

# **Maternal and Child Health Services Title V Block Grant**

## **California**

# Table of Contents

Table of Contents .....	2
I. General Requirements .....	4
I.E Executive Summary .....	4
II. Components of the Application/Annual Report .....	7
II.A State Overview .....	7
II.B Five Year Needs Assessment Summary .....	15
II.B.1 Action Plan Process .....	15
II.B.2 Findings .....	15
Domain: Women/Maternal Health .....	15
Domain: Perinatal/Infant Health .....	16
Domain: Child Health .....	16
Domain: Children with Special Health Care Needs .....	17
Domain: Adolescent Health .....	17
Domain: Cross-cutting/Life Course .....	17
II.C State Selected Priorities .....	19
II.D Linkage of State Selected Priorities with National Performance and Outcome Measures .....	22
II.E Linkage of State Selected Priorities with SPMs and SOMs .....	24
II.F Five Year State Action Plan .....	25
II.F.1 State Action Plan and Strategies by MCH Population Domain .....	51
Domain: Women/Maternal Health – Annual Report (FY 2014-2015) .....	51
Domain: Women’s/Maternal Health - Plans for the Application Year (FY 2016-2017) .....	52
Domain: Perinatal/Infant Health – Annual Report (FY 2014-2015) .....	54
Domain: Perinatal/Infant Health - Plan for the Application Year (FY 2016-2017) .....	57
Domain: Child Health Annual Report - (FY 2014-2015) .....	59
Domain: Child Health - Plan for the Application Year (FY 2016-2017) .....	61
Domain: Children with Special Health Care Needs - Annual Report (FY 2014-2015) .....	63
Domain: Children with Special Health Care Needs - Plan for the Application Year (FY 2016-2017) .....	67
Domain: Adolescent Health - Annual Report (FY 2014-2015) .....	69
Domain: Adolescent Health - Plans for the Application Year (FY 2016-2017) .....	70
Domain: Cross-Cutting/Life Course- Annual Report (FY 2014-2015) .....	70
Domain: Cross-Cutting/Life Course - Plan for the Application Year (FY 2016-2017) .....	79

Other Programmatic Activities.....	86
II.F.2 MCH Workforce Development and Capacity .....	89
II.F.3 Family Consumer Partnership .....	92
II.F.4 Health Reform .....	94
II.F.5 Emerging Issues.....	96
II.F.6 Public Input placeholder .....	99
II.F.7 Technical Assistance.....	99

## I. General Requirements

### I.E Executive Summary

The services provided by California's Title V program reflect a commitment to improve the health and well-being of mothers, children, adolescents and their families by the California Department of Public Health (CDPH) Maternal, Child and Adolescent Health (MCAH) Division and the California Department of Healthcare Services (DHCS), Systems of Care Division (SCD). At the conclusion of the first year of the 2016-2020 Title V Block Grant application cycle, California refined the focus of its strategies in order to have organized, logical, evidence-based approaches that will achieve realistic and important objectives as reflected in the revised Action Plan.

During the process of selecting evidence-based or –informed strategic measures (ESMs), state performance measures (SPMs), and national performance measures (NPMs), measurement feasibility also played a role in the refinement of the Action Plans. Analysts and epidemiologists examined the logic of the proposed strategies and the surveillance capabilities in making the final selections.

For the first year of the new five-year goal period, MCAH and SCD performed mostly developmental activities to lay the groundwork for subsequent activities. These developmental activities included environmental scans to determine baseline activity, staff training in new areas such as intimate partner violence (IPV), protocol development, logic model development and review, and partnership building with stakeholders and content-area experts. In addition to the developmental activities, ongoing activities such as case management/referral and technical assistance (TA) were continued or expanded in ongoing programs such as the Preconception Health Council of California, the infant mortality Collaborative Improvement and Innovation Network (CoIIN), Black Infant Health (BIH) Program, Comprehensive Perinatal Services Program (CPSP), Adolescent Family Life Program (AFLP), developmental screening for all children including those with special health care needs, systems and environmental change initiative for obesity reduction, baby friendly hospitals for breastfeeding promotion, and referrals for care to Medi-Cal and Medi-Cal Managed Care Division (MMCD).

**Women/Maternal Health Domain:** *Highlighted Accomplishments*—MCAH engaged IPV stakeholder groups in activity planning, trained staff on One Key Question, and continued surveillance activities for maternal morbidity while planning for new Action plan activities in the upcoming year.

*Changes to the Action Plan; Highlights*—The proposed objectives were unchanged. Several strategies for addressing IPV were replaced with streamlined activities in chronological order related to policy development, technical assistance and training.

**Perinatal/Infant Health Domain:** *Highlighted Accomplishments*—MCAH received the Virginia Apgar Prematurity Campaign Leadership award for achieving an 8% decline in premature birth rates, and had 79 hospitals certified as Baby-Friendly for breastfeeding.

*Changes to the Action Plan: Highlights*—The proposed objectives were unchanged. An extraneous strategy was removed and several strategies were strengthened with active language to improve clarity and specificity.

**Child Health Domain: Highlighted Accomplishments**—MCAH conducted several training webinars for local MCAH programs and staff and revised the Scope of Work (SOW) with MCAH local health jurisdictions (LHJs) to establish protocols to increase developmental screening in children.

*Changes to the Action Plan: Highlights*—Two objectives were eliminated because of limited state staff resources to provide guidance and coordination. The limited capacity to address this domain is a key feature of the state reorganization plan and workforce development.

**Children with Special Health Care Needs Domain: Highlighted Accomplishments**—SCD performed site visits, provided oversight of the pediatric palliative care waiver, conducted a survey of the CCS administrators of Telehealth to help expand the reach of the services, and redesigned the high risk infant follow up program to align with the Quality of Care Initiative of California Perinatal Quality Care Collaborative (CPQCC) which served over 10,000 children and made almost 12,000 referrals in 2015.

*Changes to the Action Plan: Highlights*—The proposed objectives were unchanged; however, several strategies were eliminated or refined to reduce the burden to local health jurisdictions (LHJs).

**Adolescent Health Domain: Highlighted Accomplishments**—MCAH continued to monitor grantees in the Adolescent Family Life Program (AFLP) in the 30 LHJs with the highest teen births and trained 11 additional agencies to implement the positive youth development (PYD) intervention focused on youth resilience skills.

*Changes to the Action Plan: Highlights*—One of the proposed objectives was eliminated (school enrollment) and replaced with a new objective (bullying prevention). After revisiting the proposed objectives, staff determined that this was a higher priority for the LHJs and that there was stronger program infrastructure and collaborations to make it realistic and achievable.

**Cross-cutting/Life Course Domain: Highlighted Accomplishments**—

*Oral Health:* 45% of LHJs actively provided education, screenings, referrals and limited dental services for children and pregnant women.

*Insurance:* Local MCAH conducted outreach and education to encourage and facilitate enrollment in Covered California, Medi-Cal and other health insurance.

*SIDS Bereavement Support:* LHJs contacted families who experienced a sudden unexpected infant death and made referrals for grief support services.

*Mental Health:* MCAH improved linkages between other State departments to address systemic barriers and create pathways to mental health service delivery.

*Substance Abuse:* MCAH staff attended training on Screening, Brief Interventions and Referral to Treatment and partnered with a non-profit organization called, "[MotherToBaby](#)" to provide services to pregnant women.

*Nutrition and Physical Activity:* MCAH provided input into the nutrition curriculum and supportive on-line tools for the Preventive Health and Safety Practices (PHSP) training for licensed childcare facilities.

*Changes to the Action Plan: Highlights*—The proposed objectives were reduced by combining two objectives into one. The significant changes in this domain were in regards to new strategies that were more direct and specific to replace vague and repetitive strategies.

California also remains committed to developing its public health workforce through sharing best practices, staff leadership development, and continuing education opportunities on emerging topics. Through coordinated trainings, MCAH and SCD work closely to ensure that clients receive timely, appropriate, and coordinated health care and ancillary services and that MCAH strengthens the infrastructure-building and systems to increase health equity.

One of the ways California ensures its effectiveness and maximal impact is through family and consumer partnerships. Our Title V funded programs maintain working partnerships with MCHB awardees, Medi-Cal, local and state education and health and human service agencies, community based organizations, advocates, and professional/provider organizations to receive valuable input on the planning, development, implementation, and evaluation of the programs.

California continues its widespread implementation of the Patient Protection and Affordable Care Act (ACA) using the Covered California marketplace and healthcare navigators. A significant policy change in health reform is that the California Senate authorized the expansion of full-scope Medi-Cal coverage to pregnant women with incomes up to 138% of the federal poverty level (FPL), effective August 1, 2015. There are two other notable developments in health care reform in California that impact the quality of health care and convenience of access: 1) the Department of Health Care Services (DHCS) approved a new policy to increase the frequency of prenatal care from eight visits to 14, beginning January 1, 2016; 2) The California Senate also approved a measure which allows the State Board of Pharmacy to set protocols for licensed pharmacists to prescribe hormonal birth control, nicotine patches, and travel medications as well as to order toxicology screens.

Several emerging issues involved Title V programs. With increased attention to health disparities related to gender and sexual orientation, Title V program staff members are participating in training to begin to evaluate the inclusivity of our policies, services, and initiatives. National attention to Neonatal Abstinence Syndrome has increased surveillance and public health planning efforts for substance abuse and mental health. In California, the drought has necessitated emerging service planning and increased attention to threats for food security. The Zika virus, with an established link to newborn microcephaly, has elicited an increase in statewide surveillance and preventive/prophylactic health messaging.

## II. Components of the Application/Annual Report

### II.A State Overview

California is the most populous state and, in terms of total land area, the third largest state in the nation. Covering over 163,696 square miles, California is home to numerous mountain ranges, valleys, and deserts. It is located in the West Coast of the United States, bordered by Oregon to the north, Mexico to the south, Nevada and Arizona to the east, and the Pacific Ocean to the west. There are 58 counties in the state with a land area ranging from 47 square miles in San Francisco to 20,053 square miles in San Bernardino. The regions with the largest land area include Inyo, Kern, Riverside, and San Bernardino Counties. Each of these counties covers an area greater than 7,000 square miles. The smallest regions - those with less than 600 square miles of land area - include Santa Cruz, San Mateo, San Francisco, and Amador Counties. [1]

- **Population**

In 2013, California's population was estimated at 38 million people. California's population will cross the 40 million mark in 2019 and grow to nearly 52.7 million by 2060. By 2020, California will have 10 counties (Alameda, Contra Costa, Kern, Los Angeles (LA), Orange, Riverside, Sacramento, San Bernardino, San Diego, and Santa Clara) with a population of more than one million each.[2]

The population's median age will rise to 37.2 by 2020, and remain as one of the younger states in the Union for the next 20 years.[3] This may be partially due to California's role as the primary gateway state for immigration. The White population is older and is not replenished by high levels of immigrants or birth rates. The Asian population structure is older than the Hispanic population and has a lower fertility rate. However, due to higher rates of immigration from Asia than from European or other countries with a predominantly White population, it is anticipated that the Asian population will grow in numbers, but its proportion to the total population will not change.

California is diverse. Its diversity is shaped by the multitude of racial and ethnic sub-groups across the state. For example, California's Asian population, the largest in the nation, demonstrates substantial diversity. The largest Asian sub-groups in California include Chinese, Filipino, and Vietnamese. Within each Asian group is variation in language and culture. While the largest numbers of Asians reside in the large population centers of Southern California in LA, Orange, and San Diego counties, counties with the largest percentage of Asian residents are in the Bay Area counties of San Francisco, Santa Clara, Alameda and San Mateo.[4] Hispanic groups in California are predominantly Mexican, followed by other Hispanic or Latino groups from Central and South America. Due to shifts in immigration patterns, an increasing number of indigenous Mexicans have settled in California. [5] While Southern California has the largest numbers of Hispanic residents, Imperial County, at 81%, had by far the largest proportion of Hispanics in 2014. In addition, more than 50% of the population in the agricultural counties of Central California is Hispanic. [4]

Trends in the racial/ethnic composition of California's population through 2020 predict a continuing decline in the proportion of White and Black population and an increase in the Hispanic population, which will comprise 41% of the population and become the largest racial/ethnic group in California. The proportion of other racial and ethnic groups in California will remain relatively stable through 2020.[6]

California is a majority-minority state, i.e., over 50% of the population is minority. In 2014, White and Hispanic groups each comprised 39% of the population, 13% Asian, 6% Black, 3% multiple race, 0.4% American Indian/Alaska Native, and 0.4% Native Hawaiian/Pacific Islander. California ranks first in the U.S. in terms of its population size for Hispanics, Whites, and Asian/Pacific Islanders. The population size of African-Americans and American Indians/Native Americans ranks fourth and fifth, respectively. In fact, one-third of all Asian/Pacific Islanders in the U.S. live in California, and the number of Hispanics is more than the entire population in 46 states. [6]

- **Economy**

California, with 12% of the U.S. population, accounts for 13% of the nation's output. If it were a country, California would be the ninth largest economy in the world. [7]

- **Age Distribution**

The population of children 0-17 years of age is projected to increase by 5% between 2010 and 2025. In 2014, the population of children who were Hispanic was 52%, compared to 27% White, 11% Asian, and 5% Black. The proportion of children that are Hispanic will continue to increase while the proportion of White children will decrease. Children of other racial/ethnic groups will remain relatively stable.

Children 0-5 years of age are in a particularly sensitive developmental period, and experiences during this time have great influence over subsequent life course health trajectories. The population of children 0-5 years of age has increased, and is projected to reach 3.8 million by 2020. As with the overall population, the proportion of Hispanic children ages 0-5 is expected to continue to increase through 2020, while the proportion that is White is expected to continue to decline. Other racial/ethnic groups are projected to remain fairly stable through 2020. [4]

In 2013, there were 7.6 million women of reproductive age (ages 15-44) in California. The largest group was Hispanic women (44%), followed by White (33%), Asian (14%) and African American (6%). The percentage of Hispanic women is expected to continue to increase among this age group through 2020 to 46%, and the percentage of White women are expected to decline to 31%. Other groups are expected to remain somewhat stable. Of particular interest are the younger women of reproductive age who demonstrate increased risks and poorer birth outcomes compared to their older counterparts.[8], [9]

- **Immigration**

In 2013, California was home to 10.3 million immigrants or nearly 27% of its population, the largest number and percentage of foreign-born residents in the U.S. International immigration has accounted for 40% of California's population growth since 2000. Further, since 39.7% of California births are to women born outside the U.S.; the well-being of this immigrant population has a strong influence on overall MCAH status in California. The leading countries of origin for immigrants are Mexico, the Philippines and China.[10] In California, immigration status is related to childhood poverty which in turn is a strong predictor of poor health outcomes. Overall, 48% of California's children have immigrant parents; 34% have at least one legal immigrant parent and an estimated 14% have at least one undocumented immigrant parent. Among these children, 24% of children with legal immigrant parents are poor and 38% of children with undocumented immigrant parents are poor.[11] California has the largest number and proportion of undocumented immigrants of any state. Many undocumented immigrants in California

experience difficulty in meeting basic needs and accessing services, while facing additional health risks related to low wage jobs that lack protections and benefits. In 2008, approximately 2.7 million undocumented immigrants lived in California, an increase from 1.5 million in 1990.[12] In 2014, approximately 41% of California's undocumented immigrants resided in LA County.[11]

- **Languages Spoken**

Limited English proficiency poses challenges for educational achievement, employment, and accessing services, and results in lower quality care for immigrant communities--each of which influences MCAH outcomes. Among California's population over 5 years of age in 2013, 15.7 million spoke a language other than English at home and 6.8 million had limited English proficiency. More than half of residents in LA, Merced, Santa Clara, Monterey and Tulare over 5 years of age spoke a language other than English at home. [13] California's linguistic diversity requires the MCAH system to develop linguistic competence in multiple languages. Among youth in California's public schools, one in four is an English language learner who is not proficient in English. [14].

- **Education**

California's public education system is extensive. In 2011-12, there were 9,895 schools distributed in 962 school districts with 6.2 million children enrolled in the K-12 system. There were 112 community colleges in 72 districts serving 1.2 million full-time equivalent (FTE) students. The California State University has 23 campuses serving 340,000 FTE students while the University of California system has 10 campuses, five medical centers and three national laboratories serving 214,000 FTE students.

In the K-12 schools, about half of the students are from low-income families, a quarter of students are English language learners, and a tenth are in special education classes that are most commonly for learning disabilities. The primary source of revenue for schools is the State (61%), followed by local funds (27%) and federal funds (12%). Programmatic funding has declined in recent years from \$8,414 per pupil in 2008-09 to \$7,598 per pupil in 2011-12. Compared to 2007, school staffing - which includes teachers, pupil support personnel, administrators, and operational support personnel - has been reduced. Statewide K-12 enrollment is projected to grow by 1.1 percent from 2011-12 through 2020-21. [7]

In 2013, 18.3% of California residents over the age of 25 had not completed high school and 10.1% had not completed 9th grade. More than a quarter of residents 25 years of age and older in Tulare, Merced, Imperial, and Kings, Monterey, Fresno, and Kern counties did not graduate from high school.

- **Poverty**

According to the 2011-2013 American Community Survey, over six million Californians - 16.8% of the population - had incomes below 100% of the FPL, which in 2013 was \$23,550 for a family of four.

Only examining the official FPL, which has been determined using the same general framework since the mid-1960's, obscures the struggles faced by many families in California because of the high cost of living in this state. The supplemental poverty measure, which produces state level poverty rates, differs considerably from the official poverty measures. In California, the supplemental poverty rate was 23.4%, the highest in the nation.[15] The major financial stressors

for households with children are housing and child care; many of these families struggle to meet the most basic needs, cannot afford quality childcare, and have limited financial resources to address crises.[16] It is also worthwhile to note that rates of poverty and low income are higher during pregnancy than when measured among children. This means that many more infants are born into financial hardship than statistics on children indicate.[17]

Research suggests that poverty in the first few years of life may undermine brain development, adversely affect overall health status and lead to both diminished success in early elementary school and lower chance of ever completing high school. Among children under age 18, the official poverty rate is higher; 23.3% of the population is in poverty, or approximately 2.1 million children. The California poverty measure, which is more California-relevant than the Supplemental Poverty measure, estimates child poverty in the state at 24.3%. Latino (31.2%) and African-American children (33.4%) have higher poverty rates than other groups. Poverty rates are higher for children living with single mothers (45.7%) than married-couple families (15.5%) or with a single father (30%). California child poverty varies tremendously by region. It is lower in the Bay Area counties and higher in the Central Valley counties. Nearly 30% of poor children in California live in LA County [18].

- **Housing**

California's high housing costs create a burden for families, resulting in less income available for other resources needed to maintain health. Lack of affordable housing also forces families to live in conditions that negatively impact MCAH outcomes: overcrowded or substandard housing or living in close proximity to industrial areas increases exposure to toxins such as mold and lead, as well as increased stress, violence, and respiratory infections. It also exposes families to urban deserts, i.e., neighborhoods lacking sidewalks, grocery stores, and parks.[19] Even for working families, the high cost of fair market rent is out of reach. In California, on average, one wage earner working at minimum wage would have to work 120 hours per week, 52 weeks per year in order to afford a two-bedroom apartment at fair market rent.[20]

The 2007 foreclosure crisis greatly impacted California homeowner families. In 2011, California had 155,000 foreclosures, the second highest rate of foreclosures in the country. [21]Foreclosure can force families into lower quality homes and neighborhoods, lead to great financial and emotional stress, and disrupt social relationships and educational continuity.

Inability to access affordable housing leads to homelessness for some families. More than 527,000 California children were homeless in 2012-13. California is ranked 3<sup>rd</sup> in the percent of child homelessness in the United States, with only New York and Kentucky having higher rates among children. [18] Homelessness in children has been linked to behavioral health problems and negatively impacts educational progress. [22]

- **Health Insurance and Healthcare Reform**

Health insurance coverage is the gateway to accessing the healthcare system and provides financial protection from health care expenses. Lacking that stable connection may mean missing out on essential preventive services, which include up-to-date recommended health screenings. [23] In 2013, it was estimated that 17.2% of California residents were uninsured.

The major health coverage provisions of the ACA went into effect in 2013, providing new options for people who did not have insurance and sweeping new protections for those who buy health

plans on their own. California was the first state to pass legislation to create a health benefit exchange called Covered California, a quasi-governmental body that follows the "active purchaser" model of benefits exchanges. [24] The legislation also allowed California to expand its Medi-Cal program to people up to 138% of the FPL. Starting October 2013, Covered California qualified low-income individuals and families for free health insurance through Medi-Cal and moderate-income families to premium subsidies to make private health coverage affordable. It provides consumer protections set forth by the ACA including the ten Essential Health Benefits. Several provisions of ACA strengthen coordination and integration of care among health care providers by establishing Accountable Care Organizations, adoption of the Patient-centered Medical Home model of care and community-based collaborative demonstration projects.

A case study of five LHJs suggests that great strides were made at the county level toward creating integrated delivery systems for the medically underserved. These counties have the partnerships and shared commitment to create seamless systems of care. The presence of safety net collaborative and/or MMCD organizations and clinic consortia afford counties the ability to secure resources and implement integration initiatives individual stakeholders might not otherwise undertake. The analysis of the 30 safety net integration "best practices" points to several common factors for success, including leadership support at the top, shared leadership among organizations, perseverance of effort, open communications, and buy-in at all levels. [25]

Medi-Cal and Covered California created an online "one-stop shop" for health coverage. By March 2014, Covered California had nearly 1.4 million enrollees and due to Medi-Cal expansion, an additional 1.5 million new Medi-Cal enrollees. Counties with the largest proportion of enrollees in Covered California include LA (28.7%), Orange (9.4%) and San Diego (8.7%). By imputed race/ ethnicity, the total enrollment in Covered California health insurance plans is comprised of 40% White, 29% Latino, 21% Asian, 4 % Black, 3% multiracial and 2% other race. [26] More than 439,000 new enrollees had picked a health coverage plan under Covered California by February 2016 and the proportion of new consumers, ages 18-34 increased from 29% in 2014 to 37% in 2016.[27] While the percentage of overall enrollment in the four largest health insurance companies decreased, regional health plans in LA (Molina Healthcare), San Diego (Share Health Plan), San Francisco (Chinese Community Health Plan) and Sacramento (Western Health Advantage) gained substantial enrollment. This illustrates that ACA not only works for the major health care plans but underscore the critical importance of local health plans.[28]

The State Health Access Data Assistance Center developed a framework to evaluate the impact of the ACA in California. Measures on health insurance coverage, affordability, and comprehensiveness of coverage, and access to care will be used to track progress on three of the major aims of ACA. [29] Based on data collected by the National Health Interview Survey, the uninsured rate dropped from 13.1% in 2014 to 8.6% in 2015.[30]

- **Health and Human Services**

California's Executive Branch of government is organized into many departments, most of which are grouped into Cabinet-level agencies. Of the seven Cabinet-level agencies in California, major health programs are administered at the state level by the California Health and Human Services Agency. Most health programs are administered by one of the following five departments: (1) DHCS, (2) CDPH, (3) Managed Risk Medical Insurance Board (MRMIB), (4)

Department of Developmental Services (DDS) and (5) Department of State Hospitals (DSH). The 2012 Budget Act, AB 1464 (Chapter 21, Statutes of 2012), the Budget Act Trailer Bill AB 1494 (Chapter 28, Statutes of 2012), and the MRMIB/Healthy Families Clean-Up Trailer Bill AB 1468 (Ch.438, Statutes of 2012) eliminated MRMIB/Healthy Families as of January 1, 2013, and provided for the transition of existing MRMIB/Healthy Families subscribers to the Medi-Cal program where they receive full scope, no share of cost Medi-Cal benefits.

Some departments administer more than one health program. For example, DHCS administers Medi-Cal (California's version of the federal Medicaid Program) as well as California Children's Services (CCS) and other programs. CCS applies for and receives Federal Financial Participation (FFP) for the administrative case management of the program for direct and enabling services rendered to State General Fund and Medi-Cal CCS-eligible children. CDPH performs various public health functions. The actual delivery of many health services often takes place at the local level and are carried out by LHJs, and by private entities, such as commercial health plans. Exceptions to the local health delivery model include DSH (operating five state hospitals for the mentally ill) and DDS (operating four Developmental Centers (DCs) that provide developmentally disabled individuals with 24-hour care). Both the state hospitals and the DCs are staffed with state employees who directly provide services to the residents of these state institutions. [31]

On May 3, 2012, the Governor established the Let's Get Healthy California Task Force to develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity. A public-private partnership brought together 23 California leaders in health and health care, supported by 19 expert advisors. To develop a statewide culture of health, a report was developed to provide a framework for assessing Californians' health across the lifespan with a focus on healthy beginnings, living well and end-of-life. Health equity and reduction of health disparities was an underlying principle guiding the establishment of 10-year health targets.[32]

- **Public Health System**

Working with local health departments and other state agencies such as the Environmental Protection Agency and the Consumer Services Agency, CDPH is the lead state entity in California providing core public health functions and essential services. All of these operate in conjunction with federal efforts to keep communities healthy by educating them about physical and mental health and operating diverse programs that include enforcement of safety and sanitary codes and mandating reporting of certain diseases to prevent disease, injury, and disability. CDPH delegates most of this authority to local health departments. [33] CDPH is organized around categorically funded programs which provide detection, treatment, prevention and surveillance of public health and environmental issues and its roles include providing funding, oversight, and overall strategic leadership for improving public health.

MCAH, the lead entity that administers the Title V Block Grant and the California Home Visiting Program (CHVP), is housed under the Center for Family Health (CFH). CFH also oversees provision of supplemental food to women, infants, and children(WIC), genetic disease screening program; and programs directed at addressing teen pregnancy; and maternal and child health. The other Centers within CDPH include the Center for Chronic Disease Prevention and Health Promotion, providing surveillance, early detection, and prevention education related to cancer, cardiovascular diseases, diabetes, tobacco cessation, injury, and obesity; the Center for

Environmental Health, identifying and preventing foodborne illnesses and regulating the generation, handling and disposal of medical waste; the Center for Health Care Quality, licensing and inspecting healthcare facilities to ensure quality of care, inspecting laboratory facilities and licensing personnel; and the Center for Infectious Diseases, providing surveillance, health education, prevention and control of communicable diseases.

- **MCAH LHJs and local CCS Counties**

Legal authority for local public health agencies is established in the California Health and Safety Code, Chapter 2, Sections 101100 – 101115, and the California Code of Regulations, Title 17, Section 1253. Local health departments are on the front line in promoting public health and responding to health emergencies. While CDPH is responsible for most policy-making and regulatory activities, the day-to-day job of protecting the public rests with the local health agencies. [34]]

California is divided into counties which are legal subdivisions of the state, (Constitution of California, Article 11, Section 1). There are 482 cities located in 58 counties. California has 61 LHJs representing 58 counties and three incorporated cities. While there is widespread variation in providing core public health functions, all 61 LHJs provide MCH services.[35] More than half of California counties have populations of 200,000 or less, presenting unique challenges in implementing a local MCAH program. Smaller LHJs generally face staffing challenges within their MCAH program and representation in the broader community. A single staff might implement several categorical programs whereas a highly populated county assigns the responsibility for a particular program to an entire unit within its health department. Smaller counties are also challenged to maintain an adequate corps of well-trained MCAH professionals. Some LHJs have dealt with these by pooling their resources regionally. In addition to providing the basic framework to protect the health of the community through prevention programs, LHJs provide health care for the uninsured, which may include mental health and substance abuse treatment services. Given the diversity of these LHJs in size, demographics, income, and culture, tremendous diversity also exists in how LHJs organize, fund, and administer health programs.

MCAH allocates Title V funds to all 61 LHJs to enable them to perform the core public health functions to improve the health of their MCAH populations, to help create a health infrastructure where barriers to improvement are identified and lowered, where evidence-based practices and best strategies are replicated and improved, and where the public and policy makers are confident to invest additional resources. All LHJs must have an MCAH Director to oversee the local program. LHJs must also conduct a community needs assessment and identify local priorities every five years. LHJs address one or more local priorities in their annual MCAH Scope of Work (SOW).

The MCAH SOWs from the LHJs, which include Title V and state- required activities, reflect the priorities of the MCAH Division and incorporate locally identified objectives. LHJs must complete activities and develop a minimum of four health objectives for their SOW. These include access and utilization of care; improving preconception health; and two objectives related to reducing infant morbidities and mortalities; with one specific to improving safe sleep practices or reducing Sudden Unexplained Infant Deaths. LHJs have the option to include additional objectives in their SOW related to increasing the proportion of the MCAH population who maintain a healthy weight; improving the cognitive, physical, and emotional development of children; and increasing conditions in adolescents that lead to improved health. MCAH provides ongoing technical

assistance (TA) such as professional development, regular statewide meetings, and conference calls with LHJs as they implement their SOW. MCAH describes LHJs accomplishments in the Title V Annual Report and uses the data to drive state program and initiative development, and identify barriers and opportunities for improvement.

LHJs must also operate a toll-free telephone number and conduct other outreach activities to link the MCAH population to needed care and services with emphasis on children and mothers eligible for Medi-Cal. Other LHJ activities include assessment of health status indicators for the MCAH population, and community health education and promotion programs. Specific MCAH categorical programs administered by LHJs include AFLP, BIH, CPSP, the Sudden Infant Death Syndrome (SIDS) education and support services, and Fetal and Infant Mortality Review. Recent cuts in state funding for MCAH programs and the decrease in Title V Block Grant funding to the State forced some LHJs to dismantle some of their MCH public health infrastructure further, compounding the challenge for local MCH programs with little requisite capacity and resources. Monitoring emerging health threats and the ability to respond to these have diminished. The networks of relationships that local MCAH have with other agencies, hospitals, and doctors are often neglected and must be rebuilt every time there is an emergency. All that can lead to slow response times. It is the persistent resolve of local MCAH leadership and a supportive local board of supervisors that local MCAH programs are being revitalized.

MCAH provides leadership to drive program and initiative development and to address emerging issues by monitoring the health status of the MCAH population, collaborating with internal and external stakeholders such as the MCAH Directors, and partnering with other programs or state departments. MCAH also communicates regularly with MCAH Action – an organization representing all 61 MCAH Directors - to address local challenges and needs by participating on monthly leadership conference calls and providing data and program reports during in-person meetings twice a year.

CCS is administered as a partnership between 58 county health departments and DHCS. All 58 county CCS departments are funded to provide oversight and coordination of enabling services for CSHCN with CCS-eligible conditions. In counties with populations greater than 200,000, county staff perform all case management activities for eligible children residing within their county. This includes determining all phases of program eligibility, evaluating needs for specific services, determining the appropriate provider(s), and authorizing for medically necessary care.

For counties with populations under 2,000 (dependent counties), SCD provides medical case management and eligibility and benefits determination. Dependent counties interact directly with families and make decisions on financial and residential eligibility.

- **Local Healthcare and Hospital Districts**

The California Legislature enacted the Local Hospital District Law [36] in 1945 to give rural, low-income areas without ready access to hospital facilities a source of tax dollars that can be used to construct and operate community hospitals and healthcare institutions, and to recruit and retain physicians and support their practices in these areas. These districts are independent from city and county governments and support a wide range of community-based health and wellness facilities and activities. Seventy-three health care districts with 43 operating hospitals in 40 counties [37] have been formed and operate 52 public hospitals or health facilities that provide a significant portion of medical care to minority populations and the uninsured in

medically underserved communities. A few districts provide health-related services such as providing grants to healthcare organizations that serve specific needs of the community. The services place great emphasis on community health and wellness programs designed to prevent or postpone acute hospital care.[38]

## **II.B Five Year Needs Assessment Summary**

### **II.B.1 Action Plan Process**

The initial Action Plan submitted by MCAH was revisited to re-assess the feasibility of the proposed programmatic approaches. MCAH staff members with expertise in each population domain were assigned to create a logic model to deconstruct the objectives and strategies to ensure that they were plausible, sequential, and complete. The design of the logic model template encouraged team members to proceed with this effort by adopting a sequential examination of the linkage between the strategies, activities, and expected outcomes. Teams also assessed the internal organizational capacity to complete the proposed work between 2016 and 2020. As a result, several key strategies required modification or deletion. The logic model was used as a framework to better identify our evidence-based strategic measures (ESM) and SPMs, and incorporate these measures into the final Action Plan which will then be linked to the national performance measures (NPM) and national outcome measures (NOM).

### **State MCAH Division Reassessment Impact**

MCAH is in the preliminary phase of a reorganization in which an external team has been hired to assist MCAH Leadership to identify and assess the Division's core functions, tasks, and identify resources and staffing gaps based on programmatic need, propose new staff positions, and place new and existing staff into new functional teams.

## **II.B.2 Findings**

### *Domain: Women/Maternal Health*

**Goal 1: Decrease Intimate Partner Violence (IPV)** – For Specific Measureable, Attainable, Realistic and Time-Bound (SMART) Objective 1, the objective was updated to reflect the adoption of an IPV protocol rather than an IPV policy. A protocol is defined as a description of procedures to address IPV. The updated objective states, By June 30, 2020, increase the number/percent of Title V funded programs (i.e., AFLP, BIH and LHJs MCAH Programs) who adopt MCAH's IPV protocol, including reproductive and sexual coercion from 40% to 60% (2013/14 MCAH Annual Reports).

Six of the original seven key strategies were eliminated and the one remaining strategy was slightly modified to be in step with the theme of the three newly created key strategies. All of the strategies are now more consistently linked and chronologically presented with an emphasis focused upon TA, training, collaboration, and evaluation of activities directed toward establishing viable and effective IPV policies. The strategies are appropriately reclassified as activities along the causal pathway from the strategy to the outcome.

**Goal 2: Decrease Unintended Pregnancy** -There were no significant changes with the strategies in SMART Objective 2 other than identifying the specific resource that we will encourage health care providers to use, the National Preconception Curriculum and resources Guide for Clinicians training module 4 "In Between Time: Interconception Health Care-Part 1: Routine Postpartum Care for Every

Woman.”

**Goal 3: Decrease Burden of Chronic Disease** - There is only one change in SMART Objective 3. The change was moving the key strategy “to increase regular well-women visits among women of reproductive age” to the more appropriate Cross-cutting/ Life Course section domain.

**Domain: Perinatal/Infant Health**

**Goal 1: Reduce Pre-Term Births and Infant Mortality** – For SMART Objective 1, one key strategy was deleted - Develop a plan to ensure coordination of existing perinatal program efforts and avoid duplication of services. The team deemed it unnecessary because accomplishing other key strategies within the domain would achieve this indirectly in the process. Another key strategy was modified to better convey the nature of the collaboration between local MCAH programs and the RPPC. The focus of the strategy changed from requiring MCAH to establish a relationship with these programs to specifying that MCAH will facilitate the coordination of activities and linkage of services with these programs as a quality improvement effort to prevent preterm births.

**Goal 2: Increase Breastfeeding Initiation and Duration** - SMART Objective 2.2 was strengthened and modified for each of the six key strategies by being more specific in the use of the action verbs (e.g., encourage, support, provide). This eliminated the vagueness of the key strategy by clearly defining the MCAH entities directly related to the action verbs. Although not noted in the Action Plan, the corresponding Logic Model for this strategy identified the target population. The first key strategy was also modified to define MCAH as the entity responsible for conducting surveillance and evaluation on breastfeeding and data sharing with local MCAH programs.

**Domain: Child Health**

The proposed original Priority 3, SMART Objectives 1 and 2 were eliminated. Based on the logic model for these two objectives, the key activities listed for each of the strategies required necessary resources to conduct the specified activities. It was determined there are not enough staff and resources to conduct the activities. The review team concluded that the outlined key strategies relating to assistance, collaboration, and policy development were unlikely to reduce cases of child abuse. Additionally, it would be difficult to develop new and achievable strategies that would accomplish the SMART Objective without adding more responsibilities for the LHJs; many of which have small staff.

**Deleted Objectives:** SMART Objective 1: By June 30, 2020, reduce motor vehicle injury hospitalizations from 11.1 per 100,000 (2103 OSHPD PDD) to 10.6 per 100,000 for children ages 0-5.

SMART Objective 2: By June 30, 2020, reduce substantiated child abuse from 13.0 per thousand for children 0 to 5 years of age (2013 Child Welfare Dynamic Support System CWDRS) to 12.3 per thousand.

**Goal 1: Provide Developmental Screening for all Children:** For readability and flow, this SMART Objective has been renumbered to SMART Objective 1. In Priority 3 SMART Objective 3, the corrected objective proposes an increase from 28.5 to 29.5% not 38.6 to 40.5%. The team used many quantitative process measures for the Intermediate and Long-term Outcomes within our Logic Model and identified the corresponding NPM (6).

## *Domain: Children with Special Health Care Needs*

Three of the six strategies were eliminated to reduce local responsibilities.

**Goal 1: Increase systems that support CYSHCN** - While SMART Objective 1 remained the same, Strategy 1 changed by defining how access to a yearly medical visit would be better assured by identifying promising practices which would increase utilization. Key Strategy 2 remained the same but was streamlined by removing specific resources that would identify the needs of CYSHCN.

## *Domain: Adolescent Health*

**Goal 1: Decrease Adolescent Pregnancies** -There were no major revisions to SMART Objective 1 to decrease adolescent pregnancies. However, key strategy 7 was eliminated – “Develop tools and standards to incorporate PYD principles, resiliency framework and training on healthy coping skills in program implementation and materials.”

**Goal 2: Build Youth Resiliency and Coping Skills to Reduce Bullying.** The original SMART Objective 2 was eliminated which states, “By June 30, 2020, increase the rate of AFLP clients enrolled in school from 77.6 percent (2015 AFLP MIS) to 81.5 percent.”

A new SMART Objective 2 was proposed: “By June 30, 2020, promote development of healthy coping skills as indicated by a 10% decrease in the percent of youth (11th graders) who report experiencing bullying for any reason from 27.6% in 2013 to 24.8%. The primary reason for the change in the SMART Objective was the MCAH local needs assessments supported bullying as a focus area. In addition, the requirement of HRSA to have at least one NPM from each of the six population domains; thus NPM # 9, related to bullying, was selected as the NPM for this domain. Key strategies identified to address the new objective include expanding the PYD framework throughout adolescent health programs in California. Incorporating the PYD/Resiliency framework through the standardization and integration of PYD principles and strategies into the AFLP programs will build youth resilience in areas of social competence and promote healthy relationships. Training AFLP and other Title V funded program staff will improve the implementation of the program elements with fidelity to the evidence-based model.

## *Domain: Cross-cutting/Life Course*

This domain underwent significant revisions of its key strategies by inserting more directed strategies, specific to the SMART Objectives, to eliminate or replace vague and repetitive strategies.

**Goal 1: Increase Access to Oral Health:** The original SMART Objective 8 under this Domain, “By June 30, 2020, increase the rate of children ages 3-11 years with a dental visit in the last year from 75.3 percent (2011/12) to 79.1 percent.” moved under Goal 1 since the objective aligns to strategies related to access to oral health.

**Goal 2: Increase Utilization of Preventive Health Services Among Women of Reproductive Age:** Two key strategies were added which supported activities related to increase use and utilization. Participation in collaborative meetings with DHCS to plan effective activities to improve access to insurance coverage and referral to ancillary health care and public health services and to

“Collaborate with LHJs and MCAH programs to implement effective ways of communicating new policies regarding health care access and services”.

**Goal 3: Increase Utilization of Preventive Health Services among Children:** Two of the original key strategies were eliminated and replaced with two new key strategies to better align activities associated with local efforts. The new strategies include, “Develop a policy and procedure for local MCAH” and “Collaborate with LHJs and MCAH program to implement effective ways of communicating policies regarding access and services.”

**Goal 4: Increase Rates of Women, Children, and Adolescents Who Have Health Insurance:** One original strategy was eliminated. Three new strategies were added that better aligned with activities associated with increasing rates of health insurance coverage.

**Goal 5: Decrease Rate of Postpartum Women Without Health Insurance:** no changes

**Goal 6: Increase Brief/Bereavement Support Services to Parents/Caregivers of all Babies who Die Suddenly and Unexpectedly:** no changes

**Goal 7: Increase Screening and Referral for Mental Health and Substance Use Services:** The Action Plan was revised to improve alignment and key strategies 4 and 5 were eliminated. Strategy 4 emphasized partnering with the CHVP, the CHVP State Interagency Team Workgroup, and Early Childhood Comprehensive Systems (EECS) to identify and address service gaps. The rationale for eliminating this strategy was that it would be included as an activity in the new strategy related to developing and implementing an evidence-based Maternal Mental Health and wellness toolkit. Strategy 5 was the provision of TA to LHJs. This key strategy was replaced by a new strategy related to increasing awareness of maternal mental health through the development of a health and wellness conceptual model for local MCAH Title V programs and the CHVP.

**Goal 8: Increase Consumption of a Healthy Diet with the MCAH Population.**

The SMART objectives in priority 8 were refined to focus on specific core program goals; the first objective involved a focused effort on promoting appropriate weight gain among pregnant women. The seven original strategies were streamlined into two specific strategies: building and sustaining partnerships and promoting culturally responsive programming using recommended best practices and national guidelines.

**Goal 9: Increase Physical Activity within the MCAH Population:** The SMART objectives in priority 8 were refined to focus on specific core program goals; the first objective involved a focused effort on promoting appropriate weight gain among pregnant women. The seven original strategies were streamlined to two specific strategies: building and sustaining partnerships and promoting culturally responsive programming using recommended best practices and national guidelines.

**Goal 10: Increase Consumption of Folic Acid by Childbearing Age Women:** SMART objective 4 remained the same but the strategy was reworded for clarity and conciseness.

## II.C State Selected Priorities

California's priority needs list for 2016-2020 is a continuation of the priority needs list identified for the 2011 to 2015 reporting period. Unlike in the 2011-2015 period, strategies to address each priority need were not included in the 2016-2020 priority statements and instead, specific objectives and strategies to address each goal were stated in the action plan.

A crosswalk between the 2011-2015 and 2016-2020 priority statements is shown in the table below, including an explanation on why these are considered a continuation of the 2011-2015 priority statements.

<b>2016-2020 PRIORITY NEEDS</b>	<b>Closely related 2011-2015 PRIORITY NEEDS</b>	<b>New(N), Replaced (R) or Continued (C) for 2016-20</b>
<b>Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age</b>	2011 Priority 4. Improve maternal health by optimizing the health and well-being of girls and women across the life course.	C- Closely related to the 2011-2015 priority statements 4, 6 and 7; the current priority is on improving women's health in general with emphasis on primary prevention particularly for women of reproductive age.
	2011 Priority 6. Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes.	
	2011 Priority 7. Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight (LBW)/prematurity, SIDS, and maternal complications in pregnancy.	
<b>Priority 2: Reduce infant morbidity and mortality</b>	2011 Priority 7. Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, LBW/prematurity, SIDS, and maternal complications in pregnancy.	C- Closely related to the 2011-2015 priority statement 7; priority need for infant health has been expanded to include strategies to address infant morbidities.

<b>2016-2020 PRIORITY NEEDS</b>	<b>Closely related 2011-2015 PRIORITY NEEDS</b>	<b>New(N), Replaced (R) or Continued (C) for 2016-20</b>
<b>Priority 3: Improve the cognitive, physical, and emotional development of all children</b>	2011 Priority 8. Support the physical, socio- emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification, and intervention strategies.	C- Closely related to the 2011-2015 priority statement 8; priority needs and strategies to address this priority are carried forward for 2016-2020.
<b>Priority 4: Provide high quality care to all CYSHCN within an organized care delivery system</b>	<p>2011 Priority 1. Modify the California Children’s Services (CCS) program, with appropriate funding, to cover the whole child</p> <p>2011 Priority 3. CCS will work with appropriate partners to define and create and implement standards for Medical Homes for CCS children.</p>	C- Closely related to the 2011-2015 priority statements 1 and 3;
<b>Priority 5: Increase access to CCS-paneled providers such that each child has timely access to a qualified provider of medically necessary care</b>	2011 Priority 2. Expand the number of qualified providers of all types in the CCS program.	C- Closely related to the 2011-2015 priority statements 2 and 3; problem need is to address access to care for CYSHCN.
<b>Priority 6: Increase conditions in adolescents that lead to improved adolescent health</b>	2011 Priority 9. Promote positive youth development strategies to support the physical, mental, sexual, and reproductive health of adolescents.	C- Closely related to the 2011-2015 priority statements 9; problem need to address adolescent physical, mental, and sexual health is carried forward for 2016-20.

<b>2016-2020 PRIORITY NEEDS</b>	<b>Closely related 2011-2015 PRIORITY NEEDS</b>	<b>New(N), Replaced (R) or Continued (C) for 2016-20</b>
<b><i>Priority 7: Increase access and utilization of health and social services</i></b>	2011 Priority 10. Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.	C- Closely related to the 2011-2015 priority statement 10; strategies developed in 2011-2015 will continue through 2016-2020.
<b><i>Priority 8: Increase the proportion of children, adolescents, and women of reproductive age who maintain a healthy diet and a physically active lifestyle.</i></b>	2011 Priority 5. Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age	C- Closely related to the 2011-2015 priority statement 5; strategies developed in 2011-2015 will continue through 2016-2020.

## II.D Linkage of State Selected Priorities with National Performance and Outcome Measures

The Guidance recommends that grantees select national performance measures where there is anticipated improvement in the baseline rate. The selection of eight of the 15 national performance measures (NPMs) for programmatic focus was informed by the programmatic objectives and strategies identified for each of the 2016- 2020 priority needs. Each of the six population domains have one or more corresponding NPMs selected. California maintained the eight NPMs that were selected last year.

The specificity of the performance measure definition as it applies to the objectives and strategies for each priority need were given primary consideration in the selection of the eight NPMs, as these are most amenable to change. Since the data will be generated by the Maternal Child Health Bureau (MCHB) and shared with grantees, less consideration was given to the data source for the NPMs and their inherent limitations such as the precision and accuracy of the estimates generated, frequency of the data collection and reporting, its proxy power to say something important about a particular health issue, its ability to speak to a broad and diverse audience about a result MCHB wants to collectively achieve and its ability to motivate the MCAH community to action. It is assumed that these criteria were vetted when MCHB pared down the list to 15 NPMs from which grantees were to select from.

The eight national performance measures selected by California by population domain include the following:

CA Priority	National Performance Measure	MCH Population Domain
<b>Priority 7: Increase access and utilization of health and social services</b>	NPM 1-Percent of women with a past year preventive medical visit	Women/ Maternal Health
<b>Priority 2: Reduce infant morbidity and mortality</b>	NPM 3-Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	Perinatal/ Infant Health
<b>Priority 2: Reduce infant morbidity and mortality</b>	NPM-4 A) Percent of infants who are ever breastfed  NPM-4 B) Percent of infants breastfed exclusively through 6 months	Perinatal/ Infant Health
<b>Priority 3: Improve the cognitive, physical, and emotional development of all children, including children with special health care needs</b>	NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	Child Health
<b>Priority 6: Increase conditions in adolescents that lead to improved adolescent health.</b>	NPM 9-Percent of adolescents, ages 12 through 17, who are bullied or who bully others	Adolescent Health
<b>Priority 4: Provide high quality care to all CYSHCN within an organized care delivery system.</b>	NPM 11-Percent of children with and without special health care needs having a medical home	Children with Special Healthcare Needs
<b>Priority 5: Increase access to CCS paneled providers such that each child has timely access to a qualified</b>	NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care	Children with Special Healthcare Needs

<b>provider of medically necessary care.</b>		
<b>Priority 7: Increase access and utilization of health and social services</b>	NPM 15-Percent of children ages 0 through 17 who are adequately insured	Cross-cutting/ Life Course

For the Maternal/Women’s Health domain, one of our goals is to increase use of preventive health services among women of reproductive age. NPM 1, the percent of women with a past year preventive medical visit was selected as a performance measure.

For the Perinatal/ Infant Health domain, one goal is to improve access to enhanced perinatal services. To address this, strategies were identified in the action plan related to improving access to NICU services. Since very low birthweight (VLBW) infants account for 53% of infant deaths, NPM 3, the percent of VLBW infants born in a hospital with a Level III+ NICU, was selected as a performance measure since VLBW infants are less likely to die if they are born/cared for in a sub-specialty facility that is appropriately staffed and equipped and with a high volume of high-risk admissions. NPM 4a, the percent of infants who were ever breastfed and NPM 4b, the percent of infants breastfed exclusively through 6 months of age were selected performance measures for our objective to increase breastfeeding initiation, duration and exclusivity.

For the Child Health domain, one of our goals is to provide developmental screening for all children. Developmental screening is designed to identify problems or delays during normal childhood development. When properly applied, screening tests for developmental or behavioral problems in preschool children allow improved outcomes due to early implementation of treatment. NPM 6, the percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool was thus selected as a performance measure.

For the CSHCN domain, the first priority need is to provide a whole child approach to CSHCN services encompassing an organized system of care, medical home and transition. This priority is related to NPM 11, the percent of children with and without special health care needs having a medical home, and NPM 12, the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care. The second CSHCN priority relates to improving access to medically necessary services. This relates most closely to NPM 11, having a medical home.

For the Adolescent Health domain, one of our goals is to reduce teen dating violence, bullying and harassment. Healthy relationships consist of trust, honesty, respect, equality, and compromise. Any violence in the form of bullying, harassment or dating violence in adolescence can negatively influence the development of healthy sexuality, intimacy and identity as a youth grows into adulthood and can increase the risk of physical injury, poor academic performance, binge drinking, suicide attempts, unhealthy sexual behaviors, substance use, negative body image and self-esteem and violence in future relationships. NPM 9, the percent of adolescents, ages 12 through 17 years, who are bullied or bully others was selected as a performance measure.

For the Cross-cutting/ Life course domain, one objective was to increase access to preventive health services. Having health insurance coverage is the gateway to having access to a regular source of care and timely and less costly medical services. NPM 15, the percent of children 0 through 17 years who are adequately insured was selected as a performance measure for this domain.

## **II.E Linkage of State Selected Priorities with SPMs and SOMs**

Sensible SPMs help our partners and stakeholders understand what is important, establish expectations in measurable terms, collect data on progress, make decisions with the collected information and adjust course when necessary. The three SPMs selected to complement the eight national performance measures and their related evidence-based or –informed strategic measures (ESMs) in this report include the following and are a restatement or variation of the SMART objectives identified in the Action Plan:

1) SPM 1. Percent of mistimed or unwanted pregnancy among women of reproductive age.

This is a slight variation of the Action Plan’s Priority 1, SMART Obj. 2: “By June 30, 2020, California will reduce the prevalence of mistimed or unwanted pregnancy among Black and Latina women with live births from 45.4% and 38.2% (2012 MIHA) to 43.4% and 37.1%, respectively.”)

2) SPM 2. Percent of births among adolescents, ages 15-17 years.

This is a slight variation of the Action Plan’s Priority 6, SMART Obj. 1: “By June 30, 2020, decrease the adolescent birth rate from 23.2 per 1000 females, 15-19 years of age (2013 BSMF) to 19.8 per 1000.

3) SPM 3. Percent of women with the recommended weight gain during pregnancy.

This is a restatement of the Action Plan’s Priority 8, SMART Obj. 2” By June 30, 2020, increase the percent of women with recommended weight gain during pregnancy from 34.3% (2013 BSMF) to 36.1.

Careful consideration of incorporating the life course approach was used in selecting the SPMs. Beyond measuring disease risk or conditions, these new SPMs, cut across critical periods of development over the life course and may influence the capacity of the population to reach its full developmental potential. The detail sheets (Form 10 B) further emphasize the influence of these SPMs on health pathways or health trajectories, their impact on individual health and economic opportunities within and across generations and their value for communities.

Selection criteria for SPMs included availability of accurate data, sufficient sample size, consistent data collection methodology over time, comparability to national data or benchmarks, relevance to program planning and monitoring, and stakeholder buy-in.

## II.F Five Year State Action Plan

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Women/ Maternal Health</b>				
<b>Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.</b>				
<p>1. By June 30, 2020, increase the number of Title V funded programs (i.e., AFLP, BIH and MCAH local health jurisdictions [LHJs]) who adopt MCAH's intimate partner violence (IPV) protocol, including reproductive and sexual coercion from 40% to 60% (2013/14 MCAH Annual Reports).</p>	<p>1. Develop and provide capacity building tools for the integration of MCAH's IPV Protocol among Title V funded programs (i.e., AFLP, BIH and MCAH LHJs).</p> <p>2. Identify, develop and implement culturally congruent trainings, technical assistance and education for implementation and sustainability of MCAH's IPV protocol.</p> <p>3. Develop and implement IPV Initiative Performance and Quality Improvement (PQI) tools to evaluate the effectiveness of MCAH's IPV protocol and related activities.</p> <p>4. Build and sustain collaborations and share practices with internal and external partners to support IPV and related efforts.</p>			
<p>2. By June 30, 2020, California will reduce the prevalence of mistimed or unwanted</p>	<p>1. Broadly disseminate the concept of a Reproductive Life Plan by developing or disseminating culturally and linguistically appropriate tools for integration into existing MCAH programs and</p>		<p>SPM 1: Percent of mistimed or unwanted pregnancy among women of reproductive age.</p>	<p>Severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>Maternal mortality rate per 100,000 live births</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Women/ Maternal Health</b>				
<b>Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.</b>				
<p>pregnancy among Black and Latina women with live births from 45.4% and 38.2% (2012 MIHA) to 43.4% and 37.1%, respectively.</p>	<p>public health departments.</p> <ol style="list-style-type: none"> <li>2. Integrate One Key Question (OKQ) into Title V programs and partner programs to promote appropriate contraception counseling to match pregnancy desire and timing.</li> <li>3. Standardize the content of the postpartum visit by collaborating with existing partners such as Medi-Cal Managed Care Plans and each LHJ's Perinatal Service Coordinator to use the National Preconception Curriculum &amp; Resources Guide for Clinicians training module 4 "In Between Time: Interconception Health Care Part 1: Routine Postpartum Care for Every Woman."</li> <li>4. Promote through collaboration with existing partners such as Medi-Cal Managed Care Plans and each LHJs Perinatal Service Coordinator the importance of attending the postpartum visit to patients during prenatal care and labor/delivery.</li> </ol>			<p>Low birth weight rate (%)</p> <p>Very low birth weight rate (%)</p> <p>Moderately low birth weight rate (%)</p> <p>Preterm birth rate (%)</p> <p>Early preterm birth rate (%)</p> <p>Late preterm birth rate (%)</p> <p>Early term birth rate (%)</p> <p>Infant mortality per 1,000 live births</p> <p>Perinatal mortality per 1,000 live births plus fetal deaths</p> <p>Neonatal mortality per 1,000 live births</p> <p>Post neonatal mortality rate per 1,000 live births</p> <p>Preterm-related mortality per 100,000 live births</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Women/ Maternal Health</b>				
<b>Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.</b>				
<p>3. By June 30, 2020, MCAH will work with partners to reduce prevalence of hypertension, diabetes, cardiovascular disease and mental illness among women at labor and delivery from 8.0%, 10.0%, 0.54% and 4.4% (2013 OSHPD PDD) to 7.4, 9.5%, 0.51% and 3.9% respectively.</p>	<ol style="list-style-type: none"> <li>1. Partner with disease-specific organizations to target prevention outreach to women of reproductive age for cardiovascular disease, hypertension, diabetes, and mental illness to ensure prevention strategies are culturally, linguistically, and age appropriate and match literacy level.</li> <li>2. Partner with Office of Health Equity, HiAP Taskforce to develop policies and initiatives to address community risk factors for chronic disease (e.g. healthy food availability, built environment, community safety, and ensure applicability to women of reproductive age.</li> <li>3. Disseminate the National Preconception Curriculum &amp; Resources Guide for Clinicians training module 5 and the Interconception Care Project of California materials to health care providers to ensure women with risk factors receive appropriate interconception and follow up</li> </ol>			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Women/ Maternal Health</b>				
<b>Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.</b>				
	care.  4. Ensure that existing MCAH tobacco prevention and data collection for smoking as a risk factor for chronic disease include the appropriate references to e-cigarettes.			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Perinatal/ Infant Health</b>				
<b>Priority 2: Reduce infant morbidity and mortality</b>				
1. By June 30, 2020, decrease the percentage of preterm births, less than 37 completed gestational weeks, from 8.8% (2013 BSMF) to 8.3%.	1. Define new and existing partnerships with state and local agencies, community-based organizations, academia, provider networks and hospitals to maximize resource capacity in addressing preterm birth reduction.  2. Facilitate the coordination of perinatal activities between MCAH LHJs and the Regional Perinatal Programs of California by supporting the local perinatal advisory councils to provide regional planning, coordination and recommendations to ensure	ESM 3.1 Percent of facilities with a plan for transport out of complicated obstetric/ maternal patients.	NPM # 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU	Infant mortality per 1,000 live births  Perinatal mortality per 1,000 live births plus fetal deaths  Neonatal mortality per 1,000 live births

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Perinatal/ Infant Health</b>				
<b>Priority 2: Reduce infant morbidity and mortality</b>				
	<p>appropriate levels of care are available and accessible to high risk pregnant women and their infants; conducting regional hospital assessments and providing technical assistance; developing a communication network among agencies, providers and individuals; disseminating educational materials and providing resource directories and referral services.</p> <p>3. Co-lead the California Prematurity Leadership Council and integrate prematurity prevention strategies that are recommended into relevant MCAH program curricula and activities with a focus on reduction of preterm births in the African-American population.</p> <p>4. Assist local agencies/partners in developing materials to educate pregnant women/women of reproductive age on the signs and symptoms of preterm labor.</p>			
1. By June 30, 2020, increase the percentage	1. Conduct surveillance and evaluation of breastfeeding outcomes, including	ESM 4.1: Percent of births that occur in facilities that provide recommended care for	NPM #4A: Percent of infants who are ever breastfed	<p>Infant mortality rate per 1,000 live births</p> <p>Post neonatal mortality rate</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Perinatal/ Infant Health</b>				
<b>Priority 2: Reduce infant morbidity and mortality</b>				
<p>of women who report exclusive breastfeeding at 3 months from 26% (2012 MIHA) to 27.2% and reduce racial /ethnic disparities.</p>	<p>measurement of trends and disparities in breastfeeding initiation, duration and exclusivity, and the quality of maternity care related to breastfeeding.</p> <ol style="list-style-type: none"> <li>Promote culturally congruent breastfeeding best practices by providing education, resources and technical assistance to funded MCAH programs and partners for the promotion of environmental change practices and programmatic policies.</li> <li>Build and sustain partnerships and collaborations with national, state and local partners to promote breastfeeding.</li> </ol>	<p>lactating mothers and their babies.</p>	<p>NPM #4B: Percent of infants breastfed exclusively through 6 mos.</p>	<p>per 1,000 live births</p> <p>Sleep-related SUID per 100,000 live births</p>
<p>2. By June 30, 2020, reduce the rate of Sudden Unexpected Infant Deaths (SUIDS) from 54.4 per 100,000 live births (2013 BSMF) to 50.3 per 100,000.</p>	<ol style="list-style-type: none"> <li>Provide the latest American Academy of Pediatrics (AAP) guidelines on infant safe sleep practices/Sudden Infant Death Syndrome (SIDS) risk reduction through two SIDS trainings each year, and the Annual SIDS Conference for SIDS coordinators, public health professionals, and emergency personnel.</li> </ol>			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Perinatal/ Infant Health</b>				
<b>Priority 2: Reduce infant morbidity and mortality</b>				
	<p>2. Update SIDS curriculum to include current recommendations on infant safe sleep practices, SIDS risk reduction for hospital staff, and childcare provider training sessions.</p> <p>3. Disseminate to LHJs the latest infant safe sleep practices, SIDS risk reduction health education materials, messages to outreach and engage parents of infants regarding safe sleep practices</p>			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Child Health</b>				
<b>Priority 3: Improve the cognitive, physical and emotional development of all children</b>				
<p>1. By June 30, 2020, increase the rate of children ages 10 months to 5 yrs. screened for being at risk for developmental, behavioral and social delay, using a parent-completed standardized developmental behavioral screening tool during a healthcare visit from 28.5 percent (2010/11 NSCH) to 29.5 percent.</p>	<ol style="list-style-type: none"> <li>1. Collaborate with relevant partners to develop goals, objectives, and activities to improve rates of behavioral, social, and developmental screening and linkage to needed services for all children and youth; especially children ages 10-60 months and at-risk populations.</li> <li>2. Provide technical assistance to MCAH programs to promote the use of Birth to 5: Watch Me Thrive! or other appropriate materials and support MCAH LHJs to develop protocols and pathways to refer children needing services to evidence-based screening and referral systems to ensure children and youth with special health care needs (CYSHCN) are identified early and connected to needed and ongoing services.</li> <li>3. Assist MCAH LHJs to develop and adopt policies to provide developmental screening, referral and appropriate linkages for all children and youth in MCAH programs using a parent-completed screening tool or other</li> </ol>	<p>ESM 6.1: No. of LHJs that implement at least two core components of the Help Me Grow System that connects at-risk-children for developmental and behavioral problems with services they need.</p>	<p>NPM 6: Percent of children, ages 9 months through 71 months, receiving a developmental screening using a parent-completed screening tool.</p>	<p>Percent of children in excellent or very good health</p> <p>Percent of children meeting the criteria developed for school readiness</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Child Health</b>				
<b>Priority 3: Improve the cognitive, physical and emotional development of all children</b>				
	validated tool; provide technical assistance to incorporate quality assurance and quality improvement plans into policies and tools.			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: CSHCN Health</b>				
<b>Priority 4: Provide high quality care to all CYSHCN within an organized care delivery system.</b>				
1. By June 30, 2020, increase the children enrolled in the California Children's Services (CCS) who receive primary and specialty care through a single system of care by 20%.	<ol style="list-style-type: none"> <li>Through the CCS Advisory Group stakeholder process, refine the selected whole child approach to optimize access to qualified providers.</li> <li>Develop a methodology to track the number of clients receiving whole child care through CMS Net and/or other DHCS data source.</li> <li>Conduct surveys of CCS families and providers to assess satisfaction with organized care delivery system.</li> </ol>			
2. By June 30, 2020 increase the number of	1. With CCS advisory group, review existing national, state, and local medical home models and tools			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: CSHCN Health</b>				
<b>Priority 4: Provide high quality care to all CYSHCN within an organized care delivery system.</b>				
<p>CSHCN who receive care within a medical home by 20%, as measured by the medical home CCS performance measure.</p>	<p>and identify best methods for CCS to promote medical homes for CSHCN.</p> <ol style="list-style-type: none"> <li>2. Explore integration of ACA health home concept with the medical home concept.</li> <li>3. Develop and disseminate materials to facilitate medical home implementation of tools that promote medical homes including medical home binders and medical home standards.</li> <li>4. Identify the number of counties with family advisory council parent health liaison family-centered care workgroup or other role supporting CSHCN including CCS.</li> </ol>			
<p>3. By June 30, 2020, increase by 20% the number of 20 year old CCS clients with selected conditions* who report having an identified adult</p>	<ol style="list-style-type: none"> <li>1. Explore current CCS transition practices including transition fair, parent liaisons, and the Redesign State Advisory Board transition workgroup findings.</li> <li>2. Increase the number of family members providing input into state and local transition practices.</li> </ol>	<p>ESM 12.1 To be determined</p>	<p>NPM 12: Percent of children with and without special health care needs who received services necessary to make transitions to adult health care</p>	<p>Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: CSHCN Health</b>				
<b>Priority 4: Provide high quality care to all CYSHCN within an organized care delivery system.</b>				
<p>subspecialist to assume specialty care.</p> <p>*congenital heart disease, cystic fibrosis, respiratory failure, T1 DM, hemophilia, ALL, sickle cell disease, cerebral palsy, s/p organ transplant.</p>	<p>3. With CCS Advisory Group, review options for CCS clients to have a visit with an adult physician through managed care.</p>			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: CSHCN Health</b>				
<b>Priority 5: Increase access to CCS-paneled providers such that each child has timely access to medically necessary care by a qualified provider.</b>				
<p>1. By June 30, 2020, increase the percent of CCS families reporting that their child always saw a specialist when needed from 72% to 90%, based on CCS/FHOP survey.</p>	<p>1. With CCS AG, explore strategies to increase access to CCS-paneled providers, with focus on rural areas, including streamlining process and developing reports of shortage areas.</p> <p>2. Based on the findings of the Title V needs assessment, define issues associated with non-participation in CCS of durable medical equipment, , pharmacy, home health and behavioral health providers, and explore methods to increase their participation in CCS.</p> <p>3. Review the criteria for providers to be CCS-paneled with the goal of increasing numbers of paneled providers while maintaining quality standards.</p>		<p>NPM 11: Percent of children with and without special health care needs having a medical home</p>	<p>Percent of CSHCN receiving care in a well-functioning system</p> <p>Percent of children in excellent or very good health</p> <p>Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1 :4 combined series of routine vaccinations</p> <p>Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza</p> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</p> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</p> <p>Percent of adolescents, ages 13 through 17, who</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: CSHCN Health</b>				
<b>Priority 5: Increase access to CCS-paneled providers such that each child has timely access to medically necessary care by a qualified provider.</b>				
				have received at least one dose of the meningococcal conjugate vaccine
2. By June 30, 2020, raise by 20% the number of Special Care Centers reporting telehealth services to improve access for underserved CSHCN.	<ol style="list-style-type: none"> <li>1. Develop a system within CMS Net or Medi-Cal to track use of telehealth services for CCS clients.</li> <li>2. Establish CCS telehealth workgroup with stakeholders including families, to build upon previous work assisting DHCS in telehealth implementation.</li> <li>3. With workgroup, assess current challenges and opportunities to expand use of telehealth for CSHCN.</li> <li>4. Conduct survey of CCS families and providers to assess perceived access to medically necessary care.</li> </ol>			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Adolescent Health</b>				
<b>Priority 6: Increase conditions in adolescents that lead to improved adolescent health.</b>				
<p>1. By June 30, 2020, decrease the adolescent birth rate from 23.2 per 1000 females, 15-19 years of age (2013 BSMF), to 19.8 per 1000.</p>	<ol style="list-style-type: none"> <li>1. Target all MCAH adolescent sexual health programs to high need and/or historically underserved populations to reduce disparities.</li> <li>2. Implement evidence-based or evidence-informed interventions in all MCAH funded adolescent sexual health programs aimed at educating adolescents on preventing pregnancy and sexually transmitted infections (STIs) including HIV.</li> <li>3. Educate adolescents in all MCAH-funded adolescent health programs regarding the use of long-acting reversible contraceptives (LARCs), condoms and other birth control methods.</li> <li>4. Provide adolescents participating in MCAH- funded adolescent sexual health programs information on and/or linkages to reproductive health services that are affordable, accessible, confidential, and youth-friendly.</li> <li>5. Identify gaps in the availability of youth-friendly reproductive health</li> </ol>		<p>SPM 2: Percent of births among adolescent females, ages 15-17years.</p>	<p>Severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>Maternal mortality rate per 100,000 live births</p> <p>Low birth weight rate (%)</p> <p>Very low birth weight rate (%)</p> <p>Moderately low birth weight rate (%)</p> <p>Preterm birth rate (%)</p> <p>Early preterm birth rate (%)</p> <p>Late preterm birth rate (%)</p> <p>Early term birth rate (%)</p> <p>Infant mortality per 1,000 live births</p> <p>Perinatal mortality per 1,000 live births plus fetal deaths</p> <p>Neonatal mortality per 1,000 live births</p> <p>Post neonatal mortality rate</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Adolescent Health</b>				
<b>Priority 6: Increase conditions in adolescents that lead to improved adolescent health.</b>				
	<p>services on an ongoing basis to inform local program strategy and statewide collaboration.</p> <p>6. Develop and implement youth-informed programs to empower parents and caregivers with skills and knowledge to strengthen effective communication with adolescents regarding sexual health.</p>			<p>per 1,000 live births</p> <p>Preterm-related mortality per 100,000 live births</p>
<p>2. By June 30, 2020, promote development of healthy coping skills as indicated by a 10% decrease in the percent of youth (11th graders) who report experiencing bullying for any reason from 27.6% in 2013 to 24.8%.</p>	<p>1. Develop policies and procedures for AFLP grantees to incorporate the Positive Youth Development (PYD)/Resiliency framework into programs that serve adolescents.</p> <p>2. Train state and local staff on the principles of PYD, resiliency and healthy coping skills for adolescents</p>	<p>ESM 9.1: Percent of Adolescents who complete the AFLP PYD evidence-informed program model</p>	<p>NPM #9: Percent of adolescents, ages 12 -17 years, which are bullied or bully others.</p>	<p>Adolescent mortality, ages 10 through 19 per 100,000</p> <p>Adolescent suicide, ages 15 through 19, per 100,000</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Cross-cutting/ Life course</b>				
<b>Priority 7. Increase access and utilization of health and social services</b>				
<p>1. By June 30, 2020, decrease the rate of Medi-Cal eligible women and children who are uninsured from 8.3% and 36.5% (2011/12 CHIS) to 7.9% and 34.7%, respectively.</p>	<p>1. Collaborate with LHJs to provide appropriate client outreach materials and resources to promote Medi-Cal/Denti-Cal enrollment for eligible families and establish a baseline number of families/clients to be assisted.</p> <p>3. Develop an oversight protocol for MCAH LHJs to ensure all persons referred for insurance enrollment complete an appointment.</p>			
<p>2. By June 30, 2020, increase the rate of children ages 3-11 years who received a dental visit in the last year from 75.3 percent (2011/12) to 79.1 percent</p>	<p>1. Under the guidance of the CDPH Oral Health Director, MCAH and Chronic Disease and Injury Control Division will collaborate to develop the State's oral health plan to identify priorities, goals, objectives and key strategies.</p> <p>2. LHJ staff informs all eligible and enrolled clients of currently available dental benefits offered by Medi-Cal, promote the dental home and Medi-Cal warm transfer service through 1-800 customer service phone number or other referral services.</p>			
<p>3. By June 30,</p>	<p>1. Develop an oversight protocol for</p>	<p>ESM 1.1: Percent of</p>	<p>NPM #1: Percent of</p>	<p>Severe maternal morbidity</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Cross-cutting/ Life course</b>				
<b>Priority 7. Increase access and utilization of health and social services</b>				
<p>2020, increase the rate of women of reproductive age with appropriate preventive care, including:</p> <p>Increase the rate of preventive visits from 61.9% (2013 BRFSS) to 65.3%.</p> <p>Increase the rate of first trimester prenatal care initiation from 83.6% (2013 BSMF) to 87.9%</p> <p>Increase the rate of postpartum visits from 88.3% (2012 MIHA) to 92.9%.</p>	<p>MCAH LHJs to ensure all persons referred for insurance enrollment complete an appointment.</p> <p>2. Partner and collaborate with DHCS, and MCAH LHJs to promote no-cost preventive services to newly enrolled women of reproductive age, including early entry into prenatal care.</p> <p>3. Finalize development and pilot test the IRIS (Internal, Reproductive, Integrative, Skin) designation for preventive care visits for young women’s health care (a clinician training program to increase utilization of preventive health services by young women, especially low income).</p> <p>4. Collaborate with Text4Baby and hospital partners to schedule and discuss the importance of the postpartum visit during prenatal care and/or labor/delivery and these messages would be delivered to pregnant women through the Text4Baby system.</p>	<p>local health jurisdictions that have adopted a protocol to ensure that all persons referred for insurance enrollment complete a preventive visit appointment</p>	<p>women with a past year preventive medical visit</p>	<p>per 10,000 delivery hospitalizations</p> <p>Maternal mortality rate per 100,000 live births</p> <p>Low birth weight rate (%)</p> <p>Very low birth weight rate (%)</p> <p>Moderately low birth weight rate (%)</p> <p>Preterm birth rate (%)</p> <p>Early preterm birth rate (%)</p> <p>Late preterm birth rate (%)</p> <p>Early term birth rate (%)</p> <p>Infant mortality per 1,000 live births</p> <p>Perinatal mortality per 1,000 live births plus fetal deaths</p> <p>Neonatal mortality per 1,000 live births</p> <p>Post neonatal mortality rate</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Cross-cutting/ Life course</b>				
<b>Priority 7. Increase access and utilization of health and social services</b>				
				<p>per 1,000 live births</p> <p>Preterm-related mortality per 100,000 live births</p>
<p>4. By June 30, 2020, increase the rate of children, ages 0 to 17 years, who receive one or more preventive visits in the last 12 months from 80.6% (2012 NSCH) to 84.6%.</p>	<ol style="list-style-type: none"> <li>1. Develop policies and procedures for MCAH LHJs to increase insurance coverage and access to preventive services for children 0-17 years old.</li> <li>2. Integrate preventive care concepts for children and adolescents into MCAH program curricula.</li> <li>3. Participate in collaborative meetings with DHCS to plan effective activities to improve access to insurance coverage and referral to ancillary health care and public health services such as WIC.</li> <li>4. Collaborate with LHJs and MCAH program to implement effective ways of communicating new policies regarding health care access and services.</li> </ol>	<p>ESM 15.1: No. of individuals seen at local health jurisdictions that were referred to Medi-Cal, Covered California or other health insurance.</p>	<p>NPM 15. Percent of children 0 through 17 years who are adequately insured</p>	<p>Percent of children in excellent or very good health</p> <p>Percent of children ages 6 months through 17 years who are vaccinated annually against seasonal influenza</p> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</p> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</p> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</p> <p>Adolescent mortality ages 10 through 19 per 100,000</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Cross-cutting/ Life course</b>				
<b>Priority 7. Increase access and utilization of health and social services</b>				
				<p>Adolescent motor vehicle mortality ages 15 through 19 per 100,000</p> <p>Adolescent suicide , ages 15 through 19, per 100,000</p> <p>Percent of children with mental/behavioral health condition who receive treatment or counseling</p> <p>Percent of adolescents who are overweight or obese (BMI at or above the 85th percentile)</p> <p>Severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>Maternal mortality rate per 100,000 live births</p> <p>Low birth weight rate (%)</p> <p>Very low birth weight rate (%)</p> <p>Moderately low birth weight rate (%)</p> <p>Preterm birth rate (%)</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Cross-cutting/ Life course</b>				
<b>Priority 7. Increase access and utilization of health and social services</b>				
				<p>Early preterm birth rate (%)</p> <p>Late preterm birth rate (%)</p> <p>Early term birth rate (%)</p> <p>Infant mortality per 1,000 live births</p> <p>Perinatal mortality per 1,000 live births plus fetal deaths</p> <p>Neonatal mortality rate</p> <p>Post neonatal mortality rate</p> <p>Preterm-related mortality rate</p>
<p>5. By June 30, 2020, increase the rate of women with pre-pregnancy health insurance from 75.3% (2012 MIHA) to 79.5% and the number of children and adolescents (age 0-17) with health insurance from</p>	<p>1. Develop a policy and procedure for local MCAH to increase insurance coverage and access to services for uninsured and underinsured eligible MCAH population.</p> <p>2. Partner with Medi-Cal to provide input on regulations that impact enrollment and referral for women of reproductive age and their dependents.</p>			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Cross-cutting/ Life course</b>				
<b>Priority 7. Increase access and utilization of health and social services</b>				
74.4% (2012 NSCH) to 78.2%.	3. Collaborate with LHJs and MCAH program to implement effective ways of communicating new policies regarding health care access and services.			
6. By June 30, 2020, decrease the rate of postpartum women without health insurance from 16.7 percent (2012 MIHA) to 16.2 percent.	<ol style="list-style-type: none"> <li>1. Develop policies and procedures for local MCAH to increase insurance coverage and access to health care services for postpartum women after 60 days of delivery.</li> <li>2. Establish collaborative meetings within MCAH Programs to develop a standardized protocol of assessing access to insurance information and services, and linkage and referrals that are available postpartum.</li> <li>3. Develop quality improvement process involving LHJs and regional perinatal programs to establish coordinated post-partum referrals after hospital discharge.</li> </ol>			
7. By June 30, 2020, 99% of parents/caregivers experiencing a	1. Contact local coroner offices to remind and encourage referral of parents of all babies who die suddenly and unexpectedly			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Cross-cutting/ Life course</b>				
<b>Priority 7. Increase access and utilization of health and social services</b>				
<p>sudden and unexpected infant death will receive grief/bereavement support services.</p>	<p>regardless of circumstances of death.</p> <ol style="list-style-type: none"> <li>2. Make grief/ bereavement support materials and peer support organizations available on the California SIDS Program website.</li> <li>3. Provide training on grief and bereavement support services to public health professionals and emergency personnel who respond to SUIDS.</li> <li>4. LHJs contact families who experience a SUID from which a referral was received from the local coroner's office to provide grief/bereavement support.</li> </ol>			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Cross-cutting/ Life course</b>				
<b>Priority 7. Increase access and utilization of health and social services</b>				
<p>8. By June 30, 2020, decrease the rate of mental health and substance use hospitalizations for persons age 15-24 from 1436 per 100,000 hospitalizations and 1754 per 100,000, to 1318 per 100,000 and 1570 per 100,000, respectively.</p>	<ol style="list-style-type: none"> <li>1. Increase MCAH LHJs awareness of maternal mental health and wellness issues that impact MCAH target populations through various educational opportunities.</li> <li>2. Develop and distribute an evidence-based Maternal Mental Health and Wellness Toolkit for local MCAH programs</li> <li>3. Develop culturally and linguistically appropriate policies and protocols for LHJs and MCAH programs to reduce discrimination, disparities, and stigmatization related to maternal mental health and wellness issues.</li> <li>4. Develop and implement evidence- based screening and brief intervention policies that require all Title V-funded programs and initiatives to screen participating women and adolescents to determine if they are at risk for mental health and substance use disorders and refer, link, and provide a brief intervention to those who screen positive.</li> </ol>			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Cross-cutting/ Life course</b>				
<b>Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active lifestyle.</b>				
<p>1. By June 30, 2020, increase the percent of women with recommended weight gain during pregnancy from 34.3% (2013 BSMF) to 36.1%</p>	<ol style="list-style-type: none"> <li>1. Conduct surveillance of weight gain during pregnancy, including measurement of trends and disparities.</li> <li>2. Promote culturally congruent best practices about weight gain during pregnancy by providing technical assistance, education and resources to funded MCAH Programs and partners for the promotion of environmental change practices and programmatic policies.</li> <li>3. Promote the national Dietary Guidelines for Americans and Physical Activity Guidelines weight assessments, counseling and referrals for all women.</li> <li>4. Identify or develop and disseminate information and tools through key partners (NEOP, WIC, CDE, Systems of Care, EMSA) to help the MCAH population meet the dietary guidelines for Americans.</li> </ol>		<p>SPM 3. Percent of women with the appropriate weight gain during pregnancy.</p>	<p>Severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>Maternal mortality rate per 100,000 live births</p>

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Cross-cutting/ Life course</b>				
<b>Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active lifestyle.</b>				
<p>2. By June 30, 2020 reduce the proportion of WIC children aged 2-4 years who are overweight or obese from 34.5% (WIC PC 2012) to 33.5%</p>	<p>1. Promote culturally congruent best practices to improve children’s weight status by providing education, resources and technical assistance to funded MCAH programs and partners for the promotion of environmental change practices and programmatic policies.</p> <p>2. Build and sustain partnerships and collaborations with nation, state and local level partners to promote interventions to address national guidelines on weight, nutrition and physical activity for young children.</p>			
<p>3. By June 30, 2020, increase the rate of meeting the age specific guidelines for physical activity from 30.4%, 16.2% (2011-12 CHIS) and 24% (2013 BRFSS) to 31.9%, 17% and 25.3% for</p>	<p>1. Promote culturally congruent best practices to promote national physical activity guidelines by providing education, resources and technical assistance to funded MCAH programs and partners for the promotion of environmental change practices and programmatic policies.</p> <p>2. Build and sustain partnerships and collaborations with national, state and local level partners to</p>			

SMART Objectives	Strategies	Evidence based or Informed Strategy Measures	Performance Measures (National and State)	National Outcome Measures
<b>Domain: Cross-cutting/ Life course</b>				
<b>Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active lifestyle.</b>				
children ages 6-11, adolescents 12-17, and women ages 18-24 respectively.	promote physical activity within the MCAH population.			
4. By June 30, 2020, increase the percentage of women who took a vitamin containing folic acid every day of the week during the month before pregnancy from 34% (2012 MIHA) to 35.9%	1. Promote culturally congruent best practices to promote folic acid intake among women of reproductive age among MCAH programs by providing education, resources and technical assistance.			

## II.F.1 State Action Plan and Strategies by MCH Population Domain

The process used to refine the State 5-Year Action Plans was similar to that employed for their construction during the needs assessment process: 1) managers identified appropriate staff to form workgroups; 2) workgroups were instructed to use the action plans to work backwards to create logic models for each priority; 3) staff reviewed the SMART objectives for each priority goal and the strategies, inputs, activities and short and intermediate objectives to determine if the strategies were appropriate to achieve the objective and if the objective was feasible with the stated resources; 4) epidemiology staff identified promising or evidence-based strategies to address the objectives; and 5) core Title V team members selected appropriate performance process and outcome measures, which were reviewed by management, and the workgroup teams for approval. Staff members involved in the Action Plan revision were trained on the logic model construction process and revision of the Action Plans.

During this logic model process, it became clear that several domains contained objectives that were not feasible; other domains omitted objectives for key priorities. As a result of the logic model exercise and the finalization of the strategy measures and performance measures, the state Action Plans were revised early 2016, and presented below.

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### *Domain: Women/Maternal Health – Annual Report (FY 2014-2015)*

For the first year of the new 2016-2020 cycle, MCAH performed mostly developmental activities to lay the groundwork for the five-year goals and activities.

#### **Goal 1: Decrease Intimate Partner Violence (IPV)**

**SMART OBJECTIVE:** By June 30, 2020 increase the percent of Title V funded programs (i.e., AFLP, BIH and LHJs MCAH Programs) that adopt MCAH's IPV Protocol, including reproductive and sexual coercion, from 40% to 60% as reported by the MCAH Annual Reports.

In the first year, MCAH performed an environmental scan of LHJs and programs to identify which programs had existing protocols that outline the appropriate procedures to be followed when addressing IPV. For a more upstream preventive approach to IPV, MCAH has established partnerships with the CDPH Safe and Active Communities; CDPH Office of Health Equity; Health in all Policies (HiAP) Taskforce sub-committee on violence; and Futures Without Violence and the CDPH Safe and Active Communities (SAC) Program to identify opportunities and recommendations for the development of the IPV program protocol, including trainings, health education materials, and quality improvement tools.

The IPV objective was modified after determining that not all MCAH LHJs and programs had an existing IPV protocol. MCAH LHJs and programs had activities that support the adoption and implementation of an IPV protocol. Therefore, MCAH has decided to develop and standardize an IPV Protocol for all MCAH LHJs and programs.

#### **Goal 2: Decrease Unintended Pregnancy**

**SMART OBJECTIVE:** By June 30, 2020, California will reduce the prevalence of mistimed or unwanted pregnancy among Black and Latina women with live births from 45.4% and 38.2% (2012 MIHA) to 43.4% and 37.1%, respectively.

In the first year, Oregon Reproductive Health Foundation conducted a training on “One Key Question” with the Preconception Health Council of California (PHCC). “One Key Question” is a screening tool designed to ensure that all primary care providers routinely ask women about their reproductive health needs using a patient empowerment framework. MCAH initiated its review of the existing Reproductive Life Planning tools for cultural and linguistic appropriateness.

As a first step to addressing the disparate rates of postpartum visit attendance, MCAH worked with Medi-Cal Managed Care Division to determine opportunities for coordination of the postpartum visit message. Eight regional health plans were identified to pilot implementation of a targeted communication strategy about the postpartum visit based on their interest in improving postpartum visit attendance particularly among Black and/or Latina women who have a low rate of postpartum visit attendance.

To ensure providers have adequate education regarding interconception health and birth spacing, MCAH partnered with the National Preconception Health and Health Care Initiative (Before and Beyond) to develop an online module with continuing medical education credits to instruct health care providers on the standard content of the postpartum visit. The final draft of the module was under review at the end of 2015.

### **Goal 3: Decrease Burden of Chronic Disease**

**SMART OBJECTIVE:** By June 30, 2020 MCAH will work with partners to reduce prevalence of hypertension, diabetes, cardiovascular disease and mental illness among women at labor and delivery from 8.0%, 10.0 %, 0.54% and 4.4% (2013 OSHPD PDD) to 7.4%, 9.5%, 0.51% and 3.9%, respectively.

MCAH began several activities outlined below to address the prevalence of chronic disease and increase the data infrastructure for public health surveillance of chronic disease. MCAH began to strengthen its ability to address social determinants of health that are believed to underlie many chronic conditions, by participating in the Office of Health Equity, Health in All Policies State (HiAP) Taskforce meetings and activities.

Several adjustments to the activity plan were made in the first year. MCAH decided not to pursue the partnership with the Chronic Disease Branch to identify and compare population-based methods for measuring chronic disease among pregnant women and non-pregnant women of reproductive age due to the newly developed CDPH data portal. The data portal will create an institution wide infrastructure for data acquisition and analysis that will include our proposed efforts. MCAH also planned to explore ways to increase usage of e-cigarette prevention in its outreach materials and surveillance mechanisms and collaborate with the California Tobacco Control Program (CTCP) to monitor their new local laws and ordinances database. MCAH will begin this exploration in 2016.

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#### ***Domain: Women’s/Maternal Health - Plans for the Application Year (FY 2016-2017)***

MCAH will continue some developmental activities outlined below to lay the groundwork for the Action Plan strategies.

### **Goal 1: Decrease Intimate Partner Violence (IPV)**

**SMART OBJECTIVE:** By June 30, 2020, increase the number/percent of Title V funded programs (i.e., AFLP, BIH and LHJs MCAH Programs) who adopt MCAH's IPV protocol, including reproductive and sexual coercion from 40% to 60% (2013/14 MCAH Annual Reports).

**IPV:** MCAH will use the results of the environmental scan of LHJs to determine what resources are needed to improve capacity for addressing IPV. MCAH will continue its ongoing partnerships with the Office of Health Equity, HiAP sub-committee on violence and the CDPH Safe and Active Communities Program. MCAH will continue to use the results of local needs assessment, health topic ranking, and key informative interviews among LHJs and MCAH programs to determine evidence-practices to build capacity among LHJs and programs to address IPV in their communities. MCAH will continue to build and sustain internal and external partnerships with CDPH Office of Health Equity; Health in All Policies; CDPH Safe and Active Communities Branch; CDHCS Office of Family Planning; Preconception Health Council of California; Futures Without Violence; and California Department of Social Services to leverage their resources and services for MCAH's LHJs and programs. In addition, MCAH will develop a program protocol with the understanding of the multifactorial aspects that increase the risk of IPV such as, behavioral, social, cultural, and environmental factors and the complexity of the interaction of these factors. The program protocol will serve as a roadmap, providing resources and directing LHJs to address IPV from their specific needs of their community.

## **Goal 2: Decrease Unintended Pregnancy**

**SMART OBJECTIVE:** By June 30, 2020, California will reduce the prevalence of mistimed or unwanted pregnancy among Black and Latina women with live births from 45.4% and 38.2% (2012 MIHA) to 43.4% and 37.1%, respectively.

**Reproductive Life Planning** MCAH will finalize the review of the Reproductive Life Planning tools for cultural and linguistic appropriateness and begin to disseminate the approved tools. Starting with the ten LHJs with the highest unintended pregnancy rates, local MCAH programs will receive training on One Key Question from Oregon Department of Public Health.

As a second step to addressing the disparate rates of postpartum visit attendance, MCAH will work with the partners identified in its Action Plan to determine opportunities for coordination of the postpartum visit message, specifically targeted to young women, Black women and Latina women.

To ensure providers have adequate training on providing appropriate preventive/restorative care to all women postpartum, the first of two online modules for continuing medical education credits will be finalized and published on the Before and Beyond website.

## **Goal 3: Decrease Burden of *Chronic Disease***

**SMART OBJECTIVE:** By June 30, 2020 MCAH will work with partners to reduce prevalence of hypertension, diabetes, cardiovascular disease and mental illness among women identified at the time of labor and delivery from \*.0%, 10.0 %, 0.54% and 4.4% (2013 OSHPD PDD) to 7.4%, 9.5%, 0.51% and 3.9%, respectively.

MCAH will build on its initial exploration of e-cigarettes surveillance and begin to explore opportunities to examine smoking trends in relationship to changes in local legislation as appropriate.

MCAH wants to partner with disease-specific organizations to target prevention outreach for women of reproductive age for cardiovascular disease, hypertension, diabetes, and chronic mental illness. MCAH will identify prospective partner organizations, host initial meetings to gauge interest, and determine appropriate follow up.

To ensure providers have adequate training to provide postpartum care to women with pregnancy complications, the second of two online modules for continuing medical education credits will be developed for self-paced instruction to coincide with the revision of the Interconception Care Project of California (ICPC). The module will include instructions for developing a follow-up plan for women with lifestyle or behavioral issues identified in pregnancy that pose a risk to their health and subsequent pregnancies.

MCAH is strengthening its ability to address social determinants of health by partnering with the Office of Health Equity, Health in All Policies Taskforce to address community risk factors for IPV. MCAH will continue to attend taskforce meetings and participate in development of projects to address the unique identified needs of the MCAH population.

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### ***Domain: Perinatal/Infant Health – Annual Report (FY 2014-2015)***

#### **Goal 1: Reduce Pre-term Births and Infant Mortality**

**SMART OBJECTIVE:** By June 30, 2020, decrease the percentage of pre-term births less than 37 completed gestational weeks from 8.8% (2013 BSMF) to 8.3%.

**Standardization of Care:** Local MCAH continued to provide perinatal support, including those of the California Perinatal Services Program (psychosocial, health education, and nutrition services, in addition to standard obstetrical services) and interventions at the beneficiary, provider, community and other stakeholder levels.

**For Beneficiaries:** Local MCAH provided presentations, counseling, and education to promote and address a strong safety net of support for pregnant and postpartum women (e.g. food security, shelter, housing, school placement). Community events and referral system improvements were made to facilitate and increase the access of eligible individuals to Medi-Cal or related services.

**For Providers:** Roundtable discussions and workforce development presentations were conducted to provide community and provider education and information on pre/interconception health education and emerging issues affecting maternal and infant health. In addition, LHJs reviewed the existing referral sources to determine their adequacy and assist providers in developing interagency agreements to improve care coordination with specialty health, home visiting and social programs and services.

**For Community:** Within the community, local MCAH worked to promote partnerships in the collaboration and delivery of perinatal services and maternal and infant care coordination, encourage the use of evidence-based tools for service delivery (e.g., use of the Edinburgh Postnatal Depression Scale women and 4Ps for substance use screening), conduct large scale community activities with local provider networks and/or health plans, and participate in trainings to promote professional development relevant to the ACA, participated on development of the Let's Get Healthy California (Goal #1 – Healthy Beginnings), healthcare access, and reduction of maternal and infant morbidity and mortality, such as life course, preconception health, and trauma-informed care.

To support the expanding Perinatal Services Coordinators (PSC) role at the local level and promote value to their functions on the provision of quality perinatal care, MCAH partnered with DHCS Managed Care Operations Division (MCO), Quality and Monitoring Section, the Local Health Plan Quality Administrators and Health Plan Nurses to discuss perinatal services, including CPSP assessment requirements and these parties' interest in developing shared strategies with MCAH to connect the local health plans with the local MCAH and PSCs. Feedback from the local plans included interest in having more discussions with CPSP, MCAH Home Visiting programs and the RPPC on addressing disparities in health care access.

MCAH also partnered with March of Dimes (MOD) to provide education, support materials, and tools to the Perinatal Services Coordinators to enhance their skills and better equip them to coordinate and facilitate local efforts in improving perinatal health and delivery of services.

The Regional Perinatal Programs of California (RPPC) and the California Perinatal Transport System continued their work in regional planning and coordination, ensuring the transport of high-risk patients to facilities with the appropriate level of care with data collection, and quality improvement surrounding patient transfer.

Systems of Care Division (SCD) and CPQCC continued responding to member questions, analyzed data for CCS-approved NICUs, and addressed outliers and concerns about quality of care.

***Prenatal Care Access:***

- MCAH continued collaboration with DHCS/ Medi-Cal Operations Division (MCO) to share resources and strategies in addressing mutual goals on perinatal health activities and outcomes, including early prenatal care entry, timely postpartum care, and availability of resources to high-risk pregnant women.
- Although public health integration with managed care is a work in progress, MCAH and MCO's Quality and Monitoring Section are committed to fostering a joint partnership to address the mutual goal of improving perinatal care access outcomes through synergy and coordination of activities and resources to benefit our high risk and vulnerable maternal population.
- MCAH monitored best practices in LHJs and shared these statewide to improve performance. LHJs continued to monitor access to early prenatal care, conduct targeted outreach to women of childbearing age and pregnant women, provide appropriate linkages and streamline processes for presumptive eligibility to increase access to early prenatal care for pregnant women.
- LHJs continued to offer the toll-free line and web information to MCAH populations.

***Direct Service Programs:*** The CPSP, AFLP, and BIH programs continued to provide case management services and linkages to health care for their target populations and educate clients regarding the importance of receiving early prenatal care for future pregnancies.

- AFLP continued to implement the PYD component into existing services.
- BIH continued to implement the new group intervention, as well as complementary case management, to improve the health and social conditions for African American women and their families.

**Trainings:** To improve birth outcomes, data quality and staff capacity, several yearlong training programs were conducted. RPPC, CMQCC, and CPQCC continued to provide TA to hospitals and LHJs that use the maternal and neonatal quality improvement toolkits and resources developed by these collaboratives.

RPPC, in partnership with the Office of Vital Records (OVR), continued to provide Birth Clerk Data Trainings emphasizing collaboration among administration, nurses, and birth clerks to obtain and accurately report birth certificate data. RPPC Directors continued to explore opportunities for nursing staff to work with birth clerks on enhanced birth data reporting in continuing efforts to improve data quality.

LA County maintained its Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative (ALC) website to provide information on resources and best practices relating to infant mortality and undoing racism. Because of its multidisciplinary local partners, MCAH worked with LA County ALC to increase capacity at the local and state levels to address the impact of racism on birth outcomes and infant health.

**Achievements in Prematurity Reduction:** MCAH participated in the Association of State and Territorial Health Officers (ASTHO) Healthy Babies Challenge, which aims to prevent premature births and reduce infant mortality. In partnership with MOD, ASTHO challenged states to reduce their percentage of premature births by 8% by 2014, using 2009 data as baseline. The percentage of premature births in California was 10.4% in 2009, decreasing to 9.6% in 2012, thus achieving the target 2014 goal in 2012. This accomplishment earned California the "A" grade in the MOD 2013 Premature Birth Report Card. In March 2014, California received the MOD Franklin Delano Roosevelt Prematurity Campaign Leadership Award for achieving the premature birth rate of 9.6%, which is the MOD 2020 goal. In addition, California was also awarded the MOD Virginia Apgar Prematurity Campaign Leadership Award in March 2015, for achieving the 8% decline in premature birth rates.

## **Goal 2: Increase Breastfeeding Initiation and Duration**

**SMART OBJECTIVE:** By June 30, 2020, increase the percentage of women who report exclusive breastfeeding at 3 months from 26% (2012 MIHA) to 27.2% and reduce racial/ethnic disparities.

MCAH provided statewide coordination for breastfeeding initiatives by maintaining the Local Breastfeeding Coordinators roster and regularly emailing them resources and funding opportunities, publishing an annual letter with breastfeeding initiation data and resources to labor and delivery hospitals, and maintaining the CDPH breastfeeding web page. Also, MCAH maintained the Breastfeeding and Healthy Living Web page which has consistently been one of the most highly visited CDPH web pages. Specifically, California Laws Related to Breastfeeding subpage received over 54,000 views in the year which ranked 72 of all CDPH web pages.

MCAH compiled and posted resources on the MCAH web page to implement California Health & Safety Code SS123366, the Hospital Infant Feeding Act and SS123367 (2013) which requires by 2025 that hospitals that have a perinatal unit adopt the "Ten Steps to Successful Breastfeeding," per the Baby-Friendly Hospital Initiative, or an alternate process including the California Model Hospital Policy Recommendations. The Regional Perinatal Program of California provided quality improvement assistance, data and training to California labor and delivery hospitals. At the end of 2015, there were 79 California hospitals that were baby--friendly certified.

In addition, MCAH worked with partners to promote breastfeeding, including working with the California Breastfeeding Coalition to put on the 2015 California Breastfeeding Summit, participated in the United States Breastfeeding Committee to reduce disparities in breastfeeding rates, and collaborated with WIC to coordinate responses on breastfeeding legislation and other enquiries.

Lastly, MCAH analyzed breastfeeding data from the Genetic Disease Screening Program (GDSP), the Maternal Infant Health Assessment Survey, and the California-specific Maternity Practices in Infant Nutrition and Care (mPINC) Survey to use in planning and evaluating breastfeeding interventions by local MCAH programs and partners. MCAH convened a Center of Family Health-wide group (California Women, Infants and Children Supplemental Nutrition Program (WIC); Genetic Disease Screening Program (GDSP); and SCD) quarterly to coordinate nutrition, breastfeeding and physical activity activities, and ensure MCAH Program (e.g. California Diabetes and Pregnancy Program (CDAPP): Sweet Success, CPSP, AFLP, and BIH) breastfeeding guidelines and educational materials, resources and assessment forms were current and consistent.

### **Goal 3: Increase Safe Sleep Practice**

**SMART OBJECTIVE:** By June 30, 2020, reduce the rate of sudden unexpected infant deaths (SUID) from 54.4 to 50.3 per 100,000 live births (2013 DSMF/BSMF)

**SIDS:** Within the community, LHJs promoted infant safe sleep practices/SIDS risk reduction activities to parents and prospective parents. For public health professionals (vague) and emergency personnel MCAH provided two Sudden Infant Death Syndrome (SIDS) trainings on infant safe sleep practices/SIDS risk reduction and grief support services. There were a total of 296 public health professionals/emergency personnel who participated in the trainings. MCAH also continued to encourage LHJs to contact their local coroner offices to remind and encourage referral of parents of babies who die suddenly and unexpectedly for grief/bereavement support services. MCAH also continued providing grief/bereavement support materials and peer support organization information available on the MCAH and California SIDS Program websites for parents experiencing a loss.

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### ***Domain: Perinatal/Infant Health - Plan for the Application Year (FY 2016-2017)***

#### **Goal 1: Reduce Pre-term Births and Infant Mortality**

**SMART OBJECTIVE:** By June 30, 2020, decrease the percentage of pre-term births less than 37 completed gestational weeks from 8.8% of all births (2013 BSMF) to 8.3%.

**Standardization of Care:** MCAH will engage in the process of implementing best practices for standardizing care and quality improvement through the activities of the CPSP, Regional Perinatal Programs of California (RPPC), California Maternal Quality Care Collaborative (CMQCC), and Action Learning Collaboratives (ALC). CPSP affords opportunities to local MCAH to build collaborative partnerships with different agencies to educate staff and refer clinical high-risk pregnant women to appropriate resources. Specifically, state MCAH will provide staff education on addressing maternal conditions and appropriate clinical referrals to specialty clinics, identify evidence-based tools for screening and interventions to share with providers and partner agencies, and partner with schools, non-profit, and faith-based organizations to identify vulnerable maternal populations needing health care access and services. The RPPC will continue to work closely with the CMQCC and CPQCC to disseminate quality improvement toolkits and resources to improve maternal and neonatal care. The ALC plans to hold more health disparities training workshops for healthcare providers to provide

preventive health tools to improve equity.

**Prenatal Care Access:** MCAH will partner with the Postpartum Quality Workgroup organized by the Department of Health Care Services to promote consistency and care coordination among primary obstetric providers and improve access and frequency to prenatal and postpartum care. MCAH will oversee the 2016 implementation of the new policy to increase the frequency of prenatal care visits from a total of eight to fourteen visits, including the initial antenatal care visit.

**Direct Service Programs:** MCAH will continue to oversee several direct client service programs designed to improve perinatal health. The Black Infant Health (BIH) Program, providing prenatal and postpartum support to African-American mothers, will continue implementing a standardized program curriculum. This will facilitate program evaluation and measurement of program outcomes. The goal of the program is to promote health equity and reduce the Black infant mortality rate.

The AFLP, which provides prenatal and postpartum support to pregnant and parenting teens, will continue to incorporate the PYD framework in all of the counties with AFLP. The goal of the program is to reduce the rate of repeat teen births and improve the circumstances for parenting adolescents including completion of secondary education and job placement.

**Prematurity Prevention:** The Association of State and Territorial Health Officers (ASTHO) Healthy Babies Challenge/Prematurity Campaign ended in 2014; however, MCAH and SCD will continue to collaborate with March of Dimes on their ongoing Prematurity Campaign. CDPH is co-hosting the California Prematurity Council with a specific focus on exploring and reporting on strategies to reduce racial/ethnic disparities in preterm birth rates. The MCAH scope of work for LHJs continues to include prematurity prevention, specific objectives on SIDS prevention and breastfeeding promotion.

## **Goal 2: Increase Breastfeeding Initiation and Duration**

**SMART OBJECTIVE:** By June 30, 2020, increase the percentage of women who report exclusive breastfeeding at 3 months from 26% (2012 MIHA) to 27.2% and reduce racial/ethnic disparities.

At least eleven counties identified “Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age” as a goal in their scopes of work and/or 5-year action plans.

MCAH will continue to maintain the Breastfeeding and Healthy Living Web page. MCAH will continue to provide TA for increasing the number of labor and delivery facilities and breastfeeding-friendly community health clinics that provide recommended care for lactating mothers and their babies. MCAH will continue to support RPPC as quality improvement experts for hospital breastfeeding policies. The Perinatal Advisory Council: Leadership, Advocacy, and Consultation (PAC/LAC) and other RPPC regions will revise the Providing Breastfeeding Support: Model Hospital Policy Recommendations (2005). MCAH is developing guidance for supporting and improving lactation accommodation for CDPH employees and LHJs. MCAH plans to partner with the California DHCS to provide guidance on lactation services that are consistent with the ACA.

MCAH will continue to collaborate to promote breastfeeding, including working with the California Breastfeeding Coalition to plan the 2017 California Breastfeeding Summit, support a Board member on the United States Breastfeeding Committee to reduce disparities in breastfeeding rates, and coordinate responses with WIC on breastfeeding legislation and other enquiries. MCAH is continuing

to convene a workgroup to collaborate to build capacity to support workplace lactation accommodation for low wage workers in California. This year, besides the CDPH Breastfeeding Page, the workgroup will provide TA for updating the Office of the State Labor Commissioner (California Division of Labor Standards Enforcement) and the California Department of Fair Employment and Housing web pages related to lactation accommodation. The workgroup is also promoting state and local “best practices” for lactation accommodation, addressing World Breastfeeding week, and, with help from the United States Breastfeeding Committee, compiling a workplace law analysis for California.

MCAH will continue to provide TA for increasing the number of labor and delivery facilities that provide recommended care for lactating mothers and their babies and community health clinics that provide professional and peer support. Specifically, MCAH will continue supporting RPPC as quality improvement experts for hospital breastfeeding policies and encourage. MCAH will encourage and support the Perinatal Advisory Council: Leadership, Advocacy, and Consultation (PAC/LAC) and RPPC to revise the Providing Breastfeeding Support: Model Hospital Policy Recommendations (2005). Within the state, MCAH will continue its efforts to improve the lactation accommodation for CDPH employees, and partner with the California DHCS to provide guidance on lactation services that support the ACA. Outside of the state government system, MCAH will continue to convene a workgroup to collaborate on increasing workplace lactation accommodation for low wage earners and provide technical input for planning the 2017 Breastfeeding summit.

### **Goal 3: Increase Safe Sleep Practice**

**SMART OBJECTIVE:** By June 30, 2020, reduce the rate of sudden unexpected infant deaths (SUID) from 54.4 to 50.3 per 100,000 live births (2013 DSMF/BSMF)

MCAH continues to provide two SIDS trainings annually on infant safe sleep practices/SIDS risk reduction and grief support services for public health professionals (vague) and emergency personnel. LHJs continue to promote infant safe sleep practices/SIDS risk reduction activities in their community. MCAH also provides infant safe sleep practices/SIDS risk reduction materials available on the MCAH and California SIDS Program websites.

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### ***Domain: Child Health Annual Report - (FY 2014-2015)***

For Fiscal Year 2014-2015, the majority of the local MCAH program activities addressing child health included strategies to address motor vehicle injury hospitalizations, child abuse and neglect, and developmental screening for children ages 0-5 years. As a result of our Title V Needs Assessment and refinement during the first year, we narrowed the range of child health issues to developmental screening to and focused our limited resources on our priority issue. LHJs were still allowed to implement programs and activities to address other local priority needs but were encouraged to focus their efforts on developmental screening for children ages zero to five.

### **Goal 1: Provide Developmental Screening for All Children**

**SMART OBJECTIVE:** By June 20, 2020, increase the rate of children ages 10 months to 5 years screened for being at risk for developmental, behavioral and social delay, from 28.5% (2010/11 HSCH) to 29.5 % using parent-completed standardized developmental behavioral screening tool during a health care visit.

**Develop Goals and Objectives:** During the 2016-2020 Needs Assessment process, MCAH worked closely with the CCS program to strengthen relationships, create a better understanding of challenges, roles, and responsibilities of each division and coordination of activities. During year 1, MCAH began a concerted effort to research and understand issues and challenges affecting children and their families related to developmental screening. MCAH also worked to identify activities LHJs are doing to promote developmental screening for children and to improve the rate of developmental screening, including linkages and referral for positive screens. To provide a policy directive to improve screening, MCAH added a requirement in the local MCAH SOW to “conduct activities in fiscal year 2015-16 to identify, refer, and link children at risk for developmental delays to services.

Because there was no increase in funding for LHJs to implement developmental screening activities, LHJs were allowed to choose from a ‘menu’ of activities from the SOW to implement and report an evaluation. Activities could be performed at the individual, provider (medical and non-medical), and/or community level and included promoting developmental monitoring, screening, identification and referral, including social-emotional (mental health) missing noun, for infants and young children 0-5 years, linking children with positive screens to needed services and disseminating standardized messaging about developmental screening. LHJ annual reports are due to MCAH on August 15th each year, providing preliminary data to inform our understanding of local activities and needs. Concurrently, MCAH worked to develop a relationship with Children Now, First 5 California Association and the Help Me Grow (HMG) project director and, along with a workgroup of MCAH Directors, created a list of suggested activities and resources to assist LHJs to increase their outreach and efforts to identify children at risk of developmental and behavioral delays and conduct screening, linkage, and referral to services as needed.

**Technical Assistance (TA):** To increase knowledge and understanding of MCAH priorities and objectives, MCAH conducted several training webinars for the local MCAH programs and their staff. On September 2015, MCAH conducted a training webinar for LHJs on the Help Me Grow (HMG) Project in California. The HMG Project is a system that connects at-risk children with needed services. HMG Project provides TA to LHJs to build on existing resources to assist in identifying at-risk children, and help families find community-based programs and services. This webinar described California activities to expand the HMG network and provide an opportunity for MCAH programs to understand their role in this system. Learning objectives included how to support providers and families to promote early detection, provide a central access point for child development information and referrals, and develop a system that facilitates greater access and collaboration. There were 86 participants on the webinar; ten evaluation survey responses reported 60% thought the webinar was excellent, 90% stated they agreed or strongly agreed that they would be able to apply the knowledge learned, 90% stated they agreed or strongly agreed that the training met their expectations. Additionally, comments were positive and viewers expressed increased knowledge of the program.

MCAH also incorporated the list of suggested resources developed in partnership with the MCAH Directors into the MCAH Program Policies and Procedures Manual--including links to resources for CYSHCN. To ensure central access to resources, CDPH/MCAH created a website for CYSHCN located at:

[http://www.cdph.ca.gov/programs/mcah/Pages/ChildrenandYouthwithSpecialHealthCareNeeds\(CYSHCN\).aspx](http://www.cdph.ca.gov/programs/mcah/Pages/ChildrenandYouthwithSpecialHealthCareNeeds(CYSHCN).aspx)

**Screening Protocols:** MCAH and CCS are developing a contract that consists of a specific SOW delineating activities and performance measures. In addition, several programs have protocols in

place to increase provider screening and parent-completed screening tool use.

Participants in the BIH program are pregnant and postpartum Black women. BIH program participants receive information related to child development postpartum during session 12 of the BIH Group Curriculum. The curriculum provides an overview of brain development, screening of the “Promoting Healthy Brain Development” video, discussion of the role parents play in assisting in infant brain development, discussion of developmental milestones with the “Learn the Signs” handout (a CDC/Act Early document), and discussion of the Ages and Stages Questionnaire (ASQ) with the pediatrician during well-child visits.

**AFLP:** case managers, providing services to pregnant and parenting teenagers, guide youth in understanding normal child development by providing child development and parenting education. This may include use of validated early childhood developmental screening tools (e.g. ASQ, ASQ Social-Emotional [SE]) and must include identification of a source of preventive and primary care for the client and her child. Case managers also provide anticipatory guidance and education regarding the importance of developmental screening and well-child visits, model appropriate parenting skills, and refer clients to parenting classes.

LHJs in Fresno, Ventura and San Joaquin counties have successfully increased developmental screening. For example, Fresno County’s Public Health Nurse (PHN) screened 80 children in childcare settings for developmental and/or behavioral delay: 58 were referred to further services of which 50 were linked to care. The referrals received are for children who are significantly outside typical behavior and development. The PHN observes each child for several hours in the childcare setting from which the referral was received. Staff at the childcare setting contribute an understanding of the child’s behavior/development and provide their observations of and interactions with the family. The PHN then meets with the mother at the child’s home to complete an ASQ and ASQ-SE as well as to gain understanding of family dynamics and the child’s history. Ventura County provided 891 developmental screenings for children 0-5 years. Of these 196 (21.9%) children had a positive screen for developmental risk of whom 118 (60.2%) were found to be eligible and/or referred for early intervention services. 409 (45.9%) children who completed the developmental screening were 0-24 months. San Joaquin County’s PHN screened 239 children and the 10 who screened positive were all referred and received services.

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**Domain: Child Health - Plan for the Application Year (FY 2016-2017)**

**Goal 1: Provide Developmental Screening for All Children**

**SMART OBJECTIVE:** By June 20, 2020, increase the rate of children ages 10 months to 5 years screened for being at risk for developmental, behavioral and social delay, using parent-completed standardized developmental behavioral screening tool during a health care visit from 28.5% (2010/11 HSCH) to 29.5%.

**Develop Goals and Objectives:** MCAH and CCS will continue to have monthly meetings to address challenges, discover better ways to coordinate activities and work together. CHVP is in the process of developing a contract with West Ed to continue the work of the California Statewide Screening Collaborative (CSSC). MCAH will be a participant on the collaborative to improve developmental screening rates.

MCAH contracts with the University of California San Francisco, Family Health Outcomes Project

(FHOP) to provide TA to state and local MCAH staff as they identify needs, develop and/or implement programs, and evaluate data and outcomes of efforts. Beginning July 1, 2016, the renewed contract has activities to support implementation of the action plan for developmental screening and activities to support services for Children and Youth with Special Health Care Needs (CYSHCN). FHOP has assisted CCS Program in conducting two needs assessments and, because of this, has knowledge of their gaps, challenges, and opportunities for providers and families.

MCAH revised the fiscal year 2016-17 MCAH SOW in collaboration with local MCAH Directors to further define the 'menu' of activities that LHJs can choose to implement to improve identification of and services for CYSHCN. These activities can be performed at the individual, provider, and/or community level and are as follows:

- Promote the use of Birth to 5; Watch Me Thrive or other screening materials consistent with AAP guidelines
- Participate in HMG or programs that promote the core components of HMG
- Work with health plans (HPs), including MCMC, to identify and address barriers to screening, referral, linkage and increase the number of HPs requiring screening per AAP guidelines and knowledge of appropriate Medi-Cal billing code for developmental screening
- Promote the yearly medical visit for children, including CYSHCN
- Adopt policies to screen, refer, and link all children in MCAH programs
- Develop quality assurance (QA) activities to ensure children are screened, referred and linked to an appropriate program
- Choose other locally developed activities to promote developmental screening, referral and linkages to an appropriate program and improve services for CYSHCN

In an effort to identify and understand barriers to developmental screening and referral systems, MCAH will explore the feasibility of a state or regional centralized point of access for connecting children and their families to services and care coordination and a data collection process (including indicators) standardized across the state.

**Technical Assistance (TA):** Developing a 'Discussion Forum' series of calls for MCAH Directors to discuss more in-depth activities, share best practices, leverage resources and address challenges and successes in increasing developmental screening, referral, and linkages for children, including CYSHCN.

In the coming year MCAH will provide TA to local MCAH programs to 1) develop and adopt policies/protocols to screen all children for developmental delays and refer and link children to services as needed; 2) promote the use of Birth to 5 or other materials that follow AAP guidelines among local provider networks, health plans, and MMCD; 3) implement HMG or HMG-like initiatives that include core components: child care provider outreach, community outreach, and centralized telephone access point and data collection; and 4) work with Children Now, First 5 California, and MCAH and the DHCS staff to identify the MMCD developmental screening billing code and obtain developmental screening data.

MCAH will work with Children Now and the California Statewide Screening Collaborative to develop a Developmental Screening Toolkit and strategies for increasing use of the preventive medical visit for children, especially CYSHCN and to develop a quality assurance (QA) and quality improvement (QI) process to monitor implementation of screening, referral, linkage, and care coordination activities.

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**Domain: Children with Special Health Care Needs - Annual Report (FY 2014-2015)**

**Goal 1: Provide high quality care to all CYSHCN within an organized delivery system**

**SMART OBJECTIVE:** By June 30, 2020 increase the children in CCS who received primary and specialty care through a single system of care by 20%.

**Site Review:** In recent years, DHCS CCS has updated and modernized the facility site review process, which has resulted in an increased number of site visits to Hospitals, Pediatric Intensive Care Units (PICUs), Neonatal Intensive Care Units (NICUs), and Special Care Centers (SCCs) by state CCS staff. Several standards were re-written and are being used in the site visits.-Site visit tools based on CCS Program standards and facility type have also been developed.

Currently, there are approximately 12-15 CCS Program site visits conducted per year. The goal of the visits is to increase access to high quality care by providing constructive guidance to centers to improve the quality of specialty care by following the CCS Program standards.

Since 2012, 69 new facilities (Hospitals, NICUs, PICUs and SCCs) have been approved and 103 facilities (Hospitals, NICUs, PICUs and SCCs) have been recertified.

**Pediatric Intensive Care Unit (PICU):** As of March 2016, 26 of 27 CCS Approved PICUs participated in the Virtual PICU Systems CCS Database, with 20 of the 26 having complete 2015 data. This is the first time the participation has been this high. In 2014, it was 14 of 26 centers participating. This will now permit statewide benchmarking and addressing quality issues of the individual centers. In keeping with the goals of Title V, this applies to ALL PICU patients, not just those with CCS coverage and all of the patients qualify as CYSHCN.

**Pediatric Palliative Care Waiver (PPCW):** CCS efforts to better organize care also include the Pediatric Palliative Care Waiver (PPCW), which provides intensive care coordination and palliative care services for CCS clients under 21 years of age with life threatening conditions through a CMS Home and Community Based Services waiver. Services are provided by participating home health and hospice agencies, with oversight by the local CCS county program. Services, county oversight, family satisfaction, claims, adherence to policy including time to services and provider qualifications are monitored by SCD periodically. This program is currently available in 10 counties and currently has 158 enrollees.

An independent evaluation of the PPCW found that the program was effective in improving quality of life for clients and families. This is achieved through significant cost savings by reducing the number of hospital days of enrollees. Pediatric palliative care and CCS Program staff and agencies receive program training from the state PPCW team. The PPCW efforts align with NPM 5. Care coordination allows clients and families in the program to use community-based service systems more easily.

The SCD administers and maintains a system of care to monitor County CCS and Provider Agency standards related to compliance with licensure/certification, training/education/experience requirements, F-CAP development/quality of care, and financial accountability. In this capacity, the SCD facilitates semi-annual trainings for County Palliative Care Program CCS Nurse Liaisons, Nurse Managers, Medical Consultants and Provider Agency administrators and clinical staff; provides bi-monthly County CCS and quarterly Provider Agency teleconference meetings; provides on-site

monitoring visits; and provides targeted TA and remediation to discuss policy and address identified compliance issues.

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.

## **Goal 2: Increase Access to Medical Homes for CYSHCN**

**SMART OBJECTIVE:** By June 30, 2020, increase the number of CYSHCN who receive care within a medical home by 20% as measured by the medical home CCS performance measure.

Another goal within the CCS-identified priority need of organized system of care is to increase the number of CYSHCN in California who receive care in a medical home. DHCS and the CCS Redesign Medical home technical workgroup are reviewing the CCS performance measure and various definitions of medical home to determine the most appropriate definition of medical home for CCS and best way to measure whether CCS clients have such a medical home.

## **Goal 3: Improve Transition Services in CYSHCN**

**SMART OBJECTIVE:** By June 30, 2020, increase by 20% the number of 20 year old CCS clients with selected condition who report having an identified adult subspecialist to assume specialty care

Over the past year, CCS has designated transition as a technical workgroup topic within the CCS Redesign. Stakeholders have reviewed and provided feedback on the current CCS transition performance measure for local CCS programs. In addition, CCS counties are providing more details about county specific transition efforts. Promising practices include county-based transition fairs, county CCS parent liaisons, and navigators that work with families to identify community resources. Also, some counties have implemented transition planning which includes identification of transition eligible clients, readiness assessment, and guidance on conservatorship. Some counties also have regular meetings with health plans and other community based resources to identify physicians and services for CCS clients as they transition to adulthood. Along with these county CCS efforts, DHCS is working with Medi-Cal managed care plans to identify and resolve transition-related issues.

## **Goal 4: Increase Access to High Quality Care**

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of CCS families reporting that their child always saw a specialist when needed from 72% to 90% based on the CCS/FHOP survey.

## **Goal 5: Maintain and Support Regionalization of Care**

**SMART OBJECTIVE:** By June 30, 2020, 99% of county CCS programs will report on use of telehealth services.

**Telehealth:** In 2014 and 2015, SCD collaborated with the Center for Connected Health Policy (CCHP) in conducting a survey of CCS Administrators on telehealth. In August 2015, CCHP released a Report: Realizing the Promise of Telehealth for CSHCN, which included findings from this survey. Some recommendations included that CCS should continue to partner with community-based providers and family advocates who work with families of CSHCN to provide information to them

regarding telehealth. Additional recommendations included expanding the list of eligible billing codes for telehealth and locations eligible for telehealth payment to include the patient's home.

CCS and GHPP providers continue to follow CCS/GHPP Numbered Letter 14-1214, Telehealth Services for CCS and GHPP Program guidelines, which are consistent with the DHCS Medi-Cal Provider Manual section on Telehealth. SCD released a set of Frequently Asked Questions about billing for telehealth services for CCS/GHPP. Through discussion with providers, SCD has learned that CCS and GHPP specialized billing codes for Specialty Care Centers and specialist consultations need to be included in the Medi-Cal claims system, and that further guidance needs to be issued regarding authorization and claiming of telehealth services.

Activities in FY 2015 by Children's Hospital in San Diego, UC Davis Center for Health and Technology, as well as private speech therapists include the following:

- Collected stakeholder feedback on pediatric palliative care needs for telehealth services with home visits.
- Discussions about telehealth and NICU care, PICU care, genetics counseling and others.
- Discussions with UC Davis Center for Health and Technology about use of telehealth for Medical Therapy Units and rehabilitation medicine.
- Development of a SCD Memo to California Medicaid Management Information System (CA-MMIS) regarding updates to CCS/GHPP, Tele audiology billing codes that can be used with telehealth modifiers
- Discussions with Rady Children's Hospital in San Diego and others about providing CCS SCC services via telehealth in rural counties.
- Provision of TA to various local health agency and CCS providers about how to bill for telehealth services.
- Ongoing dialogue and problem solving with CCS/GHPP programs and billing units CA-MMIS and Xerox claims contractor.
- Preliminary planning for a telehealth educational conference.

The plan is to release an updated CCS/GHPP Numbered letter to clarify billing issues for these programs during FY 2016-2017.

**High Risk Infant Follow Up:** 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 other 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 associated 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.

Infants discharged from CCS-approved NICUs with CCS-eligible medical conditions or who are at high risk to develop such conditions are followed in a CCS HRIF Program. Three multidisciplinary outpatient visits are authorized by CCS up to age three to identify problems, provide and complete referrals, and monitor outcomes.

Total # of individual children served between Jan 1, 2015 – Dec 31, 2015 = **1,075,910,759**

Total # referral/registrations between Jan 1, 2015 – Dec 31, 2015 = **11,705**

Total # of services (Standard and Additional Visits) between Jan 1, 2015 – Dec 31, 2015 = **13,163**  
Total # of referral/registrations submitted from April 2009 through Dec 31, 2015 = **60,946**

**Child Health and Disability Prevention (CHDP) Program:** The screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, is known as the DHCS 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 CHDP Gateway process.

Health assessments are a key component of a functioning health system, and the CHDP Program provides a mechanism so that EPSDT-eligible children receive necessary preventive health assessments and direct referrals to a dentist.

The majority of children eligible for Medi-Cal are mandatorily enrolled in a MMCD plan. The CHDP Program serves as technical advisors for health assessment schedules recommended by Bright Futures. The CHDP Program works with the Immunization Branch of CDPH to ensure that administration of federally approved vaccines by Vaccines for Children (VFC) providers is payable. The CHDP Program also supports follow-up referrals to dental providers.

**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 and any intermediate, community and regional-level NICU. The NICUs are encouraged to develop policies to screen admitted neonates whose clinical course and care would be unlikely to detect CCHD before discharge. DHCS is attempting to evaluate hospital CCHD screenings 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 that will enable DHCS to evaluate hospital-level screening program specificity.

**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.

The MTP is now using the Gross Motor Functional Classification System, Expanded and Revised (GMFCS-ER), Manual Ability Classification System (MACS) and the Communication Function Classification System (CFCS) to classify levels of function in gross motor, fine motor, and communication skills to assist in measuring functional outcomes. In addition, under the auspices of the CCS Executive Committee, the state and county MTPs worked together to create the Medical Therapy Program Advisory Committee, a group whose purpose is to establish a consistent forum for Statewide Medical Therapy Program (MTP) therapists with administrative and/or supervisory responsibilities at the county level to collaborate/consult with one another and the State Therapy Consultant or their designee through regular meetings and electronic communication. This group provides a wide range of skills and experience to support identifying and undertaking statewide projects and concerns for the MTP.

**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 and expertise to help obtain and receive follow-up from 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. For calendar year 2014, there was an active statewide caseload of 62,421 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 among children and youth in foster care. Recent state legislative actions have cited concerns with the use of psychotropic drugs in children. Of significance in 2015, SB 319 added to the PHN's list of activities, monitoring, and oversight of psychotropic medication to children in foster care during the PHN's medical care planning and coordination for the child. SB 238 required the CDSS to develop and provide training to the PHNs with respect to this activity. DHCS will continue to monitor concerns in this area.

DHCS administers the HCPCFC in coordination with local program representatives to develop related policy guidance and provide TA and consultation to the foster care PHNs in this area as necessary.

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**Domain: Children with Special Health Care Needs - Plan for the Application Year (FY 2016-2017)**

**Goal 1: Provide high quality care to all CYSHCN within an organized delivery system**

**SMART OBJECTIVE:** By June 30, 2020 increase the children in CCS who received primary and specialty care through a single system of care by 20%.

MCAH is using the information from the LHJ CSHCN Assessment survey and is working with MCAH Directors to develop a list of suggested activities to identify and better serve CYSHCN. Such activities include community-based services, identifying CSHCN by monitoring, screening, assessment, and referrals for all children, providing services for CSHCN and facilitating care coordination, such as youth transitioning to adult services, and interagency coordination and collaboration with CCS. MCAH has incorporated some of these strategies as requirements into the LHJ SOW where LHJs will be able to add activities to address CSHCN health needs.

One of the identified priorities for the next five years for this population is to improve the cognitive, physical, and emotional development of all children, including CSHCN, and improve the systems that support CSHCN. The following strategies are among those proposed:

1. Identify and establish collaborations with other state partners, stakeholders and other community groups to increase the practice of social-emotional and developmental monitoring and screening and linkages to needed services for all children, especially at-risk populations;
2. Develop shared policies with state partners to increase alignment among systems and practices to increase rates of culturally and linguistically appropriate social-emotional and developmental screening, referral, and linkages;
3. Promote the use of Birth to 5: Watch Me Thrive materials, and support LHJs to develop

protocols and pathways to refer children needing services to local evidence-based screening and referral systems, including using a parent-completed screening tool, to ensure CSHCN are identified early and connected to needed services; and

4. Support LHJs to establish networks and connections among MCAH programs, primary care providers, Federally Qualified Health Centers, Rural Health Clinics, CCS, CHDP Programs, community clinics, and other pediatric providers to support developmental monitoring and screening at or in close connection with healthcare providers.

DHCS has identified priority needs for this domain, in particular for CCS clients, including having standards and policies in place to facilitate the provision of high quality care within an organized care delivery system to all CYSHCN. This priority need was a key factor in developing models for the CSHCN portion of the 1115 Waiver of 2010–2015. The first 1115 waiver pilot was initiated in 2013 in San Mateo County through the County Organized Health System, Health Plan of San Mateo. The goal was to have all health care for the CCS child organized within one system. DHCS developed and is currently preparing to administer a family satisfaction phone survey to assess the families' knowledge and satisfaction with the demonstration project, knowledge and satisfaction with their care coordinator, access, and satisfaction with providers, satisfaction with the medical services provided, and to establish a baseline to compare against future surveys.

In 2014, DHCS initiated another effort to improve the CCS program, CCS Redesign. For CCS Redesign, a stakeholder advisory board composed of individuals from various organizations and backgrounds with expertise in both the CCS Program and care for CYSHCN was created. The goals of this stakeholder process include maintaining a patient and family-centered approach, provide comprehensive treatment for the whole child, improve care coordination through an organized delivery system, improve quality, streamline care delivery, and maintain cost neutrality. Because of the success of the San Mateo Whole Child model, DHCS is proposing to expand this whole child model to other counties with a County Organized Health System, with advisory group feedback. A second task of the CCS Redesign advisory group is to improve the CCS program in counties not participating in the whole child model. There are four focus areas of this CCS Program Improvement, 1. Medical home, 2. CCS eligibility determination, 3. appropriate referrals to SCC, 4. Youth Aging-out Transitions. Each area is being reviewed by the CCS Redesign stakeholder group in the next year.

Within the organized care delivery system a priority is the goal of improving services for children and youth with special health care needs (CYSHCN) as they transition to adult services. . Proposed strategies include identifying gaps and barriers in existing services for CYSHCN transitioning to adult services; partnering with relevant agencies including but not limited to internal DHCS partners, provider agencies, local health plans and family and CSHCN advocacy organizations. The goal is to define and develop effective transition planning to ensure continuity of medical care, continued skill building, and access to other community supports.

**SMART OBJECTIVE:** By June 30, 2020, increase the number of CYSHCN who receive care within a medical home by 20% as measured by the medical home CCS performance measure.

### **Goal 3: Improve Transition Services to CYSHCN**

**SMART OBJECTIVE:** By June 30, 2020, increase by 20% the number of 20 year olds CCS clients with selected condition who report having an identified adult subspecialist to assume specialty care.

### **Goal 4: Increase Access to High Quality care**

**SMART OBJECTIVE:** By June 30, 2020, increase of CCS families reporting that their child always saw a specialist when needed from 72% to 90% based on CCS/FHOP survey.

## **Goal 5: Maintain and Support Regionalization of Care**

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### *Domain: Adolescent Health - Annual Report (FY 2014-2015)*

#### **Goal 1: Decrease Adolescent Pregnancy**

**SMART OBJECTIVE:** By June 30, 2020, decrease the adolescent birth rate from 23.2 per 1000 females, 15-19 years of age (2013 BSMF) to 19.8 per 1000.

MCAH implements three adolescent sexual health (ASH) programs which address primary and secondary pregnancy prevention, which include: the Personal Responsibility and Education Program (CA PREP); Information & Education program (I&E); and the AFLP. For each of these, MCAH monitors grantees and provides the infrastructure to support program implementation including training, TA, and systems development for data collection, monitoring and evaluation. Of these three programs, AFLP is the focus of this section as it is the only ASH program funded by Title V.

Thirty-two agencies were funded to implement AFLP, which serves expectant and parenting youth under 19 years of age. Many agencies implemented the PYD program model, which is a standardized intervention that is based on PYD principles integrated with life planning. The PYD intervention focuses on building youth resilience skills (social competence, problem-solving, sense of purpose and autonomy) and provides information and support around family planning, education and work, building healthy relationships, and accessing health care. The development and federal evaluation of the PYD intervention is funded by the federal Office of Adolescent Health (OAH).

Early in fiscal year 2014-2015, MCAH reviewed recommendations from the University of California, San Francisco (UCSF)'s formative evaluation of the PYD intervention to revise the intervention and translate tools into Spanish. PYD agencies were trained and thirteen AFLP agencies were identified to participate in the federal evaluation through OAH and Mathematica Policy Research (MPR).

To improve the ability of agency staff to respond to emerging needs, MCAH began planning efforts for the Adolescent Sexual Health Annual Meeting: Reaching & Teaching Diverse Populations, which featured educational workshops such as mandated reporting, creating a culture of consent, and creating inclusive environments for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth.

#### **Goal 2: Build Youth Resiliency and Coping Skills to Reduce Bullying**

**SMART Objective:** By June 30, 2020, promote development of healthy coping skills as indicated by a 10% in the percent of youth (11<sup>th</sup> graders) who report experiencing bullying for any reason from 27.6% in 2013 to 24.8%

The original SMART Objective focused on high school graduation rates, since there was not a corresponding NPM; MCAH revised the SMART Objective to align with the NPM relating to bullying.

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**Domain: Adolescent Health - Plans for the Application Year (FY 2016-2017)**

**Goal 1: Decrease Adolescent Pregnancy**

**SMART OBJECTIVE:** By June 30, 2020, decrease the adolescent birth rate from 23.2 per 1000 females, 15-19 years of age (2013 BSMF) to 19.8 per 1000.

**Teen Pregnancy Prevention:** Thirteen AFLP sites have been identified to undergo a federal evaluation of AFLP PYD funded by the Office of Adolescent Health. MCAH launched the revised PYD intervention with select sites, which was informed by the formative evaluation in fiscal year 2014 described above. MCAH will continue to work with the federal Office of Adolescent Health and Mathematica Policy Research, the University of California, San Francisco, and local partners to support the federal evaluation of AFLP PYD.

MCAH will provide TA and training to the 24 AFLP agencies currently implementing the PYD intervention. In 2016, MCAH plans to provide additional training to support implementation of PYD in the field. Additionally, MCAH plans to release an RFA in 2016 to fund agencies with greatest need for and capacity to deliver services for expectant and parenting youth.

**Goal 2: Build Youth Resiliency and Coping Skills to Reduce Bullying**

**SMART Objective:** By June 30, 2020, promote development of healthy coping skills as indicated by a 10% in the percent of youth (11<sup>th</sup> graders) who report experiencing bullying for any reason from 27.6% in 2013 to 24.8%.

**Resiliency and Bullying:** To address upstream factors related to adolescent wellbeing, MCAH elected to revise the Action Plan priorities to include youth resiliency and coping skills to reduce bullying. Preliminary activities for the upcoming year include reviewing existing protocols to identify gaps in curricula, identify evidence-based or evidence-informed curricula to reduce bullying in school, health care and case management settings, and develop policies and procedures for MCAH program grantees to begin to include anti-bullying content.

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**Domain: Cross-Cutting/Life Course- Annual Report (FY 2014-2015)**

**Goal 1: Increase Access to Oral Health**

**SMART OBJECTIVE:** By June 30, 2020, decrease the rate of Medi-Cal eligible women and children who are uninsured from 8.3% and 36.5% (2011/12 CHIS) to 7.9% and 34.7%, respectively.

MCAH collaborated with CDPH/Chronic Disease and Injury Control Division (CDIC) regarding Oral Health. Fortunately, the State Dental Director resides in this division. The collaboration included the hiring of a staff person who is responsible for addressing oral health in the MCAH population.

**\*Note: Assumption is that those who are Medi-Cal eligible are automatically enrolled in Denti-Cal.**

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of children 3-11 years with a dental visit in

the last year from 75.3 percent 2011/12) to 79.1.

During 2014-15, about 45% of LHJs actively provided education, screenings, referrals, and limited dental services for children and pregnant women. LHJs also relied on collaboration with local oral health coalitions to bring outreach programs and preventive services to MCAH target populations.

MCAH promotes the California perinatal clinical oral health guidelines to assist health care professionals deliver oral health services to pregnant women and their children. MCAH also dispatches updated information, web links, grant resources, and educational materials to local oral health advocates and coordinators. Last year, the oral health policy consultant encouraged public health nurses in LHJs to promote and apply fluoride applications to children aged 1-5 years and many LHJs are continuing these activities. One area of interest is the pediatric dental benefits offered by CA Health Benefit Exchange under the ACA. Dental benefits for children younger than 19 years are embedded into all medical plans offered by Covered CA for 2015.

MCAH assists LHJs in developing oral health activities to increase community access and outreach. For example, two oral health 5-year work plans are posted on the CDPH/MCAH website for LHJs to use in preparing objectives and activities for their SOWs. The goal of one work plan is to increase access and link children to a dental home when possible to ensure they get preventive care on an annual basis. The goal of the second work plan is to increase access for women to receive oral health care by a dentist during their pregnancy. A few examples of oral health activities in LHJs are as follows:

- Contra Costa County provided 4,855 low-income children with fluoride varnish applications in 17 schools.
- Humboldt County worked to improve access to dental care throughout the county by continuing the work of the Oral Health Initiative, targeting communities with the highest rate of decay and conducting focus groups in Latino, American Indian, and Hmong communities to look at oral health messaging and how to best address oral health in these communities.
- San Benito County worked with the San Benito County Healthy Mothers, Healthy Babies Coalition to begin addressing the gaps in children's dental health care access. MCAH contacted the local mobile dental clinic to begin to collaborate on mobile dental clinic outings.
- Alameda County trained 28 WIC staff on the importance of oral health.
- Siskiyou County held two dental clinics in collaboration with WIC. Oral health services included a quick oral exam to identify immediate problems, application of varnish, and oral health education. They are contracting with a mobile dental clinic to bring to Siskiyou County to treat some of the urgent cases that are identified in the WIC/MCAH oral health clinic oral exams.
- 10 LHJs submitted collaborative surveys indicating they were working with partners to improve the oral health of their community.

Several LHJs are proactive in promoting community awareness and linking Medi-Cal eligible families, including children to dental care. In addition, partnerships have been created with the school system, Rural Health Care Centers and Federally Qualified Health Centers regarding educating parents on the importance of healthy eating, tooth decay prevention for children, proper gum care for babies until the first tooth arrives, early detection of childhood carries, and establishing a dental home. San Joaquin County has coordinated round table discussions with providers regarding the importance of dental care. Alameda County continues to implement a dental care service program, where children and families receive anticipatory guidance, screening assessments, fluoride applications, and case management assistance to a dental home at selected WIC sites. This dental initiative was also offered at the Native American Health Center. In addition, Alameda County has organized school-

based/school-linked dental programs emphasizing prevention (including fluoride varnish, sealants, outreach and case management services, as appropriate, to obtain insurance assistance and access to a dental home) that served low income, (Medi-Cal eligible and/or enrolled) racially and ethnically diverse students. Small rural counties identified the lack of dental providers who serve Medi-Cal clients. In addition, transportation has also been a barrier in accessing dental services.

## **Goal 2: Increase Utilization of Preventive Health Services Among Women of Reproductive Age**

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care from 61.9% (2013 BRFSS) to 65.3%.

For FY 2014-15, approximately 40% of the Local MCAH programs documented quality improvement activities which were conducted with the aim to increase the quality of postnatal care services delivered to women of childbearing age.

Text4Baby promotes utilization of preventive health services among women and children by sending messages about well-baby immunizations, preterm birth prevention, prenatal care and postpartum visits with text appointment reminders (available in 33 counties), and smoking cessation. FY 2014-15: Approximately 40% of the Local MCAH programs documented use of Key provisions of the ACA (T4B) to promote the utilization of preventive health services among women and children. For the upcoming FYs MCAH will conduct internal collaboration to increase the LHJs utilizing Text4Baby.

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of first trimester prenatal care initiation from 83% (BSMF) to 87.9%

MCAH promotes the Text4Baby program to promote health coverage screening and enrollment. Text4baby is reaching individuals early in their pregnancy and provides information to women to enroll in affordable health care insurance. As a result of Text4Baby, 39% of women are enrolled during first trimester. Text4Baby is reaching women in high and low income areas; however, a higher percentage of Text4Baby users live in zip codes with the highest levels of poverty compared to the overall U.S. distribution.

The BIH Program provides assistance to women with accessing early prenatal care upon enrollment. As part of the intake process, BIH participants complete an assessment that includes obtaining information about health insurance status, the location of their health care provider and prenatal care initiation. Women who are identified who do not have health insurance, a health care provider or have not started prenatal care are provided referrals and assisted with obtaining insurance, a prenatal provider and obtaining prenatal care appointments.

CPSP and AFLP provide assistance and referrals to initiate early prenatal care.

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of post-partum visits from 88.3% (2012 MIHA) to 92.9%

FY 2014-15: Approximately 40% of the Local MCAH programs documented quality improvement activities were conducted with the aim of increasing the quality of postnatal care services delivered to women of childbearing age. For the upcoming FYs MCAH will assist the local MCAH programs to continue their efforts at improving postnatal care to include interconception care.

The BIH Program promotes and encourages participants to attend their six-week postpartum visit with their health care provider. During prenatal session 6 and postpartum session 14, discussions are held

regarding the importance of receiving care during the postpartum period. BIH LHJ staff also conduct home visits before and after delivery to discuss maternal health care topics which include the importance of attending their postpartum check-up.

### **Goal 3: Increase Utilization of Preventive Health Visits among Children**

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of children, ages 0-17 years, attending one or more preventive visits in the last 12 months from 80.6% (2012 NSCH) to 84.6%.

The BIH Program promotes and encourages participants to ensure that their infants attend all well-child visits with their pediatric health care provider. Participants that have not identified a pediatric care giver for their infant are provided with referrals. During prenatal sessions 6 and 7 as well as postpartum session 15, discussions are held regarding how important it is for their infant to attend all preventive health care visits. BIH LHJ staff also conduct home visits before and after delivery to discuss infant health care topics which include the importance of scheduling and attending all well-child, preventive health care check-ups.

As part of the Local MCAH SOW, each LHJ will develop and adopt a protocol for early childhood screening for all children.

### **Goal 4: Increase the Rates of Women, Children, and Adolescents who have Health Insurance**

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of women with pre-pregnancy health insurance from 75.3% (2012 MIHA) to 79.5% and the number of children and adolescents (ages 0-17) with health insurance from 74.4% (2012 NSCH) to 87.2%.

Key provisions of the Affordable Care Act created a shift in the number of beneficiaries receiving Medi-Cal FFS services over to MMC). As a result of the Section 1115 Demonstration Waiver approval for Medi-Cal, DHCS expects the FFS Medi-Cal eligible only, full scope population to continue to decline as beneficiaries shift from FFS to managed care. There is a declining trend from 2004 to 2013 in Medi-Cal FFS beneficiary participation with an opposite trend seen for Medi-Cal beneficiaries participating in MMC during the same time period. However, DHCS data from 2010 suggests approximately 33% (807,878) of the total 1,664,036 FFS Medi-Cal Only beneficiaries are undocumented residents entitled only to emergency and/or pregnancy-related services.

California will continue to conduct outreach and education to encourage and facilitate enrollment in Covered California, Medi-Cal and other health insurance. Each year, Covered California and state and local partners continue to enroll eligible residents into Covered California health plans or refer them to Medi-Cal to complete the enrollment process. The majority of the local MCAH programs have developed a triaging system to improve clients' access to affordable or free health care services through the 1800 toll free number or resource listings on the LHJ's website. Local MCAH also continues to improve relationships with the safety net clinics such as the FQHCs to provide a reasonable sliding scale program for those who cannot afford adequate care.

### **Goal 5: Decrease the Rate of Postpartum Women without Health Insurance**

**SMART OBJECTIVE:** By June 30, 2020, decrease the rate of postpartum women without health insurance from 16.7% (2012 MIHA) to 16.2%.

For the FY 2014-2015 the Local MCAH programs documented a total of 47,510 referrals to no or low-

cost health insurance coverage (inclusive of Medi-Cal). Eighty-nine percent of the local MCAH programs documented that they made referrals to Medi-Cal, 66% made referrals to CHDP or to WIC. Local MCAH programs continue to provide outreach and referrals to health insurance coverage for pregnant women, infants, and families and provide supportive activities to ensure continuous access to recommended health care services. These activities include identification of high-risk populations, targeted outreach, case finding, and care coordination for women, children, and adolescents who are not linked to a source of care. Other high-risk groups targeted are CYSHCN, low-income pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes. The LHJs promote public health services to a network of providers and provides a listing of community resources available that may not be covered by their current insurance or those belonging to pregnancy-related Medi-Cal scope only after 60 days or those not eligible for Medi-Cal.

**Text4Baby:** In addition, Text4Baby promotes utilization of preventive health services among women and children by sending messages about well-baby immunizations, preterm birth prevention, prenatal care and postpartum visits with text appointment reminders (available in 33 counties), and smoking cessation.

### **Goal 6: Increase grief/bereavement support services to parents/caregivers of all babies who die suddenly and unexpectedly**

**SMART OBJECTIVE:** By June 30, 2020 99% of parent/caregivers experiencing a sudden and unexpected infant death will receive grief/bereavement support services.

**Sudden Infant Death Syndrome (SIDS) Program:** CDPH/MCAH provided two SIDS trainings on grief and bereavement support services to public health professionals and emergency personnel. LHJs contacted families who experienced a sudden unexpected infant death from which a referral was received from the local coroner's office to provide grief support services. MCAH made grief/bereavement support materials and peer support organization information available on the MCAH and California SIDS Program websites. MCAH continues to encourage LHJs to contact their local coroner offices to remind and encourage referral of parents of babies who die suddenly and unexpectedly.

### **Goal 7: Increase Screening and Referral for Mental Health and Substance Use Services**

**SMART OBJECTIVE:** By June 30, 2020, decrease the rate of mental health and substance use hospitalizations for persons age 15-24 from 1436 per 100,000 hospitalizations to 1318 per 100,000.

**Mental Health:** MCAH collaborates to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery. Toward this end, MCAH established a mental health collaborative group of both internal and external stakeholders such as "2020 Moms," local MCAH representatives, and state leadership representatives from DHCS to provide guidance, collaboration and coordination of maternal mental health and wellness efforts.

MCAH programs continue to address mental health needs and access to mental health services as part of a comprehensive approach to health. MCAH acknowledges that there has been a push to screen women for depression, both during pregnancy and the postpartum period and has continued to work with programs in the local jurisdictions, including the BIH programs, AFLP, and CPSP to identify and refer clients at risk for mental health disorders to appropriate assessment and treatment.

- The Mental Health Services Administration (MHSA) provides funding dedicated to statewide suicide prevention programs, which are currently being implemented by Cal MHSA. DHCS

administers grants to LHJs under MHSA, which provide direct services.

- BIH has programs in 15 LHJs where greater than 90% of African American live births occur in California. The program has three primary areas to address maternal mental health and wellness: (1) initial participant assessment is conducted by a mental health professional and on-going case conferencing is done for women with high needs; (2) Perinatal mood and anxiety disorders (PMAD) activities are integrated into both prenatal and postpartum group sessions to ensure a primary prevention focus; and (3) a public health nurse completes an Edinburgh Postnatal Depression Scale (EPDS) on all participants 6-8 weeks postpartum and refers them to services as needed.
- AFLP is a case management-based program that offers services to pregnant and/or parenting youth throughout 30 California counties. Upon entering the program, participants complete the Comprehensive Baseline Assessment (CBA) which includes six questions designed to alert case managers to immediate mental health issues. Following the CBA, program participants complete one of the following depression screenings: Patient Health Questionnaire (PHQ-9), PHQ-9 Modified for teens, or the EPDS screening tool.
- CPSP providers continue to provide psychosocial assessments and interventions to help pregnant and postpartum women understand and deal effectively with the biological, emotional, and social stresses of pregnancy with referrals, as appropriate. From January to July 2015, there were a total of 29,931 enhanced CPSP psychosocial services provided to pregnant and postpartum women.

**Substance Abuse:** In 2015, MCAH and LHJ staff attended training on Screening, Brief Interventions, and Referral to Treatment, a benefit reimbursable by Medi-Cal. This is a comprehensive health promotion approach for delivering early intervention and treatment services to people with, or at risk of developing, alcohol use disorders. MCAH partnered with a non-profit organization called, “MotherToBaby, California”, federally funded by Health Resources and Services Administration Cooperative, to provide education and additional resource to the local MCAH for pregnant women exposed to substances (last 3 words are awkward). The organization provides free and confidential telephone and e-mail service information to pregnant women who are concerned about exposure to medications, chemicals including illicit substances, second-hand smoke and possible teratogens. “MotherToBaby, California” presented at the 2015 Perinatal Services Coordinators’ Annual Meeting and has since been used by local MCAH programs as a resource. In addition, this organization has also partnered with the RPPC Directors to make this resource available to hospital providers.

MCAH, in partnership with Ventura County, developed a Marijuana Informational brochure that can be adopted by other LHJs for standard messaging.

AFLP screens for substance use using the CRAFFT Screening Tool, a six-question behavioral health-screening tool recommended by the American Academy of Pediatrics’ (AAP) Committee on Substance Abuse for use with adolescents. CRAFFT is a mnemonic acronym of the first letters of key words in the six screening questions (Care, Relax, Alone, Forget, Family or Friends, Trouble). Based on the results of their screening, case managers refer clients with mental health needs to the appropriate community resources available in the county.

### **Goal 8: Increase the Consumption of a Healthy Diet within the MCAH Population**

MCAH engaged in several activities to promote nutrition and physical activity and prevent/reduce obesity. MCAH partnered with DHCS to provide guidance on including medical nutrition therapy in its benefits packages.

**SMART OBJECTIVE:** By June 30, 2020, increase the percent of women with recommended weight

gain during pregnancy from 34.3% (2013 BMSF) to 36.1%.

MCAH engaged in several activities to promote nutrition and physical activity and prevent/reduce obesity. MCAH coordinated its physical activity promotion activities with the CDPH Physical Activity Collaboration Team. MCAH convened a Center for Family Health-wide group (California Women, Infants and Children Supplemental Nutrition Program (WIC), Genetic Disease Screening Program (GDSP), and SCD) quarterly to coordinate nutrition, breastfeeding and physical activity activities, and ensure MCAH Program (e.g. CDAPP: Sweet Success, CPSP, AFLP, and BIH) nutrition and physical activity guidelines and educational materials, resources and assessment forms are current and consistent.

MCAH maintained the MCAH Nutrition and physical Activity web page with over 360,000 views on the website. The adolescent cookbook which includes healthy foods and physical activity tips was the highest ranked subpage with about 25,000 views last year.

MCAH completed the Adolescent Nutrition and Physical Activity guidelines, including sections on weight. In June 2015, a webinar on how to use the guidelines was presented to local MCAH directors and contractors.

MCAH promoted systems and environmental change interventions to the MCAH Directors to increase community physical activity in their upcoming five-year action plans. Resources were regularly emailed to encourage MCAH programs to consider systems and environmental change interventions work. The MCAH Systems and Environmental Change Toolkit was updated and a webinar was developed and presented to the MCAH Directors/contractors to provide resources for them to work on “walkability.”

A sample of a local initiative to campaign and increase healthy diets and physically active lifestyles included: San Bernardino County professionals and lay community members including registered dietitians, First 5 San Bernardino staff, WIC staff, lactation educators, hospital staff, postpartum nurses, pregnant women and women of childbearing age, Preschool Services, Inland Empire Breastfeeding Coalition, CHDP, and CPSP providers and staff at public and private agencies and community-based organizations.

**SMART OBJECTIVE:** By June 30, 2020, reduce the proportion of WIC children aged 2-4 years who are overweight/obese from 34.5% (WIC PC 2012) to 33.5%.

MCAH maintained the MCAH Nutrition and physical Activity web page with over 360,000 views on the website.

MCAH was one of the authors of the nutrition curriculum and supportive on-line tools for the Emergency Medical Services Authority (EMSA) training for licensed childcare facilities. Effective January 2016, those receiving licenses (or their designees) will be required to take a training utilizing this finalized curriculum that includes:

- Healthy nutrition on the developing child and on the overall health of children ages 12 and younger.
- Basic information about California’s Healthy Beverages in Child Care Law (AB 2084).
- Best practices for feeding infants and toddlers including breast milk, iron fortified formula, and introducing first foods;
- Age-appropriate healthy foods that are based on current Dietary Guidelines for Americans.
- How to cut back on foods high in solid fats, added sugars, and salt.
- Using food labels to assist making healthy choices.

- Best Practices for Building Healthy Eating Habits in Children, including the division of responsibility.

In addition to providing input to the nutrition curriculum and on-line tools for the PHSP, MCAH completed the Adolescent Nutrition and Physical Activity guidelines, specifically Body Image, Fruit and Vegetables, and Vegetarian sections. This created an opportunity for the MCAH Directors to integrate efforts to increase community physical activity in the upcoming five-year action plan.

Examples of local initiatives to campaign and increase healthy diets and physical activity included:

- Modoc County conducted 184 presentations with nutrition messages to preschool and school age children. The content included discussing benefits of each harvest of the month, sampling the harvest of the month, vitamins and minerals in the harvest of the month, discussing the importance of healthy eating, drinking, and exercise, teaching kids where veggies/fruit come from, and reading a book with healthy message.
- San Bernardino County educated professionals and lay community members (including registered dietitians, First 5 San Bernardino staff, WIC staff, lactation educators, hospital staff, postpartum nurses, pregnant women and women of childbearing age, Preschool Services, Inland Empire Breastfeeding Coalition, CHDP, and CPSP providers and staff at public and private agencies and community-based organizations regarding exercise that contribute to the reduction of childhood obesity.

***Nutrition for Children and Youth with Special Health Care Needs:*** Nutrition plays a key role in the development of all children. However, Medical Nutrition Therapy (MNT) is fundamental to the cognitive, physical, and emotional development for much of the CYSHCN population as many CCS eligible conditions such as cystic fibrosis, metabolic disorders, chronic inflammatory diseases of the gastrointestinal system, renal diseases, liver diseases, and some neurological conditions rely on MNT as an essential component of treatment. Without appropriate nutrition interventions, children with certain metabolic disorders are at high risk for developing severe cognitive impairment. Other conditions that lead to malnutrition such as cerebral palsy, cystic fibrosis, inflammatory bowel disease, etc. greatly increase the risk of morbidity and mortality in the CCS population. To counter act the negative consequences of poor nutritional status in the CCS population, all CCS clients with nutrition concerns related to their CCS eligible condition are required to be assessed and evaluated at least twice year by a CCS-paneled Registered Dietician (RD) in a SCC to ensure the prescribed MNT leads to optimal cognitive, physical and emotional development.

***The Child Health and Disability Prevention Program (CHDP):*** Registered Dietitians provided approximately 100 obesity related trainings (Counseling the Overweight Child, Body Mass Index (BMI) Training, Glucose and Cholesterol Screening for Pediatric Obesity, and How to Accurately Weigh and Measure Children) throughout the state. LA County CHDP Program provided obesity related trainings at 51 sites reaching 36 providers and 363 physician assistants, nurses, and medical assistants during the last fiscal year.

Two CHDP Programs have continued to implement The Active and Healthy Families (AHF) Childhood Obesity program at a number of sites. Active & Healthy Families (AHF) is a family-based medical group appointment program, which teaches healthy eating and exercise habits to low-income families served by Federally Qualified Health Centers (FQHC). In the counties with an AHF program or similar program, CHDP trains the AHF's team, which consists of a provider, a registered dietitian, and a promotora or community health worker, monitors the sessions, and evaluates the program.

Specifically, San Mateo County CHDP Program has been instrumental in developing educational materials for patients, disseminating information to county health professionals and CHDP providers, and implementing the 5-2-1-0 Let's Go obesity prevention campaign throughout the county.

## **Goal 9: Increase Physical Activity within the MCAH Population**

**SMART OBJECTIVE:** By June 30, 2020 increase the rate of meeting the age specific guidelines for physical activity from 30.4%, 16.2% (2011-12 CHIS) and 24.0% (2013 BRFSS) to 31.9%, 17% and 25.3% for children ages 6-11, adolescents 12-17, and women ages 18-24, respectively.

MCAH engaged in several activities to promote physical activity. MCAH coordinated its physical activity promotion activities with the CDPH Physical Activity Collaboration Team. MCAH convened a Center for Family Health-wide group (California Women, Infants and Children Supplemental Nutrition Program (WIC), Genetic Disease Screening Program (GDSP), and SCD) quarterly to coordinate nutrition, breastfeeding and physical activity activities, and ensure MCAH Program (e.g. CDAPP: Sweet Success, CPSP, AFLP, and BIH) nutrition and physical activity guidelines and educational materials, resources and assessment forms are current and consistent.

MCAH maintained the MCAH Nutrition and Physical Activity web page with over 360,000 views last year on the website. MCAH was one of the authors of on-line tools for the Emergency Medical Services Authority (EMSA) training for licensed childcare facilities. Effective January 2016, those receiving licenses (or their designees) will be required to take a training utilizing this finalized curriculum. A preliminary resource web page was posted and includes how to increase physical activity and reduce screen time.

MCAH completed the Adolescent Nutrition and Physical Activity guidelines, specifically Body Image, Fruit and Vegetables, and Vegetarian sections. In June 2015, a webinar on how to use the guidelines was presented to local MCAH directors and contractors.

MCAH promoted systems and environmental change interventions to the MCAH Directors to increase community physical activity in the upcoming five-year action plan. Resources were regularly emailed to encourage them to consider systems and environmental change interventions. The MCAH Systems and Environmental Change Toolkit was updated and a webinar was developed and presented to the MCAH Directors/contractors to provide resources for them to work on "walkability." Examples of local initiatives to campaign and increase healthy diets and physically active lifestyles included:

- Modoc County conducted 184 presentations with messages to preschool and school age children. The content included discussing the benefits of exercise and reading a book with healthy message.
- San Bernardino County educated professionals and lay community members including registered dietitians, First 5 San Bernardino staff, WIC staff, lactation educators, hospital staff, postpartum nurses, pregnant women and women of childbearing age, Preschool Services, Inland Empire Breastfeeding Coalition, CHDP, and CPSP providers and staff at public and private agencies and community-based organizations regarding exercises that contribute to the reduction of childhood obesity.

**Nutrition and Physical Activity:** MCAH provided input into the nutrition curriculum and supportive on-line tools for the Preventive Health and Safety Practices (PHSP) training for licensed childcare facilities. Effective January 2016, those receiving licenses (or their designees) will be required to take the training. The training will include the following topics:

1. Healthy nutrition on the developing child and on the overall health of children ages 12 and younger.
2. Basic information about California's Healthy Beverages in Child Care Law (Assembly Bill 2084).

3. Best practices for feeding infants and toddlers including breast milk, iron fortified formula, and introducing first foods;
4. Age-appropriate healthy foods that are based on current Dietary Guidelines for Americans.
5. How to cut back on foods high in solid fats, added sugars, and salt.
6. Using food labels to assist make healthy choices.
7. Best Practices for Building Healthy Eating Habits in Children, including the division of responsibility.

## **Goal 10: Increase the Consumption of Folic Acid by Childbearing Age Women**

**SMART OBJECTIVE:** By June 30, 2020 increase the percentage of women who took a vitamin containing folic acid every day of the week during the month before pregnancy from 34% (2012 MIHA) to 35.9%.

MCAH distributed English and Spanish folic acid posters and pamphlets to local agencies to promote daily preconception intake of 400 mcg folic acid. The state WIC program also printed and distributed the MCAH-developed folic acid materials. MCAH maintained the Folic Acid sub-web page as a central location to disseminate resources to promote daily preconception intake of 400 mcg folic acid. It had approximately 4000 views in the year. The January 2015 National folic acid week was promoted to MCAH programs and contacts through emails encouraging use of state and national resources.

MCAH monitored daily folic acid intake during the month before pregnancy through the MIHA survey.

### *Domain: Cross-Cutting/Life Course - Plan for the Application Year (FY 2016-2017)*

## **Goal 1: Increase Access to Oral Health**

**SMART OBJECTIVE:** By June 30, 2020, decrease the rate of Medi-Cal eligible women and children who are uninsured from 8.3% and 36.5% (2011/12 CHIS) to 7.9% and 34.7%, respectively.

MCAH is collaborating with CDPH/Chronic Disease and Injury Control Division (CDIC) regarding Oral Health. The State Dental Director resides in this division. The collaboration includes the hiring of a staff person who is responsible for addressing oral health in the MCAH population.

**\*Note: Assumption is that those who are Medi-Cal eligible are automatically enrolled in Denti-Cal.**

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of children 3-11 years with a dental visit in the last year from 75.3 percent (2011/12) to 79.1.

**Oral Health:** CDPH has a new State Dental Director and an oral health epidemiologist in the new Oral Health Unit (OHU). MCAH will collaborate with the OHU and the State Dental Director on oral health issues and future projects. MCAH will be working collaboratively with the new Dental Director on the State's Oral Health Plan with an emphasis on improving the oral health of pregnant women and young children.

The primary goal of MCAH oral health activities is to ensure that LHJ staff inform all eligible and enrolled clients of dental benefits available from Medi-Cal, and promote the dental home and Medi-Cal warm transfer service through the 1-800 customer service phone number or other referral

services. In the coming year this will be achieved by working with LHJs to implement the new California Oral Health Plan, focusing on access and use of Denti-Cal services and establishment of the dental home. MCAH will also help LHJs develop or adopt policies and best practices to promote dental benefits to at-risk populations and undocumented women and provide professional and workforce development opportunities, resources and TA to local MCAH programs to improve staff knowledge regarding the importance of the dental home, education, and prevention.

A key activity will be providing TA to local MCAH Programs to implement quality assurance and improvement processes. One example of this is the MCAH Director monthly discussion forum calls to address enrollment issues. There is an expanded opportunity for enrollment promotion because the California Health Benefit Exchange Board has decided to offer in 2016 optional stand-alone family dental plans, which includes dental coverage for adults.

**Goal 2:** Increase Utilization of Preventive Health Services Among Women of Reproductive Age

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care from 61.9% (2013 BRFSS) to 65.3%.

MCAH would like to increase the utilization of preventive health services among women of reproductive age as an opportunity to provide preconception care prior to pregnancy and as an essential clinical component to preventing future morbidity. In the first year, MCAH will analyze the existing efforts to refer or market insurance to women of reproductive age, children, and adolescents. The analysis will include identified gaps that can be addressed by programmatic focus, new materials, or direct campaigning. MCAH will partner with the San Francisco Department of Public Health to increase patient-centered care for women through the finalization of the IRIS designation for Excellence in Young Women's Health Care. IRIS stands for Integrated, Reproductive, Internal and Skin, four areas that are emphasized as points of importance for young women's health care.

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of first trimester prenatal care initiation from 83.0% (BSMF) to 87.9%

The BIH Program, CPSP, and AFLP staff will continue to assist women with accessing early prenatal care upon enrollment and stressing the importance of keeping all prenatal care appointments during pregnancy. The LHJ staff will continue to provide referrals to women who have not yet identified a prenatal health care provider. These MCAH Programs will continue to collaborate with community partners in order to utilize current lists of prenatal care providers.

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of post-partum visits from 88.3% (2012) MIHA to 92.9%

The BIH Program will continue to promote and encourage participants to attend their six week postpartum visit with their health care provider. The BIH Program curriculum will continue to discuss the importance of attending postpartum visits during prenatal session 6 and postpartum session 14. The BIH PHN will continue to conduct home visits before and after delivery and as needed, to discuss the importance of attending postpartum check-ups and other maternal health care topics. For the upcoming FYs MCAH will assist the local MCAH programs to continue their efforts at improving postnatal care to include interconception care. CPSP and RPPC will continue to develop clinical linkages that promote postpartum visits with provider and hospitals.

### **Goal 3: Increase Utilization of Preventive Health Visits among Children**

**SMART OBJECTIVE:** By June 30, 2020, increase the percent of children, ages 0-17 years, attending one or more preventive visits in the last 12 months from 80.6% (2012 NSCH) to 84.6%.

MCAH LHJs along with funded BIH Program LHJ staff will continue to encourage participants to ensure that their infants attend all well-child, preventive health care visits. The BIH Program curriculum will continue to provide information during session 7 about the importance of preventive health visits for their infants and young children. The BIH Program LHJ staff will continue to collaborate with community partners such as CHDP and MCMC in order to provide participants with current names of pediatric care providers.

Two trainings will be planned, one for the Adolescent Health Work Group Conference and another statewide or national conference. In preparation for implementing additional strategies in the coming years, MCAH will develop a work plan with the California Health Benefit Exchange Board, CPSP, WIC, and Text4Baby to promote health insurance enrollment and timely visits.

### **Goal 4: Increase the Rates of Women, Children, and Adolescents who have Health Insurance**

**SMART OBJECTIVE:** By June 30, 2020, increase the rate of women with pre-pregnancy health insurance from 75.3% (2012 MIHA) to 79.5% and the number of children and adolescents (ages 0-17) with health insurance from 74.4 (2012 NSCH) to 87.2%.

MCAH LHJs along with BIH and AFLP Programs will continue to refer women who do not have health insurance to Covered California.

### **Goal 5: Decrease the Rate of Postpartum Women without Health Insurance**

**SMART OBJECTIVE:** By June 30, 2020, decrease the percent of postpartum women without health insurance from 16.7% (2012 MIHA) to 16.2%.

For women and children, MCAH programs will focus on administrative efforts to promote in-person referrals and ensure follow-ups to increase referral completion rates. Preventive care concepts will be included in the LHJs MCAH Policies and Procedures Manual to ensure that all persons in MCAH programs are referred for enrollment in health insurance and complete a preventive visit. Activities include: verify health insurance status, assist clients to enroll in health insurance, link clients to a health care provider for a preventive visit, develop a tracking mechanism to verify that the client enrolled in health insurance and completed a preventive visit, and conduct quality assurance activities to ensure that protocols are implemented as intended and revised as needed.

### **Goal 6: Increase grief/bereavement support services to parents/caregivers of all babies who die suddenly and unexpectedly.**

**SMART OBJECTIVE:** By June 30, 2020 100% of parent/caregivers experiencing a sudden and unexpected infant death will receive grief/bereavement support services.

***Sudden Infant Death Syndrome (SIDS) Program:*** LHJs will continue to contact families who experienced a sudden unexpected infant death from which a referral was received from the local coroner's office. MCAH will continue to make grief/bereavement support materials and peer support organization referrals available on the MCAH and California SIDS Program websites. CDPH/MCAH

will continue to provide two SIDS trainings on grief and bereavement support services to public health professionals and emergency personnel.

LHJs will continue to contact families who experienced a sudden unexpected infant death upon receiving referrals from the local coroner's office to provide grief support services. CDPH/MCAH will continue to encourage LHJs to contact their local coroner offices to remind and encourage referral of parents of babies who die suddenly and unexpectedly.

### **Goal 7: Increase Screening and Referral for Mental Health and Substance Use Services**

**SMART OBJECTIVE:** By June 30, 2020, decrease the rate of mental health and substance use hospitalization for person age 15-24 from 1436 per 100,000 to 1318 per 100,000 hospitalizations

LHJs will continue to work on developing and strengthening coalitions with public/private agencies and healthcare providers to determine how best to identify women at risk and how to develop appropriate referral sources. LHJs will continue to develop and implement coordinated and integrated systems of care to address perinatal substance use prevention. MCAH will continue to participate in the Fetal Alcohol Spectrum Disorder (FASD) Task Force and will continue its efforts on preconception health education and promotion, including augmenting and monitoring its preconception health website. The Federal Office of Minority Health established an Advisory Board to Preconception Peer Educators at California Community Colleges and Universities and will partner with LHJs and local organizations to plan campus and community outreach campaigns and events to promote harm reduction strategies to reduce preconception and prenatal alcohol exposure. These outreach strategies will include social media.

MCAH will continue ongoing quality improvement and education efforts to learn about emerging best practices for reducing binge drinking. Because California has unique alcohol consumption patterns arising from the popularity and cultural significance of locally produced wine, MCAH will continue to explore ways to find culturally appropriate strategies to reduce heavy consumption patterns and prevent illegal consumption by minors. Among the strategies will be to engage the Teen Pregnancy Prevention programs, I&E and CA PREP, to enhance their ability to include substance abuse prevention as a teen pregnancy prevention strategy.

MCAH is developing a Maternal Mental Health and Wellness conceptual model to improve the health and wellness of California's MCAH populations by increasing health equity and reducing health disparities of perinatal mood and anxiety disorders (PMAD). The efforts to address PMAD will include primary, secondary, and tertiary prevention activities. Major activities will be: (1) increasing local MCAH programs awareness of PMAD and the impact on the MCAH population; (2) develop and distribute evidence-based Toolkits to local MCAH programs; and (3) develop culturally and linguistically appropriate policies and protocols for local MCAH programs to reduce discrimination and stigmatization related to maternal mental health.

### **Goal 8: Increase the Consumption of a Healthy Diet within the MCAH Population**

**SMART OBJECTIVE:** By June 30, 2020, increase the percent of women with recommended weight gain during pregnancy from 34.3% 2013 BMSF) to 36.1%.

**Nutrition:** The overall emphasis for the nutrition and physical activity plans for the next year is to continue to target racial and ethnic disparities.

MCAH will use the Birth Statistical Master File and the MIHA survey to monitor weight gain during pregnancy.

Nutrition and physical activity interventions will continue to target racial and ethnic disparities. LHJs will continue to address nutrition and physical activity with at least 14 LHJs having identified nutrition and physical activity campaigns as a goal in their scopes of work and/or 5-year action plans.

MCAH will continue to collaborate with state programs and agencies, experts and local MCAH directors to offer counseling, such as guidelines on dietary intake and physical activity tailored to client circumstances/stage of change for overweight and obese women of reproductive age. Per recommendations by the IOM's Committee to Reexamine IOM Pregnancy Weight Guidelines (2009), MCAH will continue to conduct routine surveillance of pre-pregnancy BMI, weight gain during pregnancy and postpartum weight retention and report the results by age, racial/ethnic group, and socioeconomic status to inform local initiatives to promote healthy weight. MCAH will continue to inform women of the importance of conceiving at a normal BMI as part of the preconception initiative, encourage women to limit their weight gain during pregnancy based on the revised IOM guidelines, and make the most current resources on pregnancy weight gain available on the MCAH website. MCAH will continue to promote use by women of Affordable Care Act provisions for Well-Woman care and obesity screening/counseling for all adults by partnering with Covered California and Medi-Cal. MCAH will continue to publicize resources that support healthy weight to healthcare providers and public health professionals and encourage their use during Well-Woman and prenatal care. Resources include the Interconception Care Project of California and the clinical toolkits on the Before, Between and Beyond website.

Ensure MCAH Program Nutrition and weight gain guidelines and educational materials, resources and assessment forms exist, have consistent messaging, and are used by CDAPP: Sweet Success, CPSP, AFLP, and BIH programs. MCAH will offer to provide guidance to DHCS to include medical nutrition therapy in its Medi-Cal benefits packages.

One of the key strategies for improving capacity for nutrition and physical activity is resource sharing. Toward this end, MCAH will maintain the email distribution list to perinatal nutritionists working with MCAH programs and provide support and TA, participate in quarterly meetings with the Women Infants and Children Supplemental Nutrition Program (WIC), Genetic Disease Screening Program (GDSP), and SCD, and maintain the MCAH Nutrition and Physical Activity (NUPA) web page. This will provide a central location to disseminate resources to promote optimum nutrition and physical activity for the MCAH population, including information on the healthy weight of a mother before and during her pregnancy and promoting a Systems and Environmental Change framework for nutrition and physical activity initiatives.

Through collaboration with external partners, MCAH will continue to promote walking as an easy, low impact, frequently available option for physical activity and facilitate pedestrian safety and walkability strategies and technical support to LHJs for implementation. Lastly, the continuous updating of the MCAH NUPA website will ensure that workplace wellness materials and MCAH Program physical activity guidelines and educational materials, resources and assessment forms are available for Local MCAH Jurisdictions, CDAPP: Sweet Success, CPSP, AFLP, and BIH.

**SMART OBJECTIVE:** By June 30, 2020, reduce the proportion of WIC children aged 2-4 years who are overweight/obese from 34.5% (WIC PC 2012) to 33.5%

LHJs will continue to address nutrition and physical activity with at least 14 that chose nutrition and physical activity campaigns as a goal in their scopes of work and/or 5-year action plans.

Nutrition and physical activity interventions will continue to target racial and ethnic disparities. MCAH will use the Behavioral Risk Factor Surveillance System (BRFSS), the California Health Interview System (CHIS) and WIC data to monitor nutrition indicators for MCAH target populations with attention to racial/ethnic inequity.

As noted in the preceding Smart Objective, one of the key strategies for improving capacity for nutrition and physical activity is resource sharing. Toward this end, MCAH will maintain the email distribution list to perinatal nutritionists working with MCAH programs and provide support and TA, participate in quarterly meetings with the Women Infants and Children Supplemental Nutrition Program (WIC), Genetic Disease Screening Program (GDSP), and SCD, and maintain the MCAH Nutrition and Physical Activity (NUPA) web page. This will provide a central location to disseminate resources to promote optimum nutrition and physical activity for the MCAH population, including promoting a Systems and Environmental Change framework for nutrition and physical activity initiatives.

Ensure MCAH Program Nutrition and weight gain guidelines and educational materials, resources and assessment forms exist, have consistent messaging, and are used within the CDAPP: Sweet Success, CPSP, AFLP, and BIH program. MCAH will offer to provide guidance to DHCS to include medical nutrition therapy in its benefits packages.

Through collaboration with external partners, MCAH will continue to promote walking as an easy, low impact, frequently available option for physical activity and facilitate pedestrian safety and walkability strategies and technical support to LHJs for implementation.

MCAH is a core team member with the Children's Council of San Francisco to be part of the Association of State Public Health Nutritionists (ASPHN) Pediatric Obesity Collaborative Improvement and Innovation Network (ColIN). The aim of the ColIN is to increase the proportion of children ages 2-5 who fall within a healthy weight range by September 2016. The focus is to promote optimum nutrition and physical activity and reduced screen time in childcare sites. California is focusing on developing an on-line resource for newly licensed child care workers who are mandated as of 2016 to take a one hour nutrition course. California joins five other mini ColIN teams from Arkansas, Louisiana, North Dakota, Ohio, and Oregon. California ColIN members are from the following organizations: MCAH, Children's Council of San Francisco, California Department of Education, California Department of Social Services, Child Care Licensing Program, California Early Care and Education (ECE) Partnership, CDPH, Nutrition Education and Obesity Prevention Branch, Emergency Medical Services Authority, First Five California, and the University of California, Davis: Human Lactation Center.

CHDP Registered Dietitians will continue to provide obesity related trainings to healthcare providers and nursing staff throughout the state and update obesity and physical activity resources. The SCC registered dietitians (RDs) and Public Health Nurse Consultants will ensure the CCS clients are assessed and evaluated at least twice per year for appropriate MNT for optimal growth, development, and health by working together on patient care, policy development and implementation, and on obtaining non-contracted enteral nutrition products when medically necessary.

## **Goal 9: Increase Physical Activity within the MCAH Population**

**SMART OBJECTIVE:** By June 30, 2020 increase the rate of meeting the age specific guidelines for

physical activity from 30.4%, 16.2% (2011-12 CHIS) and 24.0% (2013 BRFSS) to 31.9%, 17.0% and 25.3% for children ages 6-11, adolescents ages 12-17, and women ages 18-24, respectively.

Physical activity interventions will continue to target racial and ethnic disparities. MCAH will use the Behavioral Risk Factor Surveillance System (BRFSS) and the California Health Interview System (CHIS) to monitor physical activity indicators for MCAH target populations with attention to racial/ethnic inequity.

One of the key strategies for improving capacity for physical activity is resource sharing. Toward this end, MCAH will continue maintain the email distribution list to nutritionists working with MCAH programs, provide support and TA, participate in quarterly meetings with the Women Infants and Children Supplemental Nutrition Program (WIC), Genetic Disease Screening Program (GDSP), and SCD, and maintain the MCAH Nutrition and Physical Activity (NUPA) web page. The web page will provide a central location to disseminate resources to promote optimum physical activity for the MCAH population, including information on the healthy weight of a mother before and during her pregnancy and promote a Systems and Environmental Change framework for nutrition and physical activity initiatives.

Through collaboration with external partners, MCAH will continue to promote walking as an easy, low impact, frequently available option for physical activity and facilitate pedestrian safety and walkability strategies and technical support to LHJs for implementation. Lastly, the continuous updating of the MCAH NUPA website will provide workplace wellness materials and MCAH Program physical activity guidelines and educational materials, resources and assessment forms and are used by the CDAPP: Sweet Success, CPSP, AFLP, and BIH program.

MCAH will continue to collaborate with state programs and agencies, experts and local MCAH directors to promote guidelines on physical activity tailored to client circumstances/stage of change and for overweight and obese women of reproductive age.

CHDP Registered Dietitians will continue to provide obesity related trainings to healthcare providers and nursing staff throughout the state and update obesity and physical activity resources. The SCC RDs and Public Health Nurse Consultants will ensure the CCS clients are assessed and evaluated at least twice per year appropriate MNT for optimal growth, development, and health by providing and working closely together on patient care, policy development and implementation, and on obtaining non-contracted enteral nutrition products when medically necessary.

## **Goal 10: Increase the Consumption of Folic Acid by Childbearing Age Women**

**SMART OBJECTIVE:** By June 30, 202 increase the percentage of women who took a vitamin containing folic acid every day of the week during the month before pregnancy from 34% (2012 MIHA) to 35.9%.

MCAH will continue to maintain the Folic Acid web page as a central location to disseminate resources to promote daily preconception intake of 400 mcg folic acid. Also promote folic acid through the Inter-conception Care Project of California and the Before, Between and Beyond website. MCAH will continue to promote folic acid by distributing English and Spanish folic acid posters and pamphlets to local agencies to promote daily preconception intake of 400 mcg folic acid. MCAH will promote the January 2017 National folic acid week to MCAH programs, partners and contacts through emails encouraging use of state and national resources.

MCAH will continue to monitor folic acid intake through the MIHA.

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### **Other Programmatic Activities**

**Collaborative Improvement and Innovation Network (ColIN):** MCAH is participating in the Infant Mortality Collaborative Improvement and Innovation Network (ColIN), a national initiative that emerged as a response to needs identified by the states of the U.S. Health and Human Services (HHS) Regions IV and VI at their Infant Mortality Summit in January of 2012. On June 14, 2012, then HHS Secretary Kathleen Sibelius announced the creation of the nation's first ever national strategy to reduce infant mortality. The Infant Mortality ColIN expansion is a key component of this strategy.

This multiyear national initiative ending in September 2016 engages federal, state, and local leaders, public and private agencies, professionals, and communities to employ quality improvement, innovation, and collaborative learning to address infant mortality reduction. Participants of ColIN learn from national experts and one another, share best practices and lessons learned, and track progress toward shared benchmarks. ColIN has technology-enabled teams that tackle a common problem. The originator of the term describes a ColIN as a “cyber team of self-motivated people with a collective vision that innovatively collaborate by sharing ideas, information, and work enabled by technology”.

The ColIN spread to HHS Region V in 2013 and has since expanded to the rest of the nation. The lead organizations are the Maternal and Child Health Bureau of the Health Resources and Services Administration and the National Institute for Children's Health Quality. Organizations providing support and TA include the Association of State and Territorial Health Officials, Association of Maternal and Child Health Programs, and March of Dimes (MOD). On July 21-25, 2014, the National Expansion Infant Mortality Summits for HHS Regions VII-X (California belongs to Region IX) and HHS Regions I-III were held at Arlington, VA.

The Infant Mortality ColIN has six topical National Learning Networks, namely, Safe Sleep, Smoking Cessation, Social Determinants of Health (SDOH), Pre/Interconception Care, Preterm/Early Term Births, and Risk Appropriate Perinatal Care. States choose up to three topics to address during the 18-month timeline for IM ColIN efforts. California is addressing Safe Sleep, Risk Appropriate Perinatal Care, and Social Determinants of Health. MCAH is the state ColIN lead. Members of the state team include MCAH staff and representatives from partner organizations, including MCAH Statewide Directors, MOD, CMQCC, CPQCC, and Best Babies Zone.

**Safe Sleep:** MCAH developed an Intervention Protocol using a culturally congruent patient engagement approach which is being implemented in two pilot BIH intervention sites, Alameda and Sacramento Counties, that have the highest disparities in African American: White Sudden Unexpected Infant Death rates among all LHJs. Implementation of the protocol coincided with the roll-out of the standardized BIH curriculum which began in July 2015.

**Risk Appropriate Perinatal Care (RAPC):** The RAPC Task Force has representatives from MCAH - RPPC and CPSP, CA Perinatal and Maternal Quality Care Collaboratives, MOD CA Chapter, CA Perinatal Transport System, CA Children's Services, Medi-Cal (Dept. of HCS), Sutter Health, LA County Public Health, MCAH Directors(Local MCAH Directors' Association), and the CA Maternal Appropriate Risk Care Project. Its main project is conducting an environmental scan

to ascertain the existence and functionality of Regional Cooperative Agreements (RCA) among CCS-approved NICUs/birthing hospitals. The scan results will be analyzed to determine whether there is a relationship between RCA functionality and selected outcomes such as prematurity and infant mortality. This project will help establish the foundation for the eventual rollout of maternal levels of care in California.

**Social Determinants of Health (SDOH):** MCAH is developing a “state assessment” report focusing on MCAH indicators that assists LHJs in addressing and incorporating social determinants into their programs and initiatives. Information on how social determinants affect health in the context of infant mortality and morbidity, and strategies to address these issues will be incorporated.

**California Home Visiting Program:** The California Home Visiting Program (CHVP) is a positive parenting program to help vulnerable families independently raise their children by focusing on comprehensive, coordinated in-home services. Currently, 26 sites in 24 LHJs are funded to provide services using one of two nationally recognized home visiting models, Healthy Families America and Nurse-Family Partnership.

Most recently, and in response to unmet needs, new partnerships have been forged between MCAH, CHVP, and DHCS to identify mental health services and Medi-Cal reimbursement mechanisms for home visiting families.

**Continuous Quality Improvement:** MCAH has focused research and evaluation efforts on its service delivery programs to increase capacity for Continuous Quality Improvement (CQI) and other data-driven efforts that will harmonize implementation and intervention goals and ultimately improve outcomes for our target populations. Informed by recent Quality Improvement planning efforts, MCAH has used participant-level performance data and contextual information collected from LHJs to refine measures of model fidelity and increase overall data capacity for program monitoring, quality improvement, and program evaluation. The result is an increased ability to evaluate existing data collection and reporting systems and ensure each new system’s functional specifications are tailored to MCAH’s specific monitoring, evaluation, and reporting needs.

**Information and Education Program:** The MCAH Division receives approximately \$1.2 Million in State General Funds to implement the I&E Program. The goal of the I&E Program is to decrease adolescent pregnancies by providing high needs youth with the knowledge, understanding, and behavioral skills necessary to make responsible decisions regarding at-risk behavior. I&E aims to help prevent adolescent pregnancies and STIs through comprehensive, medically accurate, culturally competent and age-appropriate educational programs which provide youth with the skills and knowledge needed to make responsible decisions regarding sexual behavior. I&E programs also provide clinical linkages to youth to ensure access to reproductive health services. I&E programs are offered through schools, juvenile justice facilities, community-based organizations (CBOs), and county offices. Currently, MCAH funds 24 I&E grantees in 14 counties. Current program interventions include:

- Life Skills Intervention: assist youth in developing life skills and access services. activities include, but are not limited to:
  - Building youth resiliency and developing healthy coping skills to address bullying
  - Providing education about the importance of healthy relationships
  - Providing resources and information to youth to assist them in accessing youth-friendly reproductive health services

- Educating youth on contraceptives, particularly LARCs, and STIs, including HIV
- Information Presentations: community presentations provide youth with knowledge and skills to make responsible decisions regarding their sexual health
- Targeted Prevention Activities: health educators work one-on-one with youth to share information on accessing reproductive health services, determining Medi-Cal eligibility, and educating them on contraceptive methods and STIs/HIV
- Community Awareness and Mobilization: Provide media and large scale public events to increase the visibility of adolescent pregnancy prevention services and resources.
- Peer-Based Education: youth are given the opportunity to act as peer counselors to deliver information and education on a variety of topics relevant to today's youth, and assist peers in accessing youth-friendly reproductive health services.

The I&E Program's three-year funding cycle ends June 30, 2016. A request for applications (RFA) for the upcoming funding cycle, July 1, 2016-June 30, 2019 was released in December 2015. MCAH received 22 applications from governmental and non-governmental organizations, as well as CBOs, requesting funding up to \$80,000. MCAH is currently in the review process and is planning to fund approximately 14 agencies, with agency contracts beginning on July 1, 2016.

**California Personal Responsibility Education Program (CA PREP):** The CA PREP provides sexual health education to adolescents via effective, evidence-based program models that have been proven to change sexual risk-taking behavior, including delaying initiation of sexual activity and increasing contraceptive use. CA PREP programming includes instruction on abstinence and contraception, and covers adulthood preparation subjects such as healthy relationships and bullying. CA PREP activities also include community engagement around improving adolescent sexual health and promotion of clinical linkages to youth-friendly reproductive health services. CA PREP is a statewide program administered by the CDPH, MCAH. Sub-awards are provided to local agencies through a competitive application process. Eligibility to apply is based on geographic need along with organizational experience and capacity. The California Adolescent Sexual Health Needs Index provides data-informed program targeting to determine the highest county-and sub-county-level need for adolescent sexual health education and services. Currently, 22 local agencies in 20 counties are funded to provide CA PREP services. The 20 counties where CA PREP agencies are located represent the diversity of California's geography and include rural, urban, and suburban settings across Northern, Central, and Southern California.

CA PREP prioritizes targeting youth who may be at higher risk of STIs and unplanned pregnancies based on their geography and/or other characteristics. Target populations include youth aged 10-19 who: reside, attend school, or receive reproductive health services in a high-need geographic area (sub-county level); are homeless or runaway youth; attend an alternative or continuation school; are in foster care; are in the juvenile justice or probation system; identify as LGBTQ; are receiving treatment for mental health or substance abuse; have special needs; are migrant farmworkers; are expectant or parenting female youth (up to age 21). Each CA PREP agency selects one or more evidence-based program models to implement, depending on their selection of target population and setting. During the 2012-2015 program cycle, 38,358 youth participated in CA PREP and 86% of the participating youth (33,152) completed the program. CA PREP evidence-based sexual health education was provided to 2,472 cohorts in 276 unique sites across California.

## II.F.2 MCH Workforce Development and Capacity

### Workforce Development in Title V

The Title V Block grant in California is administered by two state organizations: the CDPH, MCAH Division and the DHCS, SCD. The primary use of the funds in MCAH is for program implementation with the work being shared between state and county employees. For SCD, the primary use of Title V funds is for administrative case management. This work is shared between the state and county professionals. Workforce development is focused differently between the two agencies: MCAH has activities at both the state and local level, whereas the SCD Division Chief and seven managers focus their development activities on the staff within the 58 counties responsible for administrative case management, policy, program, evaluation and fiscal administration of the services provided to CYSHCN.

### Workforce Development for program specific staff

**CYSHCN:** The SCD provides ongoing, current training for internal medical and administrative staff employed by 58 partnering counties. Much of the training over the past year has been directed toward ensuring that CCS Program clients receive appropriate, timely, and coordinated services. Specifically, the Service Authorization Request (SAR) process, transitioned to electronic fax format in August 2012 and continues to be completely electronic.

Further, in collaboration with the fiscal intermediary (FI), SCD participated in monthly Medi-Cal Provider trainings statewide to provide CCS program overview and requirement information, and to identify key contact information throughout SCD, CCS, DHCS, and the FI. In addition, five county trainings were facilitated for Northern and Southern regions of the State to teach new 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 and Periodic Screening, Diagnosis, and Treatment (EPSDT) and cochlear implant policies and procedures were also conducted throughout the year for select State/County staff on an "as needed" basis. The CCS Program conducts bi-weekly Nurses Huddles training sessions for County Nurses, local County CCS Administrators, and SCD nurses to discuss CCS Policy changes, Center for Medicaid Service (CMS) Net issues, CCS Information Notices, CCS Numbered Letters, and any other issues that may be affecting SAR adjudication and care of CCS-eligible children and adolescents. The SCD staff nurses continue to have biweekly conference calls with County nursing staff to discuss new policies, procedures, emerging issues or concern; and to provide related TA.

SCD Nurse Consultants (NC) are assigned different counties and serve as 'mentors' to the county nurses. The NCs answer questions, help with the county nurses training, visit the counties and help with their backlog, and occasionally review SARs before they are either authorized or denied to ensure the SARs are adjudicated correctly.

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 plans, procedures, and fiscal guidelines for reimbursement for CCS Program and local county staff services.

**Palliative Care program workforce development:** SCD provides semi-annual trainings for county pediatric palliative care nurse liaisons, medical consultants and administrators, as well as bi-monthly teleconferences with county staff.

**Newborn Hearing Screening Program - Workforce Development and Capacity:** DHCS does not provide direct training to hospitals or providers on the day-to-day operations for the NHSP program. Through a contract with Natus, the hearing coordination centers provide two semi-annual meetings with all NHSP hospital directors and their screening staff. At the semi-annual meeting, Neometrics provides a refresher course for the Infant Data Management System (IDMS). The IDMS is the online statewide database that tracks all screening results. All hospitals ensure their NHSP screening staff receive the proper training needed to perform NHSP screening.

*Outcomes of workforce development trainings provided IDMS Training:* All hospital NHSP directors attend the semi-annual training and receive the IDMS refresher course. The IDMS training covers, demographic data entry, hearing screening results data entry and troubleshooting questions. All hospitals provide training certification for their screening staff that includes review of NHSP program, screening equipment use, and IDMS use.

*Health competencies (including but not limited to knowledge or skills gained, practice changes, and/or partnerships developed) IDMS Training:* Hospital NHSP directors have an opportunity to network and build relationships with other NHSP hospital directors, receive updates on DHCS policies and review statewide and hospital specific NHSP performance data. Attendees learn proper NHSP screening methods and data entry protocols.

The BIH program provides a group-based intervention with case management services to improve birth outcomes for African-American women in California. The two main areas of workforce developments have been regional trainings that allow for smaller groups of staff to improve specific skills to improve service delivery. In addition, BIH has integrated the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA MCHB) leadership competencies. In the trainings, staff focus on a single area of improvement (e.g. improved critical thinking skills, practice self-reflection, etc.). These trainings have received very positive evaluations reporting that they help put theory into practice. The second area of workforce development are the BIH annual meetings which bring all of the BIH sites together. These meetings focus primarily on standardized program implementation and the use of best practices.

The MCAH adolescent sexual health effort has three primary service areas: (1) AFLP, (2) I&E, and (3) CA PREP. AFLP provides a range of services to pregnant and parenting adolescents and their partners. CA PREP and I&E's goal are to reduce rates of births and sexually transmitted infections including HIV among high-need youth populations. Central to their workforce development efforts was the Adolescent Sexual Health Conference, which brought together experts to inform staff about current issues in adolescent health and best practice strategies. Topics included sexual violence prevention, working with teens that have experienced trauma, meeting the needs of LGBTQ youth. The participants provided positive feedback on the selection of workshops and the opportunity to collaborate with other adolescent health programs. The adolescent health programs also offer opportunities to participate in additional trainings via webinars throughout the year.

CPSP provides a wide range of culturally competent services to Medi-Cal pregnant women, from conception through 60 days postpartum. There are two main workforce development activities. First, the professional development meeting held annually for the local Perinatal Services Coordinator, which focuses on key topic areas critical to their improved performance. Recent

topics presented were maternal mental health, perinatal substance use, and adverse childhood events. Second, CPSP Provider Trainings are offered online and in-person to enhance professional skills. The results of the meetings and trainings were positive and provided an opportunity to collaborate and share best practices with their colleagues in other LHJs.

CDAPP Sweet Success are providers in the community that provide health services to pregnant women who have diabetes. The CDAPP Sweet Success Resource and Training Center supports and trains our CDAPP Sweet Success Affiliates through monthly web-based training and on-line resources.

### **Workforce Development activities for CDPH staff**

MCAH contracts with the University of California San Francisco, FHOP to provide TA to state and local MCAH staff as they identify needs, develop and/or implement programs, and evaluate data and outcomes of efforts. MCAH has select health measures that we ask FHOP to publish on an annual basis. FHOP also updates data for our counties so they can examine and identify various health trends. Beginning July 1, 2016, the renewed contract has deliverables for supporting implementation of the action plan for developmental screening and to support services for CYSHCN. FHOP has also assisted California Children's Services (CCS) Program to conduct two needs assessments and, because of this, has knowledge of their gaps, challenges, and opportunities for providers and families.

***MCAH Resource Sharing Best Practices Survey 2015:*** This survey showed the LHJs were very interested in addressing Mental Health (65%), Substance Use (59%), and Late or Inadequate Prenatal Care (43%).

MCAH sponsored a statewide Directors Education Day in the Fall that combined education training with WIC and MCAH staff. The top three training and education choices were perinatal substance abuse (30%), increased access to health care (17%), and promoting partnership with WIC by implementing MCAH/WIC integrated best practice interventions (14%).

MCAH identified the top skills-based training topics of interest to them were working with Medi-Cal, MMCD, and Covered CA (45%), creating systems change (41%), and impacting social determinants of health (37%).

FHOP and the state MCAH program asked the LHJs how often they have used the data sources since completing their Title V Needs Assessment. The top three were the Improved Perinatal Outcomes Data Report (57%), the California Adolescent Health Data Set (Adolescent Sexual Health Working Group Data Tables) (51%), and the Youth Risk Behavior Surveillance System (YRBSS) (48%).

The Needs Assessment and development of a Five-Year Action Plan provided an opportunity to train newly hired MCAH staff in program planning. For example, several of the strategies that have been proposed to address the SMART objectives for Maternal and Women's Health involve workforce development and capacity. Two of the key strategies to address IPV involve developing protocols to improve screening which will involve staff training. There is also an emphasis on staff stress management and targeted training on Domestic Violence by SAC to increase the program capacity to preventively teach young people to engage in healthy, respectful relationships.

To address unintended pregnancy, staff will receive training on One Key Question and a

postpartum visit protocol to help case managers and providers with appropriate care provision. To create analytic capacity for chronic disease monitoring, partnerships with the Maternal Quality Indicators Work Group, Chronic Disease Branch, and MCAH epidemiology staff will familiarize each other with their skill sets to improve the capacity for surveillance larger than the population of pregnant women, but for all women of reproductive age.

***Developing Public Health Professionals:*** MCAH has a history of developing future public health professionals through its longstanding relationships with public health schools. These relationships have created opportunities for internships in program, policy, and epidemiology. Through our partnership with University of California, Davis, MCAH staff served as practicum project mentors for Master in Public Health and dietetics students and provided lectures on public health practice to the introductory public health course.

MCAH is also an active participant of the California MCH Training and Transformation Network, a collaborative of 11 California-based academic institutions funded by MCHB to promote a cross-disciplinary approach that will prepare the next generation of MCH leaders to transform the MCH field into the broader systems and policy context of California's changing healthcare system. The Network aims to foster the knowledge, skills, and relationships among trainees and embraces a life course orientation for a comprehensive and networked approach to transforming the health system.

MCAH has provided input and letters of support to training grant applications submitted by the University of California Davis MIND Institute Center for Excellence in Developmental Disabilities grant for 2016-2021 to address the needs of Californians with disabilities through training, TA, information dissemination, and translational research, emphasizing early identification and intervention, employment and health care. MCAH offered mentorship and has provided a letter of support to the University of California at LA Pathways for Students in Health Professions Maternal and Child Health Pipeline Training grant renewal. The program targets students early in their educational training to instill the knowledge and experiences that will lead to more careers in MCH.

MCAH also continues to support the California Epidemiologic Investigation Service (Cal-EIS) fellowship program by hosting training fellows in the Epidemiology Branch and by hosting graduate students in the Preconception Health Initiative and the Nutrition and Physical Activity Initiative.

MCAH is also providing StrengthFinders training for all staff as a form of professional development so that all staff can complete an assessment and gain insight into their top talents. Organization research has shown that a strengths-based approach can improve individual engagement and workplace productivity.

***Critical Workforce Development and Training Needs:*** Recognizing the need to adequately address maternal mental health and wellness, there is a need to address perinatal mood and anxiety disorders. Tools and Best Practices to increase community awareness, decrease stigma, and train staff would be beneficial.

### **II.F.3 Family Consumer Partnership**

California's Title V program strives to establish and maintain working partnerships with other Federal Maternal and Child Health Bureau (MCHB) awardees, Medi-Cal, MMCD, local and state education and health and human service agencies, community based organizations, professional health organizations, providers, community advocates, community members and other stakeholders that have a vested interest in promoting the health of the MCAH population. Family members, former

clients, caregivers, and interested laypersons provide valuable input and perspective in the planning, development, implementation, and evaluation of MCAH and SCD's children and CYSHCN programs, services, and policies administered through CCS.

LHJs report on their collaborative work in their annual reports. Most recently, the 61 LHJs reported working on 317 collaborative efforts. The majority (79%) of LHJs indicated that the collaborative membership represents the diversity of the population in the community and most of the LHJs (62%) included representation from MCAH programs (mothers, women, children, adolescents) or their families.

Local MCAH programs encourage consumers of services to voice their concerns and provide suggestions on how to improve the quality and effectiveness of services through a quality assurance and improvement process, satisfaction surveys or focus groups. Results of these surveys are reported in the LHJs annual reports. MCAH invites family and consumer input on an ongoing basis via phone, e-mails or listservs. The MCAH webpages provide a mechanism for the public to e-mail inquiries and comments directly to MCAH.

CCS provides a statewide, organized, regionalized system of care for CYSHCN. This includes setting standards for hospitals and other special care centers that include multidisciplinary care teams and access to appropriate specialists. While CCS only covers children who meet specific diagnostic and financial criteria, the standards and regionalized systems of care created to serve CCS benefit the broader group of CYSHCN receiving services in this regionalized system of care. Twenty-six out of 28 pediatric intensive care units in the state are reviewed and approved by CCS including 100% of facilities providing the highest acuity services. CCS has approved 126 out of 128 NICUs.

Local CCS programs provide case management and care coordination services to help families navigate the system. Family and consumer partnerships are another area of strength for the CCS program. Local (county) CCS programs maintain parent liaisons through Family Voices of CA Member Council Agencies. These liaisons train CCS staff on family perspectives, help families access services, and provide conflict resolution assistance for CCS staff and family members. Families have participated in NICU quality workgroups and hospital length of stay workgroups in collaboration with CPQCC.

Examples of family/consumer partnership at the State level include the California SIDS Advisory Council, which consists of nine members appointed by the CDPH Director. The advisory council has three members who represent the SIDS parents' groups. About 22 parents/family members attended the 2015 Annual SIDS Conference. Parents of FASD-affected individuals attend the quarterly FASD Task Force meetings and participate in the discussion of agenda items. They are active members of task force member organizations such as Arc of California-Riverside.

Statewide, DHCS seeks to involve families in multiple aspects of policymaking and care for CCS Program clients. Efforts are coordinated through Family Voices of California (FVCA), Children's Regional Integrated Services System (CRISS) and the LA Partnership for Special Needs Children/ CCS Workgroup.

CCS participates in FVCA webinars and the FVCA annual Health Summit. FVCA has collaborated with DHCS and other partners on various committees, taskforces, state senate hearings, the CCS Program redesign, and the Title V Needs Assessment, ensuring that parents and community

members are involved in these processes. Some FVCA Council Member Agencies renew their Parent Health Liaison contracts with their local CCS to train CCS Program staff on family perspectives, and provide conflict resolution assistance.

CRISS is a coalition of more than 50 organizations including local CCS, family support organizations, and pediatric providers and hospitals in a 27-county region of Northern California with the goal of creating seamless care for CCS clients. CRISS has been an active participant in the CCS Program redesign effort and the Title V Needs Assessment. CRISS works on supporting medical homes and on transition issues through both the CRISS Family-Centered Care and MTP. CRISS is monitoring implementation of Covered California's CSHCN services and its impact on families' out-of-pocket costs and limits for durable medical equipment and other services.

Another mechanism for program input is client feedback. The BIH program obtains feedback from the program experiences of BIH participants upon formally exiting the program and censoring data from participants who discontinue the program prior to completion.

## II.F.4 Health Reform

**Scope of ACA in California:** Covered California is the marketplace for the Patient Protection and ACA. Covered California helps individuals compare health insurance plans and choose the plan that works best for their health needs and budget. It is overseen by a five-member board appointed by the Governor and the Legislature. Individuals can use Covered California to learn if they qualify for federal financial assistance that can lower the cost of health insurance and also find out if they are eligible for Medi-Cal. By February 2015, there were over 9 million enrolled beneficiaries from all 58 counties.

As one of the states that opted-in Medicaid expansion, California expanded Medi-Cal, the state's Medicaid program, to more low-income adults and increased the proportion of beneficiaries participating in managed care. The increase was driven by the state's expansion of managed care in formerly Fee-For-Service-only counties, as well as the direction of newly enrolled individuals into managed care delivery systems.[39] In January 2016, there were over 10 million persons enrolled in MMCD Health Plans an increase of 1.2 million persons from January 2015.[40] Senate Bill 857 (Chapter 31, Statutes of 2014) added Welfare and Institutions Code Sections 14005.22 and 14005.225, authorizing the expansion of full-scope Medi-Cal coverage to pregnant women with incomes up to and including 138 percent of the FPL. The expansion of this coverage became effective on August 1, 2015.[41]

**Medi-Cal and Pregnancy:** For the pregnant population, the expansion of full scope Medi-Cal coverage for newly eligible pregnant women included a requirement for them to enroll into MCMC. However, pregnant women within the transition period from Fee-For-Service Medi-Cal to MCMC were allowed to remain with their existing FFS provider through the remainder of their pregnancy and postpartum period. In August 2015, the Centers for Medicare and Medicaid Services (CMS) approved California State Plan Amendment (SPA) 14-0021-MMI, which authorizes DHCS to expand full-scope Medi-Cal benefits to low-income pregnant women with incomes above 60 percent of the FPL up to and including 109 percent of the FPL, who were previously only eligible for pregnancy-only coverage under the program.

CMS also approved an amendment to California's Medicaid Section 1115 "Bridge to Reform" Demonstration Waiver to expand full-scope Medi-Cal benefits to low-income pregnant women with incomes above 109 percent up to and including 138 percent of the FPL. These amendments also

authorizes the state to require pregnant women with incomes up to and including 138 percent of the FPL to enroll in a MMCD health plan in the counties in which such plans are available. This amendment was effective July 31, 2015.

Effective August 1, 2015, with the approval of SPA 14-0021 and the waiver amendment, all new pregnant women applicants whose incomes are at or below 138 percent of the FPL will receive full scope Medi-Cal benefits. DHCS is working with county partners, health plans, and stakeholders on a notice to inform pregnant women who are receiving pregnancy-only Medi-Cal benefits regarding the expansion.

**Coverage for Children:** Medi-Cal provided coverage to nearly 60% of California children between the ages of zero and five. Within seven of California's counties, Medi-Cal provided coverage to 80% or more of the children ages 0 to 5 residing within the county. Over 57% of children ages 0 to 5 residing in LA County are afforded health care coverage through Medi-Cal.[42]

LHJs continue to ensure timely well-child visit appointments after cancellations or change in providers, or provide timely access to care for CYSHCN through different partnerships (community-based, interagency providers, local MCMC plans, Healthy Start, UC Davis MIND Institute and Help me Grow programs).

**Infrastructure Improvements:** ACA's expansion on health care access allowed each LHJ to evaluate their existing systems of care infrastructure on a continuing basis by considering opportunities to maximize and leverage resources with local partners, minimize gaps in care and address maternal, adolescent, child, and infant health disparities.

*Leveraging Resources with Local Partners:*

Since more beneficiaries are served by a network of providers contracted through MCMC plans, a partnership continues to evolve between MCAH and Medi-Cal Managed Care Division (MMCD), the agency that oversees California's MCMC plans. MCAH in partnership with MMCD continues to engage the local MCMC plans during the quarterly Postpartum Quality Workgroup meetings to foster information sharing, promote ways to achieve improvements in care access, and address public health issues related to maternal and infant health. For example, MCAH is currently collaborating with CDPH Immunization Branch to increase tetanus, diphtheria and acellular pertussis (Tdap) immunization of pregnant women and with local CHDP programs to improve care coordination for referrals to mental health and developmental services.

*Minimize Gaps in Care:*

MCAH collaborated with the DHCS in preparation for the implementation of a new policy regarding increasing the number of prenatal care visits from eight to 14 including initial antenatal care. This new policy was implemented on January 1, 2016 to align with the guidelines set forth by American Congress of Obstetricians and Gynecologists on frequency of obstetrical visits. To ensure access to visits, LHJs provide transportation vouchers to pregnant women who have difficulty traveling to their prenatal care providers.

**Enrollment Assistance to Address Disparities:** The majority of the LHJs leverage their existing MCAH programs such as Home Visiting, AFLP, BIH, Perinatal Care Guidance and the CPSP to link women, infants and children to low-cost or affordable health insurance including Medi-Cal. Examples of coordinated activities within the local MCAH and local MCMC plans include sharing of service resources and training and care coordination. Over 65,000 clients were referred to Medi-Cal according to the annual progress reports submitted by the LHJs between 2014-2015.

Examples of outreach activities performed by LHJs to enhance improved access of the MCAH population to low-cost, affordable or free health insurance and services include: working collaboratively with local Medi-Cal eligibility workers in providing consistent messages to the public regarding eligibility requirements; directly engaging with the MCAH population during community events, engaging with providers through roundtable discussions in collaboration with the regional perinatal network and local Medi-Cal representatives, and partnering with safety net clinics such as the Federally Qualified Health Centers or Rural Health Centers on providing low-cost services through a sliding scale program for persons ineligible for Medi-Cal services.

## **II.F.5 Emerging Issues**

**Gender and Sexual Orientation Inequity** - LGBTQ individuals often face challenges and barriers to accessing needed health services and, as a result, can experience worse health outcomes. These challenges can include stigma, discrimination, violence, and rejection by families and communities, as well as other barriers such as inequality in health insurance sectors, the provision of substandard care, and outright denial of care because of an individual's sexual orientation or gender identity.[43], [44], [45]

An individual's relationship with providers is an important component of access to care. Significant numbers of LGBTQ individuals report negative experiences when seeking care, ranging from disrespectful treatment from providers and staff, to providers' lack of awareness of specific health needs. More than half of LGBTQ patients reported that they have faced cases of providers denying care, using harsh language, or blaming the patient's sexual orientation or gender identity as the cause for an illness.[46] Fear of discrimination may lead some people to conceal their sexual orientation or gender identity from providers or avoid seeking care altogether.

Research also has found that LGBTQ individuals are at elevated risk for mental health and behavioral health conditions, reportedly as much as two and a half times more likely to experience depression, anxiety, and substance misuse.[47] A history of discrimination and stigma contributes to higher rates of mental illness.[48]

Women are significantly more likely than men to have experienced some form of sexual violence. However, among women, LGBTQ women are significantly more likely to experience sexual and relationship violence than cisgender (a person whose gender identity aligns with their assigned sex at birth) heterosexual women[49]

As the population of recognized sexual and gender identities expands beyond the binary cisgender heterosexual concept, so must the acceptance and sensitivity of our health care providers who have contact with these individuals in the health care setting. The BIH program, AFLP, and local MCAH programs need to be standard-bearers of health equity inclusive of sexual orientation and gender equity for all populations served by MCAH programs. Creating a safe environment can encourage LGBTQ individuals to come back more frequently, to seek assistance for their health care needs in a timelier manner, and hopefully communicate, by word of mouth, to their community members their positive experience at the local Title V funded programs.

**Substance use during pregnancy** – In 2014 close to 1,190 California newborns were diagnosed with drug withdrawal syndrome known as Neonatal Abstinence Syndrome (NAS), up more than 50% from a decade earlier according to hospital discharge data from the California Office of Statewide Health Planning and Development. In California, because hospitals aren't required to give newborns

or mothers toxicology tests, many babies with NAS go undetected because NAS babies don't necessarily show any symptoms during their two- to three-day hospital stays. Most will not show any signs until they're back at home, sometimes as late as a week.

Illicit drug use is not always the cause of NAS. Doctors sometimes legitimately prescribe strong painkillers to expectant mothers suffering from an injury or painful pregnancy. In these cases, doctors may weigh weaning an infant off painkillers against the possible danger posed to the pregnancy if a mother remains in pain. Given the increase in NAS, MCAH should champion efforts to improve screening for substance use during obstetric care during preconception and in early pregnancy. Efforts must be taken to ensure that efforts do not result in health inequity by ensuring equitable implementation among all women (without race/class profiling) and emphasizing access to treatment rather than punitive measures and incarceration.

**California Drought and Food Security; Farmworkers and their families** – During extended adverse climatic conditions the poorest of our people are at greatest risk, specifically migrant farmworkers from California's Central Valley and their families. Considering that 2015 marks the fourth year of the California drought, many rural communities have been left with limited water usage. Farmers have had to prioritize on acreage and planting, making decisions that trickle down and impact the farmworker.

A study of the impact of California's drought on 336 households of farm-working Latino families with young children found that almost half (46%) reported food insecurity.[50]. [51], [52] Characteristics related to greater food insecurity included fewer years of maternal education and a lower maternal acculturation score. A focus group was formed of 13 mothers and 13 fathers who were also enrolled in a 5-year study found that grocery habits changed during the drought and families were only able to afford to purchase necessary foods. The mothers emphasized the stress they experienced and feelings of incompetency as their financial situation worsened.

As parents tried to adapt and navigate very limited employment options, they left their children in strangers' homes so that mothers could work. Children may develop feelings of abandonment as the shift to a different household may create psychological stressors for both parents and children. Also, medications became less of a priority and this tradeoff could jeopardize the child's health and lead to serious health problems. With the continuation of the California drought and water shortage, MCAH and partners should increase attention to the unique regional food and social support needs of migrant workers and families.

**California Senate Bill (SB) 493** was signed in October 2013, which allows the State Board of Pharmacy to set protocols for licensed pharmacists to prescribe hormonal birth control and over-the-counter nicotine patches, and certain prophylactic medications for travel abroad as well as order tests that evaluate efficacy and toxicity of certain medications. Before receiving a prescription, customers are required to fill out a health questionnaire and have their blood pressure taken. It is too early to determine the impact this law will have on health care utilization for women of reproductive age and health outcomes such as teen birth rates and unintended pregnancy.

**Zika** is a virus which is transmitted to people by Aedes mosquitoes. In 2015, an increase of Zika virus infections in Brazil was noted concurrently with an increase in microcephaly among women who experienced infection during pregnancy. The connection between Zika and microcephaly has now been established. To date, there has been no local transmission of Zika virus in California. As of January 15, 2016, five cases of Zika virus disease have been reported in California, all in travelers returning from other countries with Zika virus outbreaks. Eight cases were among pregnant women

and one case was sexually transmitted.

CDPH has requested that healthcare providers voluntarily report Zika virus infections. The CDPH laboratory can provide preliminary laboratory testing and coordinate confirmatory testing, which is currently provided by the US Centers for Disease Control and Prevention (CDC), CDPH and soon private labs will also offer testing. Measures in CDPH are being taken to provide up to date information to California health care providers and the public as more is known about the disease, transmission, and its relationship to birth outcomes. California will participate in the CDC Zika Pregnancy Registry but LHJs already express concern about this given the lack of resources to support the registry. California is committed to testing all pregnant women with suspected exposure, tracking them during the pregnancy and monitoring infant outcome for at least one year. The California Birth Defects Monitoring Program will be expanded to support this work.

**Congenital Syphilis:** From 2012 to 2014, the annual number of reported early syphilis cases among women more than doubled from 248 cases to 594. The annual number of reported congenital syphilis cases more than tripled during the same period, from 30 to 100. Syphilitic stillbirths also increased, from one case in 2012 to six cases in 2014. The increasing trend of syphilis among women appears to continue in 2015. Most of the congenital syphilis cases have been reported in the Central Valley and Los Angeles County. CDPH has not identified a cause for the increase in congenital syphilis, which is often associated with poverty and lack of access to health care. Most of the women who gave birth to babies with congenital syphilis did not receive adequate or timely prenatal care.

Seeking and receiving comprehensive prenatal care, including getting tested, to avoid transmitting infections to their babies is a crucial opportunity to be screened for syphilis. CDPH is addressing the rise of syphilis cases by working with local health departments to identify causes, reach out to infected pregnant women to make sure they and their partners are treated, intensify efforts to follow-up on contacts of syphilis cases, particularly women of childbearing age, and promote linkages to prenatal care and prenatal screening, including third trimester and delivery screening.

**Immunization During Pregnancy:** MCAH is a collaborative partner in the National Governors' Association (NGA) Center for Best Practices Learning Collaborative on Accelerating Statewide Improvements in Maternal and Child Health grant (ending in September 2016). California has formed a care coordination collaborative led by the DHCS/Office of the Medical Director with representatives from CDPH/MCAH, CDPH Immunization Branch, DHCS/Medi-Cal Managed Care, University of California Davis Pediatric Infectious Disease, Sacramento County Public Health, Molina Healthcare of CA, Anthem, Inc., and Health Net of CA. California is focusing on increasing childhood immunization rates among low-income children, increasing Tdap rates among pregnant women, and improving continuity of care for vulnerable pregnant women and children. An Action Plan is being finalized with TA from NGA. MCAH involvement centers on strategies to promote Tdap immunization among pregnant women through the CPSP and MCAH LHJs. Strategies to increase childhood immunization rates in children less than 2 years of age, specifically focusing on children enrolled in Medi-Cal, will be implemented in Sacramento County with participation from the three managed care health plans. An in-state NGA TA workshop is scheduled to take place on May 5, 2016.

MCAH is also working with the CDPH Immunization Branch to increase trace-back surveillance on childhood pertussis cases through participation in a six-month CDPH Innovation Project using a pertussis supplemental form in two LHJs with the highest number of pertussis cases. Enhancing pertussis disease surveillance in local health departments will help local Communicable Disease Controllers, local Immunization Coordinators and local MCAH staff to provide feedback to prenatal care providers, determine if Tdap was offered, and identify barriers to offering immunization if not being done.

## **II.F.6 Public Input placeholder**

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## **II.F.7 Technical Assistance**

MCAH is interested in identifying analytical and reporting models for measuring inequity and would benefit from guidance from the Federal Maternal and Child Health Bureau. We are interested in understanding new developments in assessing health inequities and social determinants of health including guidance on developing a measure or indicator, analytic approaches (absolute vs. relative; selection of reference population for comparison, weighting comparison groups by group size), and interpretation and presentation of results.

MCAH would like to interface with other Project Launch state grantees to learn how their community councils are assessing local resources and needs, creating strategic plans, and using evidence-based prevention and health promotion strategies. California could review these elements and possibly develop better methods for screening program participants, integrating mental health consultation into existing program models, providing additional workforce development trainings for program staff, and providing family strengthening and parenting skills training.

Access to care for the MCAH population is challenging on a couple of fronts. California has approximately 22 rural counties, predominantly in the northern and eastern part of the State. In some cases, residents are actually geographically closer to services in a neighboring county than services within their county of residence. In the urban areas geography is not necessarily the issue as much as 1) lack of transportation (including inefficient transit systems), 2) lack of childcare, 3) inability to take off time from work, 4) limited family support systems, 5) cultural barriers, and 6) domestic stressors. Greater understanding of evidence-based strategies to address access to care barriers among the population we serve would be welcomed.