessed on February 3, 2015.

51. Seven (7) comments reviewed from:
Wang, E. (2014, December 8). How Homelessness Can Compromise Mental Health. The San Francisco Public Press, San Francisco, CA. Retrieved from: http://sfpublicpress.org/news/2014-11/how-homelessness-can-compromise-mental-health. Last accessed on February 3, 2015.

52. Three (3) comments reviewed from:
The Bee Editorial Board. (2014, December 9). EDITORIAL: Fresno County fills big gap in teen mental health care. The Fresno Bee, Fresno, CA. Retrieved from: http://www.fresnobee.com/2014/12/09/4278198_editorial-fresno-county-fills.html?rh=1. Last accessed on February 3, 2015.

53. One (1) comment reviewed from:
Shumaker, L. (2014, December 17). Mental health treatment barriers–and solutions. SFGate, a sister-site of the San Francisco Chronicle, San Francisco Bay Area, CA. Retrieved from: http://blog.sfgate.com/lshumaker/2014/12/17/mental-health-treatment-barriers-and-solutions/. Last accessed on February 3, 2015.

54. Two (2) comments reviewed from:
Guzman, K. (2014, December 21). Live Oak's Cypress High students fight mental health barriers. Santa Cruz Sentinel, Scotts Valley, CA. Retrieved from: http://www.santacruzsentinel.com/social-affairs/20141221/live-oaks-cypress-high-students-fight-mental-health-barriers. Last accessed on February 3, 2015.

55. Eighteen (18) comment reviewed from:
Valdez, E. (2014, December 24). Lawsuit: Poor mental health care led to girl's suicide. ABC10, San Diego, CA. Retrieved from: http://www.10news.com/news/family-sues-san-diego-alledging-poor-mental-health-care-in-juvenile-hall-led-to-girls-suicide. Last accessed on February 3, 2015.

56. Thirty-nine (39) comments reviewed from:
Anderson, B. (2015, January 4). Fresno County restoring crisis mental health services. The Fresno Bee, Fresno, CA. Retrieved from: http://www.fresnobee.com/2015/01/04/4314215/fresno-county-restoring-crisis.html. Last accessed on February 3, 2015.

Attachment 8 – References

REFERENCES:

1. California Department of Finance. (2009). *2008 California Statistical Abstract*. 48th edition. Sacramento, CA. Retrieved from http://www.dof.ca.gov/html/fs_data/stat-abs/documents/CaliforniaStatisticalAbstract2008.pdf.
2. U. S. Census Bureau. (2010). *State and County Quick Facts, California*. Retrieved from http://quickfacts.census.gov/qfd/states/06000.html Retrieved on September 9, 2014.
3. California Department of Finance. (December 2014). *Report P-1 (County), Population Projections for California and Its Counties 2010-2060*. Sacramento, CA. Retrieved from http://www.dof.ca.gov/research/demographic/reports/projections/p-1/. Retrieved on April 22, 2015.
4. U.S. Census Bureau. (2014). *2011-2013 American Community Survey 3-Year Estimates, California*. Retrieved from http://www.census.gov/acs/www/. Retrieved on November 12, 2014.
5. California Department of Finance. (December 2014). *Report P-3 Population Projections by Race/ Ethnicity, Detailed Age, and Gender, 2010-2060*. Sacramento, CA. Retrieved from http://www.dof.ca.gov/research/demographic/reports/projections/P-3/. Retrieved on April 22, 2015.
6. California Department of Finance. (2014). *California grew by 356,000 residents in 2013 - Press Release*. Retrieved from http://www.dof.ca.gov/research/demographic/reports/estimates/e-1/documents/E-1_2014_Press_Release.pdf. Retrieved on October 13, 2014.
7. Legislative Analyst's Office. (January 2, 2013). *CAL FACTS 2013*. Retrieved from http://www.lao.ca.gov/reports/2013/calfacts/calfacts_010213.pdf. Retrieved on October 5, 2014.
8. Ventura, S.J., M.A., T.J. Mathews, M.S., and B.E. Hamilton, Ph.D.,. (2001). *Births to teenagers in the United States, 1940-2000, in National Vital Statistics Reports*. Hyattsville, MD. p. 10.
9. Hoffman, S.D., *Kids having kids: Economic costs and social consequences of teen pregnancy*. 2008: The Urban Institute Press.
10. California Department of Public Health. *2011 Birth Statistical Master File*. Sacramento, CA.
11. Fortuny K., R.C. and Capps, R. March 2007. The Characteristics of Unauthorized Immigrants in California, Los Angeles County, and the United States. Retrieved from http://www.urban.org/research/publication/characteristics-unauthorized-immigrants-california-los-angeles-county-and-united-states.
12. Passel, J.S. and Cohn, D. (2009, April 14). *A Portrait of unauthorized immigrants in the United States.* Retrieved from http://www.pewhispanic.org/2009/04/14/a-portrait-of-unauthorized-immigrants-in-the-united-states/.
13. U.S. Census Bureau. (2014). *American Community Survey 3-Year Estimates, California 2014*. Cited 2014, Nov.12. Washington, DC. Retrieved from http://www.census.gov/acs/www/.
14. California Department of Education. (2010). *Number or English Learners by language, 2008-2009*. Sacramento, CA.
15. Short, K. (October 2014). *The supplemental poverty measure: 2013. Current Population Reports*. Washington, D.C. Retrieved from http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-251.pdf.

16. Pearce D.M. December 2009 Overlooked and undercounted 2009: Struggling to make ends meet in California. Seattle, WA. Retrieved from http://www.selfsufficiencystandard.org/docs/CA%20Overlooked%20%20Undercounted%202009.pdf.
17. Braveman, P., et al. (November 27, 2008). *Poverty, near-poverty, and hardship around the time of pregnancy.* 1. 20-35. DOI: 10.1007/s10995-008-0427-0. Retrieved from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=19037715.
18. Bohn, S. and Levin, M. (August 2013). *Child Poverty in California*. Sacramento, CA. Retrieved from http://www.ppic.org/main/publication_show.asp?i=721.
19. Beyers, M., et al. August 2008. Life and Death from Unnatural Causes: Health and Social inequity in Alameda County. Oakland, CA. Retrieved from http://www.acphd.org/data-reports/reports-by-topic/social-and-health-equity/life-and-death-from-unnatural-causes.aspx.
20. Wardrip, K., Pelletiere, D., and Crowley, S. (April 2008). *Out of Reach 2007-2008*. Washington, D.C. Retrieved from http://nlihc.org/sites/default/files/oor/2007-2008-OOR.pdf. Retrieved on May 15, 2010.
21. Kaiser Family Foundation. California: Measures of State Economic Distress: Housing Foreclosures and Changes in Unemployment and Food Stamp Participation. Retrieved from http://www.statehealthfacts.org. Retrieved on March 22, 2012.
22. Bassuk, E., et al. 2014. American's Youngest Outcasts: A Report Card on Child Homelessness. Waltham, MA. Retrieved from http://www.homelesschildrenamerica.org/mediadocs/280.pdf.
23. Collins, S., et al. April 2013. Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act. Washington, D.C. Retrieved from http://www.commonwealthfund.org/~/media/files/publications/fund-report/2013/apr/1681_collins_insuring_future_biennial_survey_2012_final.pdf. Retrieved on October 31, 2014.
24. Kaiser Family Foundation. December 2011. The California Health Landscape. Retrieved from http://kff.org/health-reform/fact-sheet/the-california-health-care-landscape/. Retrieved on June 5, 2012.
25. Gardner, A.P. April 2012. Laying the Foundation for Health Care Reform: Local Initiatives to Integrate the Health Care Safety Net. San Francisco, CA. Retrieved from http://laborcenter.berkeley.edu/pdf/2012/foundation_health_care_reform.pdf. Retrieved on November 6, 2014.
26. California Health Benefit Exchange. (June 2014). *2014 Open Enrollment Data Book*. Retrieved from http://hbex.coveredca.com/data-research/2014-Open-Enrollment-Data-Book/2014%20Open%20Enrollment%20Data%20Book%20Webinar.pdf. Retrieved on Nomvember 6, 2014.
27. California HealthCare Foundation. (August 2012). *Monitoring the impacts of the Affordabe Care Act in California: stakeholder input and priorities fact sheet*. Retrieved from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MonitoringImpactsACA.pdf. Retrieved on November 6, 2014.
28. Collins, S., Rasmussen, P.W., and Doty, M. July 2014. Tracking trends in health system performance. 16. Retrieved from

http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf. Retrieved on November 6, 2014

29. Taylor, M. (February 2013). *2013-2014 Budget: Analysis of the Health and Human Services Budget*. Sacramento, CA. Retrieved from http://lao.ca.gov/analysis/2013/ss/hhs/health-human-services-022713.aspx. Retrieved on November 6, 2014.
30. California Health and Human Services Agency. (December 2012). *Let's Get Healthy California Task Force Final Report*. Sacramento, CA. Retrieved from http://www.chhs.ca.gov/Documents/___Let%27s%20Get%20Healthy%20California%20Task%20Force%20Final%20Report.pdf. Retrieved on November 6, 2014.
31. Institute of Medicine. November 2002. The Future of the Public's Health in the 21st Century. Washington, D.C. Retrieved from https://www.iom.edu/Reports/2002/The-Future-of-the-Publics-Health-in-the-21st-Century.aspx.
32. Little Hoover Commission. (2013). *To Protect & Prevent: Rebuilding California's Public Health System*. Sacramento, CA. Retrieved from http://www.lhc.ca.gov/studies/170/report170.pd. Retrieved on November 6, 2013.
33. Shore, K. and Yakes, B. (January 2007). *Understanding California's public health system. Issue California Health Policy Forum Issue Brief.* Retrieved from http://www.cahpf.org/GoDocUserFiles/208.CHI%20Brief%20California.pdf. Retrieved on May 13, 2015.
34. State of California. *Health and Safety Code. Government Code, Section 29400-29304, section 3200, et. seq*.
35. Legislative Analyst's Office. (April 2012). *Overview of Health Care Districts*. Sacramento, CA. Retrieved from http://www.lao.ca.gov/handouts/Health/2012/Overview_Health_Care_Districts_4_11_12.pdf. Retrieved on November 6, 2015.
36. Taylor, M. (April 2006). *California's health care districts*. Oakland, CA. . Retrieved from http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CaliforniasHealthCareDistricts.pdf. Retrieved on May 16, 2015.
37. U.S. Department of Health and Human Services and Office of Disease Prevention and Health Promotion. *Healthy People 2020*. Washington, DC. Retrieved from http://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives. Retrieved on March 11, 2015.
38. U.S. Department of Health and Human Services. (2014). *Healthy People 2020*. Retrieved from http://www.healthypeople.gov/node/3492/data-details. Retrieved on December 5, 2014.
39. National Survey of Children's Health. (2011-12). *Child and Adolescent Health Measurement Initiative.* Retrieved from http://www.childhealthdata.org/browse/snapshots/nsch-profiles?rpt=16&geo=6. Retrieved on March 10, 2015.
40. Centers for Disease Control and Prevention. *Human Papillomavirus ACIP Vaccine Recommendations*. Retrieved from http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hpv.html.

41. Office of Disease Prevention and Health Promotion. *Healthy People 2020: Mental Health and Mental Disorders Data Details.* Retrieved from https://www.healthypeople.gov/node/3498/data-details.
42. National Survey of Children's Health. *Maternal and Child Health Bureau Chartbooks: 2011/12 National Survey of Children's Health.* Retrieved from http://childhealthdata.org/learn/NSCH, Data from http://mchb.hrsa.gov/nsch/07cshcn/.
43. Centers for Disease Control and Prevention. (2014, December 16). *Chlamydia - CDC Fact Sheet*. Retrieved from: http://www.cdc.gov/std/chlamydia/stdfact-chlamydia-detailed.htm. on June 4, 2015.
44. California Department of Public Health. (March 2009). *Death Statistical Master File (1) List of Variables*. Retrieved from http://www.cdph.ca.gov/data/dataresources/requests/Documents/Death%20Statistical%20Master%20File%20Variables.pdf. Retrieved on June 4, 2015.
45. Mays, V.M., Cochran, S.D., and Barnes, N.W., *Race, Race-Based Discrimination, and Health Outcomes Among African Americans*, in *Annual review of psychology*. 2007. p. 58, 201-225.
46. Bishaw, A. (June 2014). *Changes in Areas With Concentrated Poverty: 2000 to 20101*. American Community Survey Reports. Suitland, MD. U.S. Census Bureau. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2014/acs/acs-27.pdf.
47. National Survey of Children's Health. ((2011-12)). *NSCH National Chartbook Profile for California vs. Nationwide.* Retrieved from http://childhealthdata.org/browse/snapshots/nsch-profiles?rpt=16&geo=1. Retrieved on June 4, 2015.
48. Center for Disease Control and Prevention. (June 2015). *Behavioral Risk Factor Surveillance System Survey Data. Atlanda, Georgia*. Atlanta, GA. Population Health Surveillance Branch (PHSB). Retrieved from http://apps.nccd.cdc.gov/brfss/. Retrieved on June 4, 2015.

Attachment 9 - Glossary of Acronyms

Glossary of Acronyms

A	AAP	American Academy of Pediatrics
	AB	Assembly Bill
	ACA	Affordable Care Act of 2010
	ACOG	American Congress of Obstetricians and Gynecologists
	AFLP	Adolescent Family Life Program
	ALC	Action Learning Collaborative
	ASQ	Ages and Stages Questionnaire
	ASTHO	The Association of State Health Officers
B	BIH	Black Infant Health
	BMI	Body Mass Index
	BRFSS	Behavioral Risk Factor Surveillance System
	BSMF	Birth Statistical Master File
C	CA	State of California
	CBA	Comprehensive Baseline Assessment
	CCS	California Children's Services
	CDAPP	California Diabetes and Pregnancy Program
	CDC	Centers for Disease Control and Prevention
	CDE	California Department of Education
	CDIC	Chronic Disease and Injury Control Branch
	CDPH	California Department of Public Health
	CFH	Center For Family Health
	CHDP	Child Health Disability Prevention Program
	CHVP	California Home Visiting Program
	CMPs	Case Management Programs
	CMQCC	California Maternal Quality Care Collaborative
	CoIIN	The Collaborative Improvement Innovation Network
	CPeTS	California Perinatal Transport Systems
	CPQCC	California Perinatal Quality Care Collaborative
	CPSP	Comprehensive Perinatal Services Program
	CSHCN	Children with Special Health Care Needs
	CTCP	California Tobacco Control Program
	CYSHCN	Children and Youth with Special Health Care Needs
D	DCs	Developmental Centers
	DDS	Department of Developmental Services
	DHCS	Department of Health Care Services
	DME	Durable medical equipment
	DSH	Department of State Hospitals

	DSS	Department of Social Services
E	EPDS	Edinburgh Postnatal Depression Scale
	EPSDT	Early and Periodic Screening, Diagnosis and Treatment
F	FASD	Fetal Alcohol Spectrum Disorder
	FFP	Federal Financial Participation
	FFY	Federal Fiscal Year (October 1 - September 30)
	FHOP	Family Health Outcomes Project
	FPL	Federal Poverty Level
	FQHC	Federally Qualified Health Clinic
	FTE	Full-time equivalent
G	GDSP	Genetic Disease Screening Program
H	HiAP	Health in All Policies
	HIV	Human Immunodeficiency Virus
	HSI	Health Status Indicator
	HVP	Home Visiting Program
I	I&E	Information and Education Program
	ICCSP	Individualized California Children's Services Plan
	ICD	International Classification of Diseases
	ICPC	Interconception Care Project of California
	IRIS	Internal, Reproductive, Integrative, Skin
L	L.A.	Los Angeles County
	LBW	Low Birth weight (<2500 grams)
	LHJ	Local Health Jurisdiction
M	MCAH	Maternal, Child, and Adolescent Health
	MCHB	Maternal and Child Health Bureau (Federal Agency)
	MHSA	Mental Health Services Act
	MCO	Managed Care Organization
	MIHA	Maternal and Infant Health Assessment
	MMCHP	Medi-Cal Managed Care Health Plans
	MMCD	Medi-Cal Managed Care Division
	MOD	March of Dimes
	MOU	Memorandum of Understanding
	MRMIB	Managed Risk Medical Insurance Board
	MTP	Medical Therapy Program
N	NICU	Neonatal Intensive Care Unit

	NPM	National Performance Measure
	NSCH	National Survey of Children's Health
	NUPA	Nutrition and Physical Activity
O	OHU	Oral Health Unit
	OSHPD	Office of Statewide Health Planninng and Development
	OVR	Office of Vital Record
P	PACT	Physical Activity Collaboration Team
	PAIS	Program Allocation, Integrity and Support
	PAMR	Pregnancy-associated Maternal Review
	PCP	Primary Care Provider
	PDD	Patient Discharge data
	PHCC	Preconception Health Council of California
	PHNs	Public Health Nurses
	PHQ-9	Patient Health Questionnaire
	PHSP	The Preventive Health and Safety Practices
	PQIP	Perinatal Quality Improvement Panel
	PREP	Personal Responsibility Education Program
	PYD	Positive Youth Development
Q	QA	Quality Assurance
R	RPPC	Regional Perinatal Programs of California
S	SAC	Safe and Active Communities
	SCCs	Special Care Centers
	SCD	Systems of Care Division
	SIDS	Sudden Infant Death Syndrome
	SIT	State Interagency Team
	SMART	Specific Measureable, Achievable, Realistic, Time-Related
	SOW	Scope of Work
	SPM	State Performance Measure
T	TA	Technical Assistance
	TPPs	Teen Prevention Programs
V	VLBW	Very Low Birth weight (<1500 grams)
W	WIC	Women, Infants, and Children Supplemental Nutrition Program
Y	YSHCN	Youth with Special Health Care Needs