



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

**State Narrative for  
California**

**Application for 2008  
Annual Report for 2006**



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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.  
***An attachment is included in this section.***

### **B. Face Sheet**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. Assurances and Certifications**

***//2008/ The State of California's Assurances and Certifications and Memorandums of Understanding are available on request. //2008//***

### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

### **E. Public Input**

***//2008/ An abridged draft of the FFY 2008 Application/Report, including data tables, was posted on the Maternal, Child, and Adolescent Health (MCAH) Branch website for review and comment. MCAH partners, including local MCAH Directors, contractors and other stakeholders were advised of the availability of the draft. The Children's Medical Services (CMS) Branch added a Title V link on the CMS website that connected to the MCAH website and made the draft Application/Report available to its partners. A CMS Information Notice was placed on the CMS Website informing stakeholders, including the California Childrens Services (CCS) administrators, local Child Health and Disability Prevention (CHDP) program directors, deputy directors and medical consultants, and CMS Branch staff, about accessing the draft Application/Report.***

***Input from and dialogue with MCAH partners is maintained throughout the year via stakeholder and other meetings for partner participation. This past year the development of the Title V Implementation Plan provided various avenues for input. In addition to posting the final draft of the Plan on the MCAH website for review and comment, input was obtained through on-site visits with representatives from local health jurisdictions, stakeholder meetings with partners from research, government and community-based organizations as well as review and input from MCAH Directors. Through semi-annual meetings and solicited dialogue on specific issues and projects MCAH Directors as well as representatives from MCAH programs provide input throughout the year.***

***See the attachment to this section for more information about Public Input. Responses to last year's Grant Recommendations are also included in the attachment.***

***//2008//***

***An attachment is included in this section.***

## **II. Needs Assessment**

In application year 2008, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

***An attachment is included in this section.***

### **C. Needs Assessment Summary**

California's 2006-2010 Title V Needs Assessment, completed in July 2005, was the culmination of more than three years of planning, analysis and evaluation among local health jurisdictions and stakeholders in partnership with the California Department of Health Services (CDHS). The Maternal, Child, and Adolescent Health / Office of Family Planning (MCAH/OFP) Branch and the Children's Medical Services (CMS) Branch of CDHS provided leadership in assessing and prioritizing the local and statewide needs of MCAH and CSHCN populations.

Each Branch undertook inclusive efforts to produce a comprehensive needs assessment. From 2003 to 2004, the MCAH/OFP Branch took a multi-level approach that involved collaborations with the University of California San Francisco (UCSF) and the state's 61 local health jurisdictions, including various state and local programs, professional groups, provider organizations, community citizens, parents, and former clients. Fifty-five of the 61 jurisdictions (90 percent) submitted needs and capacity assessments in 2004. The Branch analyzed this data on local-level needs and process methodology. In April 2005, 46 stakeholders participated in a stakeholder meeting. The participants discussed the data and issues and, based on agreed criteria for ranking, provided recommendations for setting state priorities.

MCAH/OFP Branch priorities were selected based on multiple considerations -- the results from the local jurisdiction needs assessment reports, the input from external stakeholders as well as input from Branch staff, the assessment of capacity at the state level, the review of published data, state-level surveillance data, and Healthy People 2010 objectives. In recognition of the inter-connectedness of many issue areas among the MCAH population, a decision was made to combine MCAH priority areas into seven priority statements that reflect inter-related topics of interest.

The CMS Branch's five-year needs assessment for Children with Special Health Care Needs (CSHCN) included an evaluation of internal capacity, with assistance from the Family Health Outcomes Project at UCSF in the collection and analysis of data as well as the facilitation of the stakeholder process, and input from stakeholders in the identification of issues and the prioritization of needs. The CMS Branch invited 37 stakeholders to participate in the identification and prioritization components of the needs assessment process. Stakeholders included representatives from local CMS and MCAH programs, California Children's Services (CCS) Technical Advisory Committees, State agencies, professional and provider organizations, and parents. All-day meetings were held in January and April 2005, in which criteria for ranking were selected and weighted, issues were identified, data were reviewed, and priorities were agreed upon for the three priority objectives for CSHCN. The priorities for CSHCN were taken directly from the output of the stakeholder process, using the top three prioritized needs.

#### **Title V Implementation Plan**

The five-year needs assessment was the first phase in a cycle for continuous improvement of maternal, child and adolescent health. Developing an implementation plan, with specific objectives and strategies that address the priorities was the next step in the process. A multi-level approach was followed to provide various avenues for input from partners. The MCAH/OFP Branch oversaw the following activities to ensure a comprehensive process:

- Input from MCAH/OFP Branch Section Chiefs and Program Managers;
- On-site meetings with local MCAH representatives from Alameda, Contra Costa, Humboldt, Los Angeles, Orange, San Bernardino, Solano, Stanislaus and Ventura Counties;
- Input from MCAH Action, the statewide organization of local health jurisdiction Maternal and Child Health Directors;
- Review and input from recognized experts in the MCAH field;
- Stakeholder meeting with representatives from research, government and community based organizations;
- Public input via Web based posting of the plan.

The CMS Branch partnered with the Champions for Progress project to develop an action plan to address the CSHCN priority areas identified in the needs assessment. The CMS Branch is one of the principals in the California Champions for Progress project, an initiative funded by the Health Resources and Services Administration (HRSA). The other partners in this project are Family Voices of California, Children's Regional Integrated Service Systems (CRISS), and the Los Angeles Partnership for Special Needs Children located at the USC University Center of Excellence in Developmental Disabilities at Children's Hospital Los Angeles. This group decided to expand the stakeholder group that had developed the list of prioritized needs to include representatives from local education, mental health, regional center, county welfare, managed health care and foundations.

The Champions stakeholder group met seven times over nine months in professionally facilitated work group meetings to consider strategies that would assist the state to achieve the six MCHB core performance measures and to meet the priorities identified by the state in its needs assessment process. Each stakeholder was charged with assisting in developing strategies for action, circulating draft documents within member organizations for feedback and support, and reaching consensus within the group on the final plan. The CMS Branch extracted the objectives and strategies that related to the three CMS priority goals. The CCS Family Advisory Committee then reviewed the document and provided comments and suggestions.

The purpose of the Implementation Plan (IP) is to focus on the MCAH/OFP and CMS Branches' roles as they relate to the identified priorities. The IP builds on existing and emerging efforts. The strategies for each objective illustrate the general direction to be taken by the Branches and serve to guide each Branch toward fulfillment of its mission.

### III. State Overview

#### A. Overview

##### Demographics

***/2008/ California is the most populous of all US states, with 37.2 million residents in 2006, an increase of 444,000 over the previous year. One in every eight of the nation's residents lives in California. The state's population has increased annually since 1940, but the rate of increase has slowed each year since 2000, from 2.0 percent in 2000-01 to 1.2 percent in 2005-06. [1] California is the third largest state in terms of land area and is more than twice the size of 35 other states. [2] //2008//***

The population increase is the result of the natural increase (the difference between the number of births and deaths), which accounts for a little over half of the total population increase, plus net migration to the state. Foreign immigration to the state far exceeded domestic migration for the period 2000-2005, with net foreign immigration totaling 1,165,624 and net domestic migration totaling 220,165. [3]

California residents are younger on average than the nation as a whole. The median age for the state in 2004 was 34, which is significantly lower than the median age in the US of 36. [4]

In 2003, there were almost 7.6 million women of childbearing age (15-44) in California. Women of childbearing age represent 22 percent of the state's total population. The 10.2 million children under age 19 account for 29 percent of the population, including 2.5 million under the age of 5 (7 percent), and over 500,000 under one year (1.5 percent). [5] Nationally, children ages 19 and under make up 28 percent of the population, and those under 5 make up 7 percent. [6] Between 2003 and 2009, the female teen population (ages 15-19) in California is projected to increase by 14 percent, and the Hispanic teen female population is projected to increase by 28 percent. [7]

Although the overall teen birth rate has declined steadily since 1991 (from 71 in 1991 to less than 38 in 2004), the decline among Hispanic teens has been slower, and Hispanics are disproportionately represented in the number of California's teen births. [8] Hispanics accounted for 71 percent of teen births in 2004 [9], while only accounting for 42 percent of the total teen population (age 15-19). [10]

The aging of the state's population is having an impact on the health and well-being of mothers and children. In California, 16 percent of all households contain at least one caregiver for someone aged 50 or older. Three quarters of those caregivers are women, and 31 percent have their own children living at home. This can pose a financial and emotional burden on families, particularly those who are low-income and/or have working mothers. [11] Addressing this growing stress on families is likely to become an increasing challenge in the future, as the proportion of the population over age 50 grows and the cost of living forces many households to consolidate and increase in size.

##### Diversity

In addition to its overall population expansion, California continued to experience growth in its ethnic diversity. The fastest growing group is Hispanics. Hispanics, as a proportion of the state population, increased from 26 percent in 1990 to 32 percent in 2000. [12] By the year 2050 the percentage of Hispanics is projected to reach 54 percent, making it the majority ethnic group in the state, as well as the majority ethnic group for twenty counties. [13] In 2000, Whites comprised 47 percent of California's population, followed by Hispanics (32 percent), Asian/Pacific Islanders (12 percent), African Americans (7 percent), and American Indian/Alaska Natives (1 percent). [14]

In 2004, 27 percent (9.5 million) of California's population was foreign-born. [15] In 2002, 27 percent of the nation's immigrants (291,191) settled in California. Nearly half (49 percent) of these immigrants were born in Latin America and the Caribbean, primarily Mexico, and 39 percent were born in Asia. [16]

In California, Hispanics are younger on average than members of other racial/ethnic groups, and this age differential is increasing. The median age of Hispanics in California in 2004 was 26, eight years younger than that of the total population (34). Among Whites, the median age was 40, and for Asians, the median age was 36. [17] Hispanic children comprised the largest proportion of school children during the 2004-05 school year, making up 47 percent of students in California. [18]

Racial/ethnic diversity and a large immigrant population contribute to linguistic diversity in California. In 2004, 41 percent of California residents over the age of five spoke a language other than English at home, compared to 19 percent nationwide. Most often this language is Spanish, however, a variety of Asian and Pacific Island languages are also spoken. [19]

## Geography

California is comprised of 61 local health jurisdictions, including 58 counties and three incorporated cities. These local health jurisdictions vary widely in geographic size, number of residents, and population density. In terms of geographic area, San Bernardino is the largest county, and San Francisco, San Mateo, and Marin Counties are the smallest. Los Angeles County is the largest in terms of population, with over 10 million residents, 28 percent of the state's total population. Alpine County has the smallest population, with fewer than 1,300 residents. [20]

Most of the state's population (98 percent) resides in urban areas [21]. Los Angeles, San Diego, Orange, Santa Clara, and San Francisco Counties all have large urban populations. Some counties, such as Fresno, Monterey, and Santa Barbara, are primarily rural but contain urban centers where most of the population resides.

Most counties in the state experienced population growth between 2000 and 2004, although the rate of growth appears to be slowing. Riverside and Placer Counties grew at the highest rate, increasing in population by approximately 4 percent each year. [22] Other counties projected to experience large increases in population include San Joaquin, Merced, and Madera. [23, 24]

## Economy

In 2004, the California's gross product ranked eighth in the world. [25] This is in spite of the fact that California has not shared completely in the economic growth the nation has experienced recovering from the recent economic recession. California's unemployment rate in 2005 was 5.4 percent, compared to the national rate of 5.1 percent. The drop in the unemployment rate in Fiscal Year (FY) 2003-04 was the first drop in unemployment since FY 1999-00. [26] The forecast through 2008 projects that California's unemployment rate will not fall or change significantly, suggesting that the slow pace of economic growth in the state will continue. [27]

The stagnant economy in the state has resulted in budget cuts that have affected maternal and child health programs and services. The state has experienced restrictions on the creation of new contracts, purchasing of equipment, hiring of staff, and travel. This has curtailed the ability of State programs to provide technical assistance and training to local health jurisdictions, compromising the ability to improve and sustain program quality.

Restrictions on State programs and services compound existing challenges faced by California's

residents who live near or below the federal poverty level (FPL). The US Census Bureau estimates that in 2004, 13.3 percent of California residents lived below the FPL. This is worse than the national rate of 13.1 percent and ranks California as the 20th worst state in terms of percent of residents in poverty. [28] Three counties in California's Central Valley ranked among the most impoverished counties in the nation: Tulare, with 20.3 percent of residents living below the federal poverty level, Kern, with 19.3 percent, and Fresno, with 17.9 percent. [29]

The federal definition for low-income is household income of less than 200 percent of the poverty level; however, in parts of California, the high cost of living creates stress for families whose incomes are not necessarily low by this definition. In 2004, California had the highest median monthly rental housing costs (\$914 per month) in the nation, and ranked 49th for home ownership among residents. [30] The population growth occurring in California only compounds this problem, as the construction of new housing units cannot keep up with increasing demand.

While the actual cost of housing varies between different regions in California, the problem exists throughout the state. Even in lower-cost areas, affordable housing is becoming increasingly scarce. In California's rural counties, a family would need to earn at least \$10.33/hour (153 percent of minimum wage) working full-time in order to afford a Fair Market Rent apartment (\$537/month for a two bedroom apartment). [31]

Homelessness is also an ongoing problem for the state. For example, in Alameda County, an estimated 12,000 people are homeless on a given night, and approximately 40 percent of those are families with children. [32]

Of the 4.6 million households with one or more children under 18 in California, 19 percent are headed by a single female parent. [33] These households are more likely to struggle to support themselves with less than adequate income.

Single parenthood, low income, and high housing costs, along with welfare reform, force most women with children into the labor force. Of the almost 6.5 million women in California between the ages of 20 and 44 (as of March 2004), 70 percent participated in the labor force. [34]

The proportion of women in the labor force, coupled with the number of single-parent households in California, creates an enormous need for childcare for working parents. Unfortunately, licensed childcare is available for only 26 percent of children with parents in the labor force. The cost of childcare for a preschooler typically consumes 53 percent of a parent's income if the parent is working full time at minimum wage. [35]

Hispanics and African Americans are disproportionately low income. The 2003 median household income was \$36,000 for Hispanics and \$40,000 for African Americans, both well below the state's median household income of \$49,320. The median household income for Whites and Asians was \$71,474 and \$67,064 respectively. The proportion of California residents living in poverty (<100 percent FPL) shows similar racial/ethnic disparities: 22 percent for African Americans, 21 percent for Hispanics, 11 percent for Asians, and 8 percent for Whites. Fifty percent of Hispanics and 43 percent of African Americans were classified as low income (<200 percent FPL). [36]

There are currently more than 6 million school-aged children in California and more than 9,000 schools. [37] Hispanic students comprise the largest and fastest growing racial/ethnic group in California schools. Of the student population, 49 percent receive subsidized school lunches. Over one quarter are classified as English learners; most of these English learners' first language is Spanish. [38]

#### Access to Health Care

In California, 18 percent of the population did not have health insurance in 2002, compared to 15

percent of the US population. Among California's Hispanic population, 31 percent were uninsured. Among California children under the age of 18, 14 percent were uninsured. Among California children, 28 percent were covered by Medicaid or Healthy Families, compared to 25 percent for the US. [39] Among the poor and low-income population in California, children were more likely to be covered by public programs than adults. Continuing to raise the rates of enrollment in public insurance programs, especially among immigrants and non-English speaking populations, remains a challenge for the state.

Another challenge for the state is meeting the health care needs of the large number of undocumented immigrants, many of whom are migrant workers. While the number of undocumented immigrants in California is difficult to measure, a recent study suggested that 2.4 million undocumented immigrants were in the State of California in 2002, over a quarter of the nation's estimated 9.3 million. It is estimated that 40 percent of the undocumented immigrants are women. [40] In one sample of undocumented immigrants in Fresno and Los Angeles Counties, half were between the ages of 18 and 34, and one quarter were children under 18. [41]

It is not surprising that, given the complicated nature of eligibility for public assistance, coupled with fear of the consequences of having to reveal one's status as undocumented, that access and participation in available services among the undocumented population is very low. Still, the most common reason given by undocumented immigrants for not seeking health care was that it was too expensive. [42] Other complications arise for undocumented immigrants who seek services in one county, then move on to another region for work. This makes it difficult to provide consistent and comprehensive services and to track services rendered to this population.

The diverse nature of California's population and geography, coupled with the changing face of the population demographically, socially, and economically, proves to be a continuing challenge for the programs of California's Maternal Child and Adolescent Health / Office of Family Planning (MCAH/OFP) Branch and Children's Medical Services (CMS) Branch.

## Major State Initiatives

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***For more detailed information about California's Major State Initiatives, please see the attachment to this section.***

### ***> Governor's healthcare proposal***

***In January 2007, the Governor unveiled comprehensive plans to reform California's healthcare system. The three essential elements in the Governor's proposal are: 1) Prevention, health promotion, and wellness; 2) Coverage for all Californians; and 3) Affordability and cost containment.***

***Highlights of the proposal of specific interest to MCAH professionals and policy makers include expanding Healthy Families/Medi-Cal for all children in families earning under 300 percent of the FPL and increasing Medi-Cal reimbursement rates by \$4 billion.***

***The Governor's emphasis on disease prevention, health promotion and healthy lifestyles promote a public health approach to improve health outcomes and help contain healthcare costs. Initiatives included in the Governor's proposal support the MCAH/OFP Title V priorities identified through the 2005 needs assessment. The related Governor's initiatives are: Diabetes (prevention and control); Healthcare Quality; Tobacco Control; and Obesity Prevention.***

**> Reorganization of CDHS**

**CDHS was reorganized into two departments effective July 2007. The new California Department of Public Health (CDPH) will protect and promote health through a focus on population-wide interventions, while the new Department of Health Care Services (DHCS) will focus on the financing and delivery of individual healthcare services.**

**In collaboration with organizational development consultants, CDHS organized management and transition teams to begin developing the guiding principles of CDPH and DHCS, perform a SWOT analysis, create an operational plan, and promote leadership development. A Public Health Advisory Committee (PHAC) will also be formed to provide expert advice and make recommendations on the development of policies and programs that seek to promote the public's health.**

**Since the reorganization, the MCAH/OFP Branch is in CDPH, and the CMS Branch is in DHCS. Though they are now in different departments, the two Branches will continue to work collaboratively as California's Title V partners. To ensure a seamless transition, MCAH/OFP worked with CMS to prepare the Interagency Agreement that provides continuing Title V funds to CMS. The Interagency Agreement was fully executed in May 2007, prior to the July 2007 effective date of the department reorganization.**

**> Prenatal screening services, umbilical cord blood banking, and pregnancy blood banking**

**Legislation passed in September 2006 will expand the California Department of Public Health's capacity to discover causes, develop prevention strategies, and increase surveillance of birth defects and genetic diseases throughout the state.**

**For 25 years, CDHS has contracted with the California Birth Defects Monitoring Program (CBDMP) to conduct research and surveillance of birth defects and maintain a birth defect registry. This new legislation will reorganize CBDMP to become part of the MCAH/OFP Branch. CBDMP will continue to collaborate with the Genetic Disease Branch (GDB) to maintain the Pregnancy Blood Bank, which stores prenatal screening blood samples from GDB's Prenatal Screening Program.**

**A prenatal screening fee increase implemented in 2007 will enable GDB to collect, process, and store more blood samples than prior capacity, as well as enable CBDMP to expand the birth defect registry. These improvements will increase research opportunities and provide more representative statistics on birth defects in the state. MCAH/OFP Branch and CBDMP staff will be developing a database linking resource in which stored pregnancy blood samples can be linked with state health outcome data. This will provide scientists the opportunity to test hypotheses about genetic and environmental causes of many children's and women's diseases.**

**The increased screening fee will also modernize and expand GDB's Prenatal Screening Program to include the quadruple maternal serum marker test. This will improve the early diagnosis and management of genetic and congenital disorders.**

**>Safe motherhood**

**The MCAH/OFP Branch works with the California Maternal Quality Care Collaborative (CMQCC) to address maternal morbidity by measuring maternal quality of care and identifying hospital-level outcomes for maternal/neonatal infections and postpartum**

**hemorrhage. The CMQCC selected the third- and fourth-degree laceration rate of hospitals as the first indicator to implement best practices while other indicators are identified.**

**The Branch has also developed the Pregnancy-Related and Pregnancy-Associated Mortality Review (PAMR) Project. The goal of this project is to examine the medical and psychosocial events leading up to death for women who died from pregnancy-related causes or within one year of pregnancy (pregnancy-associated deaths) so that the Branch and its stakeholders can develop a public health component to reduce such deaths. The Branch has partnered with UCSF and the Public Health Institute to begin abstracting and reviewing data on 60 selected cases of maternal deaths, which includes reviewing death certificates and coroner's reports.**

**In February 2007, the PAMR Advisory Committee held its first case review meeting. The initial cases reviewed highlighted a number of areas for clinical and public health intervention. The Committee will meet every 2-3 months to review case summaries and develop recommendations for CMQCC and the Branch.**

**The MCAH/OFP Branch and UCSF are currently planning for the next round of case abstractions to begin July 2007. Data abstraction forms will be revised for the second year of cases to reflect any improvements identified in the first year's review.**

#### **> Preconception care**

**The MCAH/OFP Branch is collaborating with various stakeholders to improve preconception care practice throughout California.**

**One strategy the Branch uses to promote preconception care initiatives is to integrate them with patient educational programs among primary care, family planning, and pregnancy care services. Through the California Preconception Care Initiative, a provider/patient resource packet was created to assist in the provision of preconception care. Other states are using this packet as a model for their own materials.**

**Local MCAH jurisdictions have undertaken preconception care activities, including the LA Collaborative, which is monitoring the success of various preconception care models. Additionally, Los Angeles and Sonoma counties initiated the Healthy Women's Weight program.**

**The Preconception Care Council of California (PCCC), formerly the California Preconception Care Advisory Committee, was established to provide direction for the integration of preconception care in public health practice, the development of policy strategies to support preconception care, and the promotion of preconception care messages to women of reproductive age. PCCC is partnering with the CDC to host the National Summit on Preconception Care in October 2007. This event will present best practices to implement the CDC objectives for preconception care. In preparation, a fact sheet was composed detailing the health of non-pregnant women aged 18-44 in California.**

**The MCAH/OFP Branch participated in the Association of Maternal and Child Health Programs 2007 annual conference, leading the preconception care plenary session. The session objectives were to establish preconception care as a framework for achieving healthy communities and discuss successful implementation strategies.**

**To quantify the impact of preconception health on perinatal outcomes, a study is underway examining the impact of preconception hospitalizations on subsequent pregnancy and birth outcomes among women aged 15-44 in California.**

**> Teen Birth Rate Resource Project**

**The Branch is collaborating with UCSF and the Office of Statewide Health Planning and Development to develop comprehensive maps of teen birth rates using geographic information system (GIS) tools. This Teen Birth Rate Resource Project (TBRR) will identify geographic locations in California with higher or lower teen birth rates so organizations can apply for resources and to target interventions to locations with greater need. The TBRR will also show whether teen birth rates have changed over time, and if this change varies by race/ethnicity and location.**

**> Perinatal Care Quality Improvement**

**CCS, in collaboration with the Regional Perinatal Programs of California (RPPC), is working with CCS-approved Neonatal Intensive Care Units (NICUs) to develop their Regional Cooperation Agreements (RCAs).**

**The RCA is a requirement for all hospitals participating in the CCS Program. Additionally, all hospitals providing perinatal services in California must have written transfer/transport agreements with facilities offering a higher level of care as required by Title 22. The RCA requires written agreements between Regional, Community and/or Intermediate NICUs, specifying mutual responsibilities.**

**CCS and RPPC conducted a series of workshops across the state in 2007 to assist hospitals in the development and implementation of the RCA. A toolkit for the RCA, "Agreements for Provision of Perinatal and Neonatal Care: A Step-by-Step Guide", is available on the CMS website. The local CCS office and the RPPC are available to the hospitals for technical assistance in the development and implementation of the RCA.**

**> Neonatal Quality Improvement Initiative**

**The CMS Branch and California Children's Hospital Association (CCHA) are jointly sponsoring a statewide Neonatal Quality Improvement Initiative (Nqi) to improve neonatal care by working toward eliminating catheter related blood stream infections in NICUs. The Nqi hospitals and participants are neonatologists, nurses, and administrators from the eight CCS-approved California children's hospitals and the six CCHA associate members which are the CCS-approved University of California medical centers and Sutter Memorial Medical Center (Sacramento).**

**The approach of the Nqi to improving quality at the point of care is the Institute for Healthcare Improvement (IHI) Breakthrough Series model. In this model, clinicians, administrators, and other experts identify best practices and potential change strategies. Similarly, the Nqi is delineating evidence-based processes of care to reduce neonatal nosocomial infections with the goal of eliminating catheter related blood stream infections; participants receive training and technical assistance to implement the agreed-on change package; and lessons learned are shared among participants with regular conference calls and focused site visits.**

**Outcomes and observational process data are being tracked from baseline through the course of the 9-month Initiative, ending in July 2007. A major focus of the evaluation will be a detailed analysis of the processes each site uses to implement and maintain evidence-based best practices. The most efficient and effective practices will be shared with all sites. This information can then be used to improve processes and outcomes in other CCS-approved NICUs throughout the state, benefiting all hospitalized infants,**

*regardless of payer source. Aggregated outcome data will be distributed to stakeholders, including the state legislature, large commercial payers, and the public.*

**> Pediatric Critical Care**

*The CCS Program has structured a system of 19 CCS-approved pediatric intensive care units (PICUs) to assure that infants, children, and adolescents have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS sets standards for all CCS-approved PICUs and periodically conducts PICU site visits to help ensure standards are followed; standards include submitting annual morbidity/mortality data to CCS.*

*The CMS Branch, in collaboration with the UC Davis School of Medicine, is developing an infrastructure for Pediatric Critical Care quality care improvement. This project will assess the need for statewide benchmarking standards to direct quality improvement efforts; conduct key informant interviews with recognized leaders in pediatric critical care; analyze existing quality improvement efforts related to pediatric critical care; and develop a methodology and reporting tool to analyze pediatric intensive care quality improvement activities. This planning effort will identify optimal approaches to the design of a future database and methods for data collection from California PICUs to meet the needs of quality improvement efforts.*

**> Pediatric Palliative Care**

*The CMS Branch is submitting a palliative care waiver to the federal government to promote the development of comprehensive Pediatric Palliative Care demonstration programs for selected children with life limiting or life threatening conditions who are enrolled in the CCS program. These demonstration programs should improve the quality of life for these children and their family members. In addition, by providing well-coordinated, comprehensive, continuous care, cost neutrality should be achieved by reducing hospital stays and other avoidable services.*

*To provide guidance on the development and implementation of the waiver, the Branch has formed a group of over 65 stakeholders that includes representatives from a variety of professional agencies, community based programs, parents, and other Divisions of DHCS. The stakeholders have been assigned to one of three subcommittees to develop the specifics of the Pediatric Palliative Care program. These subcommittees include Eligibility, Service Delivery, and Outcome Data and Analysis. The Branch has also developed a Pediatric Palliative Care website and a stakeholder listserv to increase communication between the Branch and stakeholders. The website has pertinent references on palliative care, details about the waiver, and committee minutes.*

*The waiver will be submitted to the federal government by January 2008 and will be implemented 6-12 months after approval. Finally, the Branch will hire an additional Public Health Medical Officer and Research Analyst to assist in the monitoring and analysis of the waiver.*

**> Mental health**

*The MCAH/OFP Branch is working to address the mental health needs of infants, children, adolescents, and mothers. California Proposition 63 Mental Health Services Act (MHSA) provides funding for the expansion of mental health services for adults and children. MCAH/OFP staff participate in the MHSA stakeholder group.*

***Many Branch programs include a mental health component, including AFLP, BIH, CDAPP and CPSP. All include assessment and referral, and some include counseling and treatment.***

***The Branch participates in statewide efforts to implement coordinated mental health services. Currently underway are the State Early Childhood Comprehensive Systems (SECCS) project and School Readiness Initiative (SRI). Before ending in early 2007, the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP) Project implemented developmental/mental health screening tools and referral protocols in two primary care pilot projects.***

***The SECCS project provides state-level leadership for programs that help prepare children for kindergarten. In 2007, SECCS staff visited local health jurisdictions to identify recommended screening tools and models of service integration and will report these findings to various stakeholders.***

***The SRI is the signature initiative of First 5 California. Mental health counseling is one of the five "essential and coordinated elements" of SRI. It is anticipated that the SECCS initiative will strengthen the health component of the SRI.***

***In January 2007, the Maternal and Child Health (MCH) Program of the UC Berkeley School of Public Health, in collaboration with the MCAH/OFP Branch, the California March of Dimes and the Department of Mental Health submitted a grant to HRSA. Entitled "Bright Beginnings: Innovative Approaches to Improving Mental Health in California," this grant aims to provide continuing education activities to MCH professionals in the area of maternal mental health over a three-year period. The grant is under review by HRSA.***

***> Human stem cell research and women's reproductive health***

***California is leading the nation in its support of the advancement of stem cell research that seeks to develop treatments and cures of childhood and adult diseases.***

***Recent legislation promotes the ethical and legal conduct of human stem cell research (HSCR) through the development of statewide research guidelines, protections for women donating oocytes for research, requirements for review and approval of HSCR by Stem Cell Research Oversight (SCRO) Committees, and state reporting requirements on HSCR. The MCAH/OFP Branch created the HSCR Unit to fulfill these legislative mandates and manage stem cell issues for CDPH.***

***In February 2006, the MCAH/OFP Branch convened the HSCR Advisory Committee. The HSCR Unit facilitated several Committee meetings in 2006, which resulted in the development of the HSCR guidelines. The Unit and Committee also consulted with the California Institute for Regenerative Medicine (CIRM) to promote consistency between its stem cell regulations and those of CDPH.***

***The Committee submitted the final guidelines to the HSCR Unit in February 2007. The guidelines are in the approval process and will be distributed to all Institutional Review Boards, SCRO Committees, and applicable research institutions in California, along with state reporting forms and supporting materials developed by the Unit. The tenure of the Committee has been extended through 2008.***

***> Preventing childhood obesity***

**California is experiencing an increase in the prevalence of obesity and related health problems. CDPH has developed a statewide obesity prevention plan to address the obesity epidemic through a public education campaign, local assistance grants, and multi-sectoral policy strategies that promote healthy eating and active living. In addition, the Governor has joined the Alliance for a Healthier Generation. The Alliance seeks to prevent childhood obesity by working with schools, food industry, and healthcare professionals, such as CDPH and DHCS staff.**

**Childhood obesity in low-income children is assessed through the Pediatric Nutrition Surveillance System (PedNSS) data. The percentage of overweight, low-income children under 5 years, receiving healthcare through CHDP, continues to be higher than national prevalence rates, at 17.4 percent. The percent of children 5-20 years who are overweight is 22.7 percent, also higher than the national rate.**

**CHDP obtains nutrition status and prevalence data on more than 1.5 million youths from CHDP providers' Confidential Screening/Billing Report.**

**The fourth California Childhood Obesity Conference was held in January 2007. MCAH/OFP was instrumental in the inclusion of topics related to maternal and child health, including breastfeeding, the life-cycle model, perinatal women's weight, and adolescent interventions.**

**MCAH/OFP is co-chairing two Women's Healthy Weight Collaboratives in LA and Sonoma County. The collaboratives receive technical support from AMCHP, CityMatCH, and CDC. LA is developing handouts on breastfeeding and preconception weight, which will be used in state-sponsored Nutrition Network Workplace grants.**

**MCAH/OFP is a CDPH representative on the Obesity Prevention Group, which will be coordinating obesity policy and program efforts and providing obesity prevention concepts to the Governor's Office.**

#### **> Breastfeeding**

**The MCAH/OFP Branch participated in the Breastfeeding Promotion Advisory Committee (BPAC) to develop strategies and implementation guidelines to promote breastfeeding in California by providing content and breastfeeding surveillance data. A collaborative with the Women, Infant and Children Branch was formed to address recommendations from the report.**

**UC Davis Breastfeeding Data Committee staff worked with Branch staff and private and public stakeholders to revise the instructions on the Newborn Screening Test form, revise the methodology for computing in-hospital breastfeeding rates, and revise breastfeeding surveillance data tables using the new methodology. The MCAH/OFP Branch will continue to publish annual breastfeeding surveillance by race/ethnicity and provide hospital breastfeeding rates for public reporting.**

**The breastfeeding page of the MCAH/OFP website has expanded its hospital breastfeeding policy toolkit and list of helpful breastfeeding links.**

**The MCAH/OFP Branch provides support to meet the requirements of the Lactation Accommodation Law and the right to breastfeed in public.**

**The MIHA survey includes questions to estimate breastfeeding duration, which are updated in consultation with BPAC and MCAH/OFP staff.**

**> Comprehensive Black Infant Health (BIH) Program assessment**

*The UCSF Center for Social Disparities in Health has completed and submitted to the Branch a comprehensive literature review of interventions for African American infant health outcomes, including infant morbidity and mortality reduction programs. UCSF is developing recommendations for an equitable method of distributing BIH resources among local BIH programs. The final BIH intervention recommendation report and the creation of a BIH data and evaluation work group are expected in late 2007. Additionally, in collaboration with the Branch and data work group, UCSF will develop a process and outcome evaluation of the BIH Program.*

**> Black Infant Health / Fetal Infant Mortality Review (BIH/FIMR)**

*The BIH/FIMR Program was undertaken by the MCAH/OFP Branch in response to the persistent disparity between African American and White infant mortality rates. The goal of BIH/FIMR is to reduce African American fetal and infant deaths through review of these deaths at the community level. Eight BIH jurisdictions participate in the Program; all have an African American combined fetal and infant death rate above the average for the 17 BIH jurisdictions statewide and all have a FIMR program. BIH/FIMR uses the national FIMR model to collect detailed information about African American fetal and infant deaths beyond vital statistics.*

*Using data obtained from BIH/FIMR, the Los Angeles MCAH Program implemented the LA Mommy and Baby Survey (LAMBS). While the African American infant mortality rate decreased from 2002 to 2003, it still remains high when contrasted with the rates for other ethnicities. The survey also revealed increased infant mortality among Hispanics. LA MCAH has undertaken efforts to reduce infant mortality in both African American and Hispanic communities through enhanced access to quality and culturally sensitive obstetrical care for at-risk women.*

**> Implementation of BASINET for BIH/FIMR**

The MCAH/OFP Branch contracted with GO Beyond to use the Baby Abstracting System and Information NETwork (BASINET) for the BIH/FIMR Program. BASINET is a web-based project management system for fetal and infant mortality review that combines data abstraction, deliberations, and detailed on-demand reporting. In-person trainings of BASINET were provided in August 2006 and January 2007 for the eight BIH/FIMR jurisdictions that are pilot testing the system. The first reports from the eight jurisdictions are expected in August 2007. Depending on the effectiveness of BASINET, it may be used in other counties with Branch-supported FIMR projects to provide more centralized and comprehensive fetal and infant mortality data at the state and local level.

**> High-risk infants**

The CCS Program requires regional affiliation among the 118 CCS-approved NICUs to assure access to appropriate intensive care services. CCS-approved NICUs are designated as Intermediate, Community, and Regional NICUs and required to comply with CCS standards which includes the submission of annual morbidity/mortality data. All CCS-approved NICUs are submitting annual data through the CPQCC and reviewing their reports on-line.

Each CCS-approved NICU facility is required to have an organized High-Risk Infant Follow-

Up (HRIF) program or a provision for these services by another NICU facility. The HRIF programs began collecting and submitting data to CMS as of July 2006. The CMS database contains 3,200 HRIF reports to date. The newly formed HRIF program is working with CPQCC to build upon the data that all CCS-approved NICUs currently submit and to evaluate outcomes. This new data program will provide analysis of outcome data that can be linked to NICU hospital data. These data will enable the providers to assess care and target quality improvement activities.

**> Use of data and geographic information system (GIS) in policy and planning**

The MCAH/OFP Branch is participating in the Department's GIS Working Group to establish centralized GIS tools for the Department. This will allow for interdepartmental use of the same GIS server and will enable sharing of Department GIS maps and data sets.

**> Improving quality of vital statistics data**

The MCAH/OFP Branch promoted changes to birth, death, and fetal death certificates to increase the data collection quality of vital statistics collected by the state. Using the birth certificate as an example, Branch efforts led to the addition of 1) obstetric estimate of gestation at time of delivery; 2) infant hearing screening; 3) maternal smoking assessment; 4) pre-pregnancy maternal weight and height measurements; and 5) APGAR scores at 1, 5, and 10 minutes.

In a complementary action, the RPPC Coordinators teamed up with the Office of Vital Records (OVR) to provide local trainings of birth certificate clerks to improve birth certificate data collection methods, resulting in significant improvements in data completeness and quality. The need for ongoing birth clerk training remains a priority for accuracy of data. In order to address this, RPPC staff and OVR are collaborating to do an additional training session that will be videotaped and made into DVD recordings to be distributed to local hospitals.

Additionally, the Branch is working with OVR to determine whether the Branch's SIDS and FIMR data collection can be incorporated into the OVR electronic death registry system.

**> Early childhood development**

Proposition 10, the Children and Families First Act of 1998, imposes a surtax on cigarette sales, which generates about \$600 million a year. The state-level First 5 California Commission receives 20 percent of the funds, while local First 5 Commissions in each county receive 80 percent. First 5 recently authorized \$400 million to its signature School Readiness Initiative (SRI) for 2006-2010.

First 5 has several other efforts addressing early childhood health and development including a gap insurance product, an oral health initiative, and an obesity media campaign. The MCAH/OFP Branch follows the activities of First 5 and helps local staff prepare SRI proposals and identify the connections between their programs and First 5 activities.

MCAH/OFP received a multi-year grant from HRSA for the SECCS project. The project provides state-level leadership for early childhood health programs that help prepare children for kindergarten. The project includes identification of recommended screening tools and best practices, as well as recognition of critical partners and funding opportunities to provide a seamless delivery of services.

MCAH/OFPP received a technical assistance grant to lead a 15-month national consortium to develop policies to improve early identification of children with developmental problems.

> Newborn Hearing Screening Program expansion

New legislation was passed that expands the Newborn Hearing Screening Program (NHSP) to all general acute care hospitals with licensed perinatal services, effective January 1, 2008. The program currently is operational in 175 hospitals that deliver over 411,000 infants per year. This expansion will include 95 more hospitals and result in an additional 130,000 infants receiving hearing screening each year. It is expected that a total of 1000 infants will be identified with hearing loss every year after full implementation.

The NHSP has numerous infrastructure building blocks in place, which will support a seamless expansion of the program. These include standards for inpatient and outpatient screening providers, certification criteria for participation in the program, guidelines for infant audiological diagnostic evaluations, and Hearing Coordination Centers (HCCs). Each HCC is responsible for a specified geographic service area to assure compliance with standards, tracking and monitoring of infants who need outpatient follow-up, and linkage of families of children identified with hearing loss to early intervention, medical, and support services.

The biggest challenge for the NHSP during this final implementation phase will be to address the increased workload in the data management arena. The program currently collects all infant data through a paper reporting system. The NHSP is in the process of procuring a data management service that will be utilized by the hospitals, HCCs, and state office for tracking and monitoring, quality assurance, program evaluation, and statewide reporting. The service will enhance the operations of the program and improve the accuracy and reliability of the data.

> Child health insurance coverage

The Department has been improving Californians' health through expanded health insurance coverage. Efforts to increase enrollment in the state-sponsored children's health care programs, including Medi-Cal and Healthy Families (HF), appear to be reducing the percentage of uninsured children.

From the inception of the CHDP Gateway in July 2003 and through December 2006, over 2.5 million children receiving CHDP assessments have been pre-enrolled for up to two months of no cost full-scope Medi-Cal benefits. Of these children, 76 percent requested joint applications from Medi-Cal/HF and 18 percent had their eligibility extended.

Effective June 2004, the CHDP Gateway was enhanced to allow deeming of Medi-Cal eligibility for infants if their mother's eligibility for Medi-Cal at the time of birth was confirmed. Eligibility is extended until the first birthday without requiring their parent(s) to complete a joint Medi-Cal/HF application. From June 2004 through December 2006, 157,378 infants were automatically enrolled in Medi-Cal as the result of a Gateway transaction.

> Oral health promotion

CDPH is responding to the high prevalence of dental disease among California's children

with a variety of strategies to increase awareness of oral health.

In FY 2005-06, 1,795,926 children received dental screenings through the CHDP program, similar to the previous year.

To assess the oral health status of elementary school children, the Office of Oral Health (OOH), MCAH/OFP, and numerous other partners conducted dental screenings in 186 elementary schools and summarized the results in a report.

CDPH contracts with UCSF to oversee the OOH's California Children's Dental Disease Prevention Program (CDDPP). Currently, the CDDPP operates school-based programs in 32 counties, providing fluoride rinses, oral home care instruction, and dental sealants. Plans to expand CDDPP are underway.

Based on a recent survey, half of the MCAH local jurisdictions identified oral health as a priority in their 5-year implementation plans. These jurisdictions have community dental health advisory boards that develop and implement local dental screening and prevention programs. Several MCAH jurisdictions rely on local CDDPP and CHDP coordinators to integrate oral health outreach programs into MCAH target populations. Local agencies, such as First 5 and WIC, work to incorporate screenings, provide fluoride varnish applications, and promote preventive oral health practices to pregnant women, new parents, and children. MCAH case management programs, such as CPSP and AFLP, enroll women and their families into Medi-Cal and Healthy Families insurance and provide them with dental referrals.

#### > Eliminating racial and ethnic disparities in health

Racial and ethnic disparities continue to exist in the areas of infant mortality, neonatal mortality, preterm delivery, low birthweight and maternal mortality in California. The MCAH/OFP Branch makes cultural sensitivity a cornerstone of every program activity.

The California Diabetes and Pregnancy Program (CDAPP) incorporates cultural competence awareness in all CDAPP trainings and materials. Direct services are provided by well-trained, ethnically diverse specialists in diabetes and pregnancy. Food plans are developed to include foods that are compatible with the dietary customs of each client.

The BIH programs have served as a national model by successfully identifying and enrolling the highest risk population, pregnant and parenting African American women, for focused interventions. Comprehensive services offered to this population include the development of client-centered, culturally sensitive education; case management; and prenatal and pediatric care.

State outreach efforts have been designed to reduce the disproportionately high rates of uninsured among California's ethnically diverse populations. To improve access to Medi-Cal services, all Medi-Cal Managed Care materials are to be made available in ten threshold languages.

#### > Adolescent Family Life Program report

In February 2007, the MCAH/OFP Branch released a report on the Adolescent Family Life Program. The report contains a history and description of the program; information about providers and funding, including fiscal challenges; a profile of female clients; and a discussion of process and outcome indicators, including early prenatal care, birthweight, repeat births and contraceptive use, educational continuation, and service referrals.

#### > Adolescent health promotion

The state formed the California Initiative to Improve Adolescent Health, based on the National Initiative to Improve Adolescent Health by the Year 2010. In response to the interest among county MCAH directors and local agencies, the MCAH/OFP Branch contracted with the National Adolescent Health Information Center (NAHIC) at UCSF. The NAHIC produced the Guide to Adolescent Health Data Sources to assist those interested in adolescent health to better assess the needs of youth in their community.

The California Adolescent Sexual Health Workgroup (ASHWG) is a standing workgroup with leadership comprised of program managers from the California Departments of Education and Public Health, the California Family Health Council, and a local MCAH director. The workgroup is committed to effectively addressing the sexual and reproductive health of adolescents; this includes developing core competencies for the provision of adolescent sexual health education and counseling. These are being widely disseminated for feedback to assure they meet the needs of intended users. Secondly, a data integration subcommittee is working to assure easy access by local health jurisdictions to sexual health and behavior data.

#### > Foster care

To improve access to and oversight of health care for foster children, the Health Care Program for Children in Foster Care (HCPCFC), a collaboration between the Department of Social Services and CMS, was initiated in 2000. This program, administered locally by CHDP, places public health nurses (PHNs) in administrative case management positions in welfare service agencies and probation departments to serve as a resource and to assure delivery of comprehensive preventive, diagnostic and treatment health services to children in foster care.

California has 86,000 foster children. HCPCFC has 271 PHNs in administrative care coordination and supervisory positions. Though the number of children in foster care is decreasing primarily due to DSS efforts to keep families together and work with the whole family, the children's medical complexity is increasing.

A Statewide Foster Care Executive Subcommittee has developed four best practice guidelines for PHNs statewide: 1) assurance of coordinated and continuous care; 2) universal review and updates of the content for the Health and Education Passport (HEP); 3) consultation and care coordination for out-of-county placement; and 4) guidelines for working in the juvenile probation departments.

#### > Fetal Alcohol Spectrum Disorder (FASD) and the Substance Abuse Task Force

State and local health jurisdictions are active in FASD prevention and intervention, in addition to the MCAH/OFP Branch being part of the statewide FASD Task Force. Several counties use the "4 P's Plus" screening tool to identify pregnant women at risk for alcohol and illicit drugs.

The Local MCAH Jurisdiction Survey on Prenatal Substance Use Screening Data report provides an inventory of existing local data that can be used to complement and augment efforts to quantify prenatal substance use statewide. Local health jurisdictions have begun interagency collaboration to maximize resources and expand services, which has resulted in improved service provision for pregnant women.

The State Epidemiologic Outcomes Workgroup (SEOW) was created to develop a system to assess the prevalence and consequences of substance use statewide. The Branch provided data to assess the prevalence and effects of substance use during pregnancy, among women of reproductive age, and among children under age 18. The system will provide county jurisdictions with local data and the analytic capacity to use these data for prevention planning, design, and evaluation.

**> Impact of federal Title V reductions on California programs**

Due to cuts in Title V funding in FY 2006-07, several MCAH/OFP programs have been eliminated or had their funding substantially reduced. The following programs and projects have been eliminated: Adolescent Sibling Pregnancy Prevention Program; technical assistance to local health jurisdictions for adolescent health improvement; and the training program for AFLP case managers. The following have received funding reductions of more than \$85,000/year each: AFLP; support services for the Childhood Injury Prevention Program; the Oral Health Program; staff support for MCAH program development; and technical assistance to local health jurisdictions from the Family Health Outcomes Project.

The amount of Title V funding has not increased; however, due to the timing of funding availability from the federal grant in relationship to the state budget cycle, additional Title V funding is being allocated in 2007 for the following efforts: To determine statistically representative data collection methods for birth defects monitoring and for prenatal blood sample storage for research purposes; to provide training to hospital staff on breastfeeding; to develop strategies to improve preconception and interconception care; to expand statewide and local efforts related to reducing maternal morbidity and mortality; and to support the stem cell research program. (These are limited term allocations.)

**> Impact of the federal Deficit Reduction Act (DRA) on California programs**

Several of the DRA of 2005 provisions are expected to have a negative impact on MCAH programs. The provision regarding verification of citizenship is likely to be particularly burdensome. In addition to affecting Medi-Cal, increased documentation requirements may impact other Medi-Cal-related programs including Family PACT (family planning services for teens and low-income women) and CPSP.

Research consistently shows that increased documentation requirements are barriers to Medi-Cal enrollment. Low-income applicants may not have the needed documentation and may find their health coverage delayed or denied while they attempt to obtain it. For teens who are eligible for confidential services (e.g., family planning), parental intervention may be necessary for obtaining verification of citizenship, thereby effectively eliminating teens' access to confidential services. Finally, some providers may stop providing services because the verification requirement is too onerous.

The effect of this requirement may ultimately be reflected in an increasing teen birth rate, an increasing number of poor birth outcomes, and a decline in access to healthcare for pregnant women and children.

California is in the process of implementing the DRA. The concerns described above are still applicable.

//2008//

***An attachment is included in this section.***

## **B. Agency Capacity**

Programs affiliated with the MCAH/OFP and CMS Branches include the following:

Adolescent Family Life Program (AFLP)  
AFLP Management Information System  
Adolescent Health Program  
Advanced Practice Nursing Program (APN)  
Battered Women's Shelter Program (BWSP)  
Black Infant Health (BIH)  
BIH Management Information System  
Breastfeeding Promotion  
California Birth Defects Monitoring Program (CBDMP)  
California Children's Services (CCS) Program  
California Diabetes and Pregnancy Program (CDAPP)  
California Perinatal Quality Care Collaborative (CPQCC)  
California Perinatal Transport System (CPeTS)  
Child Health and Disability Prevention Program (CHDP)  
Childhood Injury Prevention Program (CIPP)  
Comprehensive Perinatal Services Program (CPSP)  
Comprehensive Perinatal Services Provider Training  
Emergency Triage Transport System (ETTS)  
Family Health Outcomes Project (FHOP) and Local MCAH Data  
Family Planning, Access, Care and Treatment (Family PACT)  
Fetal Infant Mortality Review Program (FIMR) and BIH FIMR  
Genetically Handicapped Persons Program (GHPP)  
Health Care Program for Children in Foster Care (HCPCFC)  
High Risk Infant Follow-up (HRIF)  
Maternal Child and Adolescent Health Program (MCAH)  
MCAH in Schools (formerly named School Health Connections)  
Medical Therapy Program (MTP)  
Newborn Hearing Screening Program (NHSP)  
Oral Health  
Perinatal Profiles and Improved Perinatal Outcomes Data Reports Website  
Regional Perinatal Programs of California (RPPC)  
Sudden Infant Death Syndrome (SIDS) Program  
Teen Pregnancy Prevention Programs  
Youth Pilot Program (YPP) and Integrated Health and Human Services Pilot

***/2008/***

***In the last two years, the above list of programs has changed as follows:***

***- The Adolescent Sibling Pregnancy Prevention Program (ASPPP) was eliminated in 2006 due to Title V funding cuts.***

***- The Adolescent Health Program was eliminated in 2006 due to Title V funding cuts, but is being reinitiated in 2008 with redirected funding.***

***- Effective January 2007, California's Birth Defect Monitoring Program was moved from Prevention Services to the MCAH/OFP Branch.***

**- The Emergency Triage Transport System is a new project funded through an Inter Agency Agreement with the CA Emergency Preparedness Office; HRSA grant.**

**- The Youth Pilot Program (YPP) and Integrated Health and Human Services Pilot has been removed from the list of MCH programs because the MCAH/OFP Branch no longer has responsibility for it. Oversight responsibility for this effort has been moved to another Branch of the Department.**

**- The Medically Vulnerable Infant Program was combined into the High Risk Infant Follow-up Program in July 2006.**

**//2008//**

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

> Support to local infrastructure

Several system-wide programs, including MCAH, CCS, and CHDP, are administered by local health departments under the direction and guidance of the MCAH/OFP and CMS Branches. In addition to setting statewide policy, the State funds local health departments for these activities.

The Youth Pilot Program (YPP) facilitates integration of CDHS services for youth in six counties. The YPP pilots allow counties to make decisions locally regarding the best use of state and local human services funds without a reduction of state and federal funds.

> Quality of maternity services

The California Perinatal Quality Care Collaborative (CPQCC) is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals (including MCAH/OFP and CMS), and business groups. It is working to develop an effective perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels. CPQCC membership has grown to over 100 hospitals. Participating hospitals receive an annual online report with comparative analysis on perinatal and neonatal data.

**//2008/ CPQCC membership has grown to 123 NICUs, three of which are in the final stages of the application process. These 123 hospitals represent over 90 percent of all neonates cared for in California neonatal intensive care units. //2008//**

//2007/ CPQCC has developed a quality assurance tool for use by hospitals in evaluating the quality of neonatal services and a CPQCC team visits member hospitals to assist with the process. //2007//

The Perinatal Quality Improvement Panel (PQIP), a subcommittee of CPQCC, recommends quality improvement objectives, provides models for performance improvement, and assists providers in a multi-step transformation of data into improved patient care through the use of toolkits, workshops, and follow-up. MCAH/OFP and CMS staff are members of the CPQCC Executive Committee and PQIP.

The MCAH/OFP Branch recently developed the Maternal Quality Collaborative (MQC), a joint effort with the CPQCC and UCLA's Maternal Quality Indicators group. The MQC Leadership Council includes members from CCS, MCAH/OFP, Medi-Cal Managed Care (MCMC), and Medi-Cal Policy Section. The MQC will direct statewide maternal quality improvement activities utilizing the methodology developed by the CPQCC.

CDAPP works to promote optimal management of diabetes in at-risk women, before, during and after pregnancy. CDAPP has care guidelines which address everything from lab values to billing and data issues. ***//2008/ CDAPP staff have begun the process for updating the CDAPP "Guidelines for Care" Manual. //2008//***

>Infants' access to care

MediCal, Healthy Families (HF) and Access for Infants and Mothers (AIM) provide health insurance coverage for infants. Medi-Cal reaches infants living in households with incomes below 200 percent of FPL. HF provides insurance coverage for infants in households with incomes up to 250 percent of the FPL; monthly premiums and co-payments for certain types of visits and prescriptions are required. AIM provides state-subsidized third party insurance for infants in households with incomes between 200 and 300 percent of FPL.

***//2008/ As of July 2004, state law requires the Managed Risk Medical Insurance Board (MRMIB) to enroll infants of mothers who participate in the AIM program into the HF program. According to statute, AIM linked infants between 250 and 300 percent of the FPL will be allowed to continue their HF coverage up to two years of age, at which time the family will be required to meet current HF eligibility.***

***In FY 2004-05, 615,204 infants under one year of age received health services through CHDP, a 9 percent increase over the previous year. Of these infants, 74 percent had Medi-Cal coverage and 26 percent were state funded, similar to the previous year. //2008//***

> Infant Health Promotion

CDHS promotes exclusive breastfeeding initiation at birth and breastfeeding during infancy. Breastfeeding is promoted across all MCAH/OFP programs serving pregnant women and infants. Informational materials regarding breastfeeding, nutrition and immunizations for women, adolescents, children, and infants, are regularly disseminated to AFLP, BIH, CPSP, and RPPC providers. The CDAPP Guidelines for Care include a chapter on breastfeeding. The MCAH/OFP website includes a page devoted to breastfeeding. The page includes data on postpartum hospital breastfeeding discharge rates, local breastfeeding coalitions, links to other breastfeeding resources, and model breastfeeding policies.

*//2007/ In 2006 MCAH/OFP and CMS completed a chapter on infant feeding for the California Daily Food Guide. The chapter, which promotes breastfeeding as the normal infant feeding method, is available on the MCAH/OFP website and serves as the state-wide recommendation for infant feeding. //2007//*

*//2007/ MCAH/OFP offers technical assistance to hospitals to improve their breastfeeding policies. A toolkit, to assist hospitals in adopting model hospital policies, was completed in 2006 and is available on the breastfeeding web page. MCAH staff have been working with Kaiser staff to facilitate Kaiser's effort to have all their labor and delivery facilities in Northern California adopt the model hospital breastfeeding policies. //2007//*

***//2008/ MCAH/OFP promotes exclusive breastfeeding for the first 6 months of life and the continuation of breastfeeding for the first year and beyond. The MCAH/OFP website's breastfeeding page now includes updated data on hospital breastfeeding rates, a model hospital policy toolkit and links to other resources for health care providers and hospitals that offer support for mothers who choose to breastfeed and return to work, need information on contraception, take medications or face emergencies. //2008//***

Birth defects remain the number one cause of infant deaths. While the causes of many congenital

defects have yet to be identified, effective measures for the prevention of a significant portion of neural tube defects are known. MCAH/OFP Branch activities focus on folic acid promotion during the preconception and prenatal periods to reduce the risk of neural tube defect-affected pregnancies. The MCAH/OFP Branch is an active participant on the National Council on Folic Acid.

***/2008/ In 2006, the MCAH/OFP Branch contributed a chapter entitled "Folic Acid Use Among California Women of Reproductive Age, 2004-05" to a report on the California Women's Health Survey by the Office of Women's Health. //2008//***

The Genetic Disease Branch (GDB) of CDHS provides newborn screening for primary hypothyroidism, phenylketonuria (PKU), galactosemia, sickle cell disease and other hemoglobinopathies to 99 percent of the newborn population. The Newborn Screening (NBS) Program is expanding to include over 40 additional metabolic conditions detectable via Tandem Mass Spectrometry, and classical congenital adrenal hyperplasia. CMS is working with the GDB to inform CCS-approved Special Care Centers (SCCs) and CCS County and Regional Offices of the expansion and to enlist their help in expediting referrals for infants with positive screening test results.

*/2007/ In July 2005, the Newborn Screening (NBS) Program expanded to include classical congenital adrenal hyperplasia (CAH) and over 40 additional metabolic conditions detectable via Tandem Mass Spectrometry (MS/MS). //2007//*

***/2008/ From July 2005 through August 2006 (639,158 screens), there were 1,150 positive screens, and 198 cases of inborn errors (including PKU) diagnosed by MS/MS testing. From July 2005 through December 2006, 54 cases of CAH were diagnosed. The CAH cutoff for infants <1000g was increased in March 2006 resulting in the false positive rate dropping from 20 percent to 4 percent. //2008//***

***/2008/ The NBS Program is expanding in August 2007 to include Cystic Fibrosis and Biotinidase Deficiency. //2008//***

Several programs of the MCAH/OFP Branch address additional causes of infant mortality and morbidity. The SIDS Program has facilitated the SIDS Risk Reduction campaign, also known as Back to Sleep (BTS) in California.

*/2007/ Between 1999 and 2004 the rate of infant deaths due to SIDS in California declined 31 percent, from 45.7 per 100,000 live births to 31.4 per 100,000 live births. In 2004 African American infants had the highest rate of SIDS at 83.7 per 100,000 live births, followed by 40.2 for White/Other infants and 23.6 for Hispanic infants. //2007//*

The Black Infant Health (BIH) Program has the goal of reducing African American infant mortality in California. BIH funds programs in 17 local health jurisdictions, which, combined, account for 94 percent of the state's African American births.

California's Fetal Infant Mortality Review (FIMR) Program, which took a significant budget cut in FY 2002-03, was expanded this year, with a \$250,000 reallocation of Title V funds. This new funding has established the Black Infant Health FIMR (BIH/FIMR) Program. The goal of the BIH/FIMR program is to reduce African American fetal and infant deaths through review of these deaths at the community level. Eight of the seventeen FIMR jurisdictions with the greatest proportion of African American births and fetal deaths have been selected for participation.

The MCAH/OFP Branch prepared a grant application to CDC for a Fetal Alcohol Syndrome Program, but it was not funded. MCAH/OFP continues to network with counties that are addressing Fetal Alcohol Spectrum Disorder (FASD).

***/2008/ As of March 2007, there are 175 hospitals certified and participating in the NHSP, down from 177 in the previous year. This number has decreased due to the closure of delivery units in some CCS approved hospitals. Of the babies born in CY 2005, over 411,000 received newborn hearing screening and 713 were identified with hearing loss. This is an incidence rate of 1.7 per 1000. Of those with hearing loss, 450 were identified before 3 months of age (63 percent), and 598 have been enrolled in Early Start, California's early intervention program (84 percent). Of those in Early Start, 403 enrolled before 6 months of age (67 percent). //2008//***

Preventive and Primary Care for Children

> Access to care

Medi-Cal and HF provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children. Medi-Cal covers children ages 1 through 5 up to 133 percent of FPL, children and adolescents ages 6 up to 19 at up to 100 percent of FPL, and young adults ages 19 to 21 at up to 86-92 percent of FPL. HF covers children from 0 through 18 years of age who are uninsured and living in households with incomes up to 250 percent of FPL. Monthly premiums and co-payments for certain types of visits and prescriptions are required.

***/2008/ As of April 2007, there were 807,782 children enrolled in HF, an 8.5 percent increase over enrollment in December 2005. //2008//***

***/2008/ Increased efforts have been made by local health jurisdictions to ensure medical care for the MCAH population. Efforts include training certified application assistants to identify the most appropriate health insurance program for women and their children; training pediatricians to perform routine dental exams on their population; and encouraging dentists to accept Denti-Cal patients. //2008//***

The CMS Branch administers the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, which is called the Child Health and Disability Prevention Program (CHDP) in California. CHDP provides preventive services, including health assessments, immunizations, screening tests, dental screening, health education, and referral for further diagnosis and treatment for Medi-Cal-funded children up to 21 years of age. Uninsured children and youth up to 19 years of age in families with incomes at or below 200 percent of the FPL are eligible to pre-enroll in Medi-Cal through the Gateway process.

***/2008/ In FY 2006-07, 2,039,935 children received screening and health assessments through the CHDP program, similar to the previous year. (The number receiving services declined by 3 percent in FY 2005-06, after having been quite stable at about 2.1 million for the previous five years.) The funding for the CHDP program remains the same as the previous year: 98 percent funded by Medi-Cal and 2 percent by state only funding. //2008//***

The CHDP Gateway, implemented in July 2003, has pre-enrolled 1.2 million children through February 2005, and 80 percent of them have requested a joint Medi-Cal/HF application. CDHS has modified the pre-enrollment process that allows the Gateway transaction to identify and "deem" certain infants less than one year of age as eligible for ongoing, full-scope, no cost Medi-Cal at the time of a CHDP health assessment. The families of these infants do not have to complete a Medi-Cal application.

***/2008/ The CHDP Gateway program pre-enrolled 2.5 million children from July 2003 to December 2006, and 76 percent have requested a joint Medi-Cal/HF application. From February 2005 to December 2006, 157,378 infants have been "deemed" eligible for full-scope, no cost Medi-Cal as a result of the modified CHDP Gateway pre-enrollment***

***process. //2008//***

> Childhood/adolescent health promotion

Injuries are the leading cause of mortality among children and youth. To reduce injury-related mortality and morbidity among children and adolescents, MCAH/OFP contracts with the Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University. CIPPP provides technical assistance and training for local MCAH programs through conferences, a list serve, and weekly literature reviews of the latest injury prevention research. The MCAH/OFP Branch funds five local MCAH jurisdictions to increase injury prevention capacity within their community.

*//2007/* Due to Title V budget cuts, funding for the MCAH/OFP contract with CIPPP has been reduced. The reduction eliminates funding for the annual statewide conference and reduces technical assistance provided to local health jurisdictions. *//2007//*

***//2008/ The funding specifically for childhood injury prevention in five local jurisdictions will be discontinued after June 2007. Counties are expected to continue to address childhood injury prevention issues with their general funding allotment. Counties have also received grants from the Office of Traffic Safety, which have enabled them to expand childhood injury prevention programs. //2008//***

As a part of the California Initiative to Improve Adolescent Health by the Year 2010, the National Adolescent Health Information Center (NAHIC) and the California Adolescent Health Collaborative (AHC) provide support to local jurisdictions interested in adolescent health. Last year the Guide to Adolescent Health Data Sources was produced to assist locals in assessing the needs of the youth in their community. NAHIC and AHC provide technical assistance to assist local programs in developing a grant application template that they can use for future applications to foundations and federal agencies. The California AHC also puts out an annual report card on key adolescent health indicators.

The MCAH/OFP Branch applied for a System Capacity for Adolescent Health Technical Assistance Grant from the Association of Maternal and Child Health Programs (AMCHP), but did not receive one.

The MCAH/OFP Branch held an Adolescent Health System Capacity Assessment stakeholder meeting in April 2005, in addition to local feedback meetings with MCAH Directors and other groups. Results of these meetings reveal that there is a great need to increase efforts in general adolescent health at the MCAH/OFP Branch and increase partnerships, especially in the areas of mental health, education, substance abuse, and juvenile justice. Local jurisdictions want to see more state staff attending local events and visiting programs so that stronger partnerships between state and local programs can be fostered. Local jurisdictions also expressed a strong need for more financial and human resources for adolescent health so that they could implement California's adolescent health strategic plan at the local level.

*//2007/* Due to Title V budget cuts, the contract with AHC for adolescent health improvement has been eliminated. Technical assistance will no longer be provided to local health jurisdictions planning and implementing the recommendations provided by the Adolescent Health Improvement Plan. *//2007//* ***//2008/ This adolescent health promotion project will be re-initiated in 2008 with redirected funding. //2008//***

The MCAH/OFP Branch participates in the multi-agency California Coalition for Youth Development. The coalition works to improve youth development throughout California through the annual Youth Development Summit and other projects. Participants include the Attorney General's Office, the Department of Education (CDE), 4-H Center for Youth Development, Friday Night Live, Department of Alcohol and Drug Programs (ADP), and the Department of Mental

Health (DMH).

/2007/ MCAH/OFP has received a multi-year grant beginning in 2003 from HRSA for the State Early Childhood Comprehensive Systems (SECCS) project. MCAH/OFP provides state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically ready for kindergarten. Two years of planning culminated in a statewide needs assessment and strategic plan to address critical components of early childhood health care systems. The project is now in the implementation phase. //2007//

***/2008/ SECCS staff visited eight local health jurisdictions to identify screening tools and best practices, models of service integration, and barriers to braiding of funds. Findings will be presented to stakeholders in 2007, and plans will be developed to address the findings. //2008//***

The MCAH/OFP Branch participates in UCSF's Childcare Health Program Advisory Committee. This organization is dedicated to enhancing the quality of childcare for California's children by initiating and strengthening linkages between health, safety, and child care communities and the families they serve. This program previously received the Healthy Child Care America (HCCA) Grant, which has now been folded into the SECCS grant. UCSF's HCCA director serves as the co-director for the SECCS grant. ***/2008/ The MCAH/OFP Branch did not participate on this Committee in 2007 due to staff changes. //2008//***

The CMS Branch continues to participate in the Childhood Asthma Initiative (CAI) through the CAI CHDP project, consisting of asthma education, trainings, resource development, and implementation of Asthma Assessment Guidelines for CHDP providers. /2007/ The Childhood Asthma Initiative grant ended July 2005. //2007//

> Services for Children with Special Health Care Needs (CSHCN)

The CMS Branch administers the CCS program that provides case management and payment of services for CSHCN. The program authorizes medical and dental services related to the CCS eligible condition. Additionally, it establishes standards for providers, hospitals, and Special Care Centers (SCCs) for the delivery of care in tertiary medical settings and in local communities, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions.

/2007/ The CCS Medical Therapy Program (MTP) provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. The number of clients enrolled in the MTP has remained fairly stable for the past four years and is currently 26,698. //2007//

***/2008/ The estimated caseload for CCS in Federal Fiscal Year (FFY) 2005-06 was 182,800. This is a four percent increase from the prior year of 175,920. Approximately 80 percent of these children were enrolled in Medi-Cal, 10 percent were enrolled in HF and 10 percent were enrolled in state-only CCS. CHDP providers continue to facilitate referrals to CCS of children with CCS eligible or potentially CCS eligible conditions. //2008//***

The CCS program is responsible for case managing the care of the CCS eligible medical condition for Medi-Cal beneficiaries and authorizes Medi-Cal reimbursement for services related to the CCS condition, including EPSDT supplemental services. CCS case manages and authorizes payment of services related to the CCS eligible condition for children enrolled in HF. Through a system of CCS-approved SCCs, CCS provides access to quality specialty and subspecialty providers for CSHCN. The SCCs are located in the outpatient departments of tertiary care hospitals and use multidisciplinary teams to address health needs and provide coordinated care for CCS beneficiaries.

Thirty-one "independent" counties fully administer their own CCS programs, and 27 "dependent" counties share the administrative and case management activities with CMS Branch Regional Offices. The Case Management Improvement Project has encouraged dependent counties to assume case management functions historically done by state Regional Office staff.

The CCS Program has structured a system of regional affiliation among the 121 CCS-approved neonatal intensive care units (NICUs) to assure that infants have access to appropriate specialty consultation and intensive care services throughout the state. CCS-approved NICUs are designated as Intermediate, Community, and Regional NICUs. NICUs that provide basic level intensive care services to infants in their communities are required to have established affiliations with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. The CCS approval process denotes the level of patient care provided in each NICU and verifies that the cooperative agreements are in place. In June 2001 the CPQCC initiated annual NICU data reporting to CCS. Annual NICU reporting is required for continuing CCS approval and reporting through the CPQCC facilitates data submission and analysis and improves reporting accuracy. The CMS Branch is requiring all CCS-approved hospitals to submit CCS NICU annual data through CPQCC beginning with CY 2004 data.

***//2008/ The number of CCS-approved NICUs is currently 118. To date all but one CCS-approved NICU are submitting data to CPQCC for 2006. //2008//***

The CMS Branch has two programs that address the needs of high-risk infants. The first allows infants that are discharged from CCS-approved NICUs to be followed in NICU High Risk Infant Follow-up clinics. Three multidisciplinary outpatient visits are authorized by CCS during the first three years of life to identify problems, institute referrals, and monitor outcomes. Visits include a comprehensive history and physical examination, developmental testing, and ophthalmologic, audiologic, and family psychosocial evaluations.

The second program, the Medically Vulnerable Infant Program (MVIP), has used a network of community-based contractors to provide home-based services to high-risk infants from NICUs and their families. Services have been provided to infants up to three years of age. Twelve contractors, including hospitals, community-based organizations and universities, have contracts until December 2005. As of March 2005, 4,282 infants have been enrolled in the program and 51,280 home visits have been made since program inception in July 2000.

*//2007/ After reviewing functions and responsibilities of the NICU High Risk Infant Follow-up (HRIF) program and the MVIP, CMS is combining these two programs into one program that addresses the needs of high-risk infants. The newly formed HRIF program will begin in July 2006, building upon the NICU HRIF programs already in place throughout the state. CMS is working with CPQCC to build upon the data that all CCS approved NICUs currently submit. The ability to collect expanded data elements will give the HRIF programs the opportunity to evaluate the outcomes of their NICU high-risk infant graduates. //2007//*

***//2008/ The 43 HRIF programs submitted 3169 registration forms between July 1, 2006 and May 15, 2007. //2008//***

The Genetically Handicapped Persons Program (GHPP) provides case management and funding for medically necessary services for people with certain genetic conditions. Most GHPP clients served in this program are adults, but 10 percent are children under 21 years. The GHPP serves eligible children with higher family incomes that make them ineligible for the CCS program. Hemophilia is the most common GHPP diagnosis followed by cystic fibrosis, sickle cell disease, Huntington's Disease, and Friedreich's Ataxia. ***//2008/ Client enrollment in GHPP is stable at about 1,550 clients (2005-2007). //2008//***

> Rehabilitation services to Supplemental Security Income (SSI) beneficiaries under the age of 16

SSI beneficiaries with a CCS medically-eligible diagnosis are served by the CCS program. During FY 2003-04, CCS received 2,057 referrals of SSI beneficiaries, and 52 percent of these were medically eligible for the CCS program. If physical and/or occupational therapy are needed, they can be provided in the CCS MTP. Children receiving SSI who have mental or developmental conditions are served by DMH, Department of Developmental Services (DDS), and CDE.

***/2008/ During FY 2006-07, CCS received 169 referrals; 72 of these applicants were medically eligible for CCS, and 97 were not medically eligible or were sent to the Social Security Administration for more information. //2008//***

> Family-centered, community-based coordinated care for CSHCN

SCCs and hospitals that treat CSHCN and wish to become CCS-approved must meet specific criteria for approval. One of the criteria used in evaluation involves provision of family-centered care (FCC). During the facility review, FCC is assessed and, as part of the review, the CMS Branch sends a follow-up report to the facility with FCC recommendations.

The CCS program facilitates FCC services for families of CSHCN. CCS staffing standards allow a parent liaison position in each county CCS program to enable FCC. County programs assist families in accessing authorized services. Many families live long distances from the site of appropriate pediatric specialty and subspecialty care. The program provides reimbursement for travel expenses (gas, bus tickets, taxis), meals for extended stays, and motel rooms for families when there are extended hospital stays.

The Children's Regional Integrated Service Systems (CRISS) (a collaboration of family support organizations, pediatric providers, statewide organizations, 14 county CCS programs in Northern California, and Family Voices of California) has a FCC Work Group that meets bimonthly. This group plans, develops and sponsors an annual fall conference (in addition to assisting with other conferences, workshops, resource fairs, and addressing issues regarding FCC); the conference for 2004 was about sexuality and youth with disabilities. /2007/ The conference for 2005 was entitled, "What Happens at 18? Conservatorship and Other Legal Rights for the CCS Client." //2007//

***/2008/ The 2006 Annual CRISS Conference, "Negotiating Multiple Transition Hurdles, One at a Time", was held in November. A CRISS mid-year workshop, "Maintaining Compassion and Avoiding Burnout", was held in June 2007. //2008//***

The CMS Branch has been directing a Champions for Progress Center Incentive Award that has involved convening a group of key stakeholders, with past investments in and knowledge of the system of care for CSHCN and their families, to meet bimonthly for twelve months to develop strategies and an action plan to address the CSHCN Title V performance measures and prioritize issues resulting from the Title V Needs Assessment process. The project is building on past efforts to develop a long-term, strategic plan for serving CSHCN; it is identifying resources within California to carry out the activities defined in the strategic plan. /2007/ There have been 25-30 stakeholders consistently participating in these monthly meetings. //2007//

***/2008/ The action plan was completed and disseminated. Implementation activities are being discussed by the Key Stakeholder Group for the MCHB grant described below. The Stakeholder Group will continue to meet quarterly, through June 2008. //2008//***

A federal Maternal and Child Health Bureau (MCHB) grant has been awarded to the University of Southern California's University Center for Excellence in Developmental Disabilities at Children's

Hospital Los Angeles (CHLA), collaborating with CRISS and Family Voices of California, for a three-year project to implement integrated community systems of care for CSHCN.

CCS is collaborating with CHLA and the California Epilepsy Foundation on a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy. The overall goal of the project is to improve access to health and other services and to facilitate the development of state-wide community-based interagency models of comprehensive, family-centered, culturally-effective care and state-wide standards of care.

LA County CCS produced a "Handbook for Los Angeles County CCS Families" in English and Spanish after working for two years with low-income, English and Spanish-speaking parents, Family Resource Centers, TASK (Team of Advocates for Kids), providers, Regional Centers, and LA CMS staff.

> Transitioning services for CSHCN

The CMS Branch recognizes the importance of transitioning care for CSHCN from pediatric to adult services. During site reviews of new SCCs and county CCS programs, transition issues are emphasized as important for the future delivery of medical care and services to the CSHCN.

CCS staff in Southern California regularly attend and participate in the Special Education Local Planning Areas (SELPA) Interagency Coordinating Transition Council. Transition committees in local county CCS programs receive input from parents and young adult clients to assess and develop ways to infuse the concept of transition into CCS services and functions. A matrix of transition activities of each of the fourteen represented counties is maintained

The CMS Branch formed a transition workgroup that has begun meeting and will ultimately develop transition policy and guidelines for the CCS program. There are healthcare professionals, experts in transitioning care, and family representatives.

/2007/ The transition workgroup has completed a survey that is being sent to county and Regional Office CCS programs to better understand what local and state CCS programs are doing to foster transition services and what the needs are for transition resources, technical assistance and training. This workgroup will also be reviewing the transition strategies from the Champions stakeholder group to help determine an implementation plan for these strategies.  
//2007//

***/2008/ Surveys were distributed to all county CCS programs. Counties were asked a series of questions for each of four MCHB core performance measures and asked to score their performance on a prescribed scale. CRISS staff have collected and summarized the survey data from 51 of the 58 counties.***

***The counties were asked the degree to which the local CCS program provides the services necessary to effect appropriate transitions to adult health care, work and independence for youth with SHCN. Rural dependent counties scored higher than larger urban and/or independent counties in the area of transition. The rural counties did not hold transition clinics, but they reported meeting with each transitioning youth (of which there may have been a small number). There was almost 100 percent compliance with the counties reporting "durable medical equipment needs, self-help needs and other MTP skills being assessed in a timely manner so that the youth at 21 exits the program with appropriate supports." In contrast, many counties outside the CRISS counties and LA (the latter where transition has been a focus) reported "no development or adaptation of transition materials" for use with their exiting young adults. Identification of adult providers was the second lowest mark for this performance measure. The average score for this performance measure was 2.53, right between "partially" and "mostly met".***

***The final report was submitted to CMS in August 2006 and has been distributed to all county CCS programs. The survey results also are being discussed in the context of the quarterly meetings of the State Key Stakeholder Group overseeing implementation of the State CCS Plan. //2008//***

/2007/ CHLA, UCLA Child and Family Health Program, LA Partnership for Special Needs Children, CRISS, CCS, and CMS Branch collaborated on a conference entitled "Family-Centered Strategies for Effective Transition for Youth with Special Health Care Needs: A Training for Providers and Families" in April 2006 in Los Angeles. Experts in the field provided information to agency staff, providers, youth and their families about the system of care for transitioning youth, transition resources, and strategies for assisting youth and their families. //2007//

***//2008/ The CRISS Project and Family Voices of California presented a workshop in English and Spanish on "Negotiating Multiple Transition Hurdles, One at a Time" in November 2006 in Oakland for nurses, physicians, CCS staff, regional center service coordinators, and youth and families. They keynote speaker's presentation was "Heartache to Hope." //2008//***

### **C. Organizational Structure**

Arnold Schwarzenegger is the Governor of California, a position he has held since November 2003. S. Kimberly Belshé is the Secretary for the California Health and Human Services Agency (CHHSA), which is a cabinet-level position reporting directly to the Governor. Sandra L. Shewry is the Director of the California Department of Health Services (CDHS), which is one of twelve departments in CHHSA. CDHS is designated to administer the MCAH program by the California Health and Safety Code Div. 106, Part 2, Chapter 1, Article 1 Sections beginning with 123225.

***//2008/ Effective July 2007, CDHS was reorganized into two departments: a California Department of Public Health (CDPH) and a Department of Health Care Services (DHCS). Mark Horton, MD, MSPH is the Director of CDPH, and Sandra Shewry is the Director of DHCS. Organizational charts for the two new departments can be found on pages 2-3 of the following website:  
<http://intranet.dhs.ca.gov/reorganization/FinalOrgChartsUpdated31407.pdf>.***

***The MCAH/OFP Branch has primary responsibility for carrying out Title V functions in California. The MCAH/OFP Branch is in the Center for Family Health of the CDPH. The CMS Branch, in DHCS, handles activities related to care of CSHCN.***

***The Deputy Director of the Center for Family Health is Catherine Camacho. The Chief of the MCAH/OFP Branch is Susann J. Steinberg, MD, and the Chief of the CMS Branch is Marian Dalsey, MD, MPH. //2008//***

Information about the MCAH/OFP Branch is provided below. Information about the CMS Branch is included in Section III D. For updated organizational charts for the MCAH/OFP and CMS Branches, see the attachments to Sections III C and III D, respectively.

> Maternal Child and Adolescent Health / Office of Family Planning Branch (MCAH/OFP)

In March 2005 the MCAH Branch was formally merged with the Office of Family Planning Branch to form the MCAH/OFP Branch. Prior to 2004, the MCAH Branch was known as the Maternal and Child Health Branch, or MCH.

Susann Steinberg, MD is Chief of the MCAH/OFP Branch, a position she has held since the two branches merged in March 2005. Prior to that, she had been Chief of the MCAH Branch since December 2002 and Acting Chief of the Office of Family Planning since May 2004. Dr. Steinberg is Board Certified in Family Practice as well as Preventive Medicine and has an MBA.

***//2008/ Since June 2007, Dr. Steinberg is on extended leave. Shabbir Ahmad, DVM, MS, PhD, is the Acting Chief of the MCAH Program, and Laurie Weaver is the Chief of the Office of Family Planning. //2008//***

Laurie Weaver is the Chief of the Office of Family Planning, a position she has held since May of 2005. Prior to coming to MCAH/OFP, Ms. Weaver was employed with the California Department of Corrections, Health Care Services Division.

Les Newman is the Assistant Chief of the MCAH/OFP Branch, a position he has held since the two branches merged in March 2005. Prior to that, he had been Assistant Chief of the MCAH Branch since February 2001. He has over twenty years working in leadership positions in California government and was previously Operations Section Chief within the MCAH/OFP Branch.

The MCAH/OFP Branch staff includes senior consultants in a variety of clinical, public health, and scientific disciplines. Emeterio Gonzalez, MD, an Obstetrician/Gynecologist and Eileen Yamada, MD, MPH, a Pediatrician, serve as medical consultants to the Branch. John Mikanda, MD, MPH assists in the evaluation of the Family PACT Program.

*//2007/ Dr. Yamada has accepted an alternate assignment as a Public Health Medical Officer and was replaced by Karen Ramstrom, DO, MSPH, effective May 2006. //2007//*

Lori Llewelyn, MPP is Title V Principal Author, a position she has held since February 2004. Mike Curtis, PhD and Eugene Takahashi, PhD oversee the compilation of state statistics for the Title V report. This Title V team works under the direction of Shabbir Ahmad, DVM, MS, PhD, Chief of the Epidemiology and Evaluation Section of MCAH/OFP.

The MCAH/OFP Branch consists of seven sections: Programs and Policy, Epidemiology and Evaluation, Operations, Administration, Clinical Services and Quality Improvement Utilization Management, Teen Pregnancy Prevention, and Domestic Violence. The last three of these sections comprise the Office of Family Planning.

***//2008/ The number of sections in the Branch has increased from seven to nine: In January 2007 the California Birth Defects Monitoring Program was moved from Prevention Services to the MCAH/OFP Branch, becoming the eighth section in MCAH/OFP. In the spring of 2007 the Programs and Policy Section was split into two sections (a Programs Section and a Policy Section), thereby increasing the total number of sections in the Branch to nine. //2008//***

#### > Programs and Policy Sections

The Programs and Policy Section of MCAH/OFP coordinates the implementation of standards of care for pregnant women, children, and infants in the AFLP, APN, BIH, BIH/FIMR, CPSP, FIMR, CDAPP, CPeTS, and SIDS Programs. Program consultants develop standards and provide consultation and technical assistance to local MCAH jurisdictions and other organizations.

Anita Mitchell, MD is the Chief of the Programs and Policy Section, effective July 2005. Dr. Mitchell is board certified in Pediatrics. Before coming to MCAH/OFP, she was the Chief Medical Officer, Medical and Public Health Programs, at the California Department of Corrections.

The Programs and Policy Section consists of four program units: two Perinatal Health Units, the Statewide Specialized Services and Programs Unit, and the MCAH in Schools Program.

The Perinatal Health Units are supervised by Nurse Consultant Supervisors Joyce Weston, BS (Nursing), MS (Healthcare Services Administration) and Leona Shields, MN, CNP. These two units consist of a staff of nine. The Perinatal Health Units provide technical assistance and consultation to 61 health jurisdictions regarding their MCAH Scope of Work and Allocation, AFLP/ASPPP, Breastfeeding Support Programs, FIMR programs, and BIH/FIMR.

The Statewide Specialized Services and Programs Unit has overall responsibility for the BIH and SIDS programs and the perinatal quality improvement contracts with the RPPC, CDAPP, CPeTS, APN and CPSP. The unit is also responsible for technical assistance and consultation to eighteen community-based organizations that provide AFLP services, eight of which also provide ASPPP services. The unit consists of five staff positions.

The MCAH in Schools Program (formerly called School Health Connections) currently has a staff of one, down from eight in 2002.

//2007/ The Programs and Policy Section has been reorganized into two program units, which cover all the responsibilities of the previous four units. The Statewide Specialized Services and Programs Unit and the MCAH in Schools Program are now within the Perinatal Health Units. The two Perinatal Health Units are now supervised by Nurse Consultant Supervisors Leona Shields, MN, CNP, and Angela Furnari RN, BSN, MPA; they currently consist of a staff of thirteen. //2007//

*//2008/*

***In early 2007 the Program and Policy Section was split into two Sections: the Programs Section, led by Anita Mitchell, MD, and the Policy Section, led by Karen Ramstrom, DO, MSPH. Dr. Mitchell is Board-certified in Pediatrics, and Dr. Ramstrom is Board-certified in Preventive Medicine and Family Medicine.***

***The two Perinatal Health Units described above are in the new Programs Section. Effective November 2006, these two Units are supervised by Angela Furnari, RN, BSN, MPA and Laurel Cima, MPA.***

***The Policy Section consists of a staff of nine, including one Public Health Medical Officer, who is certified in Preventive Medicine and Family Medicine. The Policy Section develops the policy and procedures in support of all MCAH programs and collaborates on Federal, State and local levels, providing expertise on multiple health priorities including nutrition, obesity, breastfeeding, physical activity, oral health, and the State Early Childhood Comprehensive System. The staff identifies relevant data points for annual reporting to ensure that local health jurisdictions address state priorities and program requirements.***

*//2008//*

> Epidemiology and Evaluation Section (EES)

The Epidemiology and Evaluation Section provides program information for monitoring MCAH/OFP program implementation, evaluating program effectiveness, and policy development. Program and population-based data are analyzed to support California's application for Federal Title V Grant Funds and Needs Assessment. The Section also provides assessment and surveillance information for use in program related research, program policy planning, and allocation of resources.

Shabbir Ahmad, DVM, MS, PhD, is Chief of the Epidemiology and Evaluation Section, a position he has held since May 2003.

The Epidemiology and Evaluation Section consists of two units with a total of 21 staff: Surveillance and Program Evaluation; and Epidemiology. The Chief of the Surveillance and Program Evaluation Unit is Mike Curtis, PhD. The Chief of the Epidemiology Unit is Eugene Takahashi, PhD, MPH.

*//2007/ As of November 2005, the EES was reorganized to include a third unit on Health Services Research. The new unit is supervised by Lori Llewelyn, MPP. The total number of staff in the EES is now 25. //2007//*

The MCAH/OFP Branch has been given the additional responsibility of implementing legislation mandating the monitoring of stem cell research in California. The Branch will provide support to the Human Stem Cell Research Advisory Committee, which will advise CDHS on the development of minimum standards for Institutional Review Boards to use in reviewing human embryonic stem cell research projects.

***//2008/ EES has added a fourth unit, the Human Stem Cell Research Unit (HSCR), to implement stem cell research legislation and collaborate with the HSCR Advisory Committee. The Unit consists of two staff positions. //2008//***

> Operations Section

The Operations Section assumes the contract monitoring functions for the Branch, including fiscal forecasting, budget related work, management of over 400 contracts, auditing functions, and working with Department of Finance and other control agencies.

Nancy Smith has been the Chief of the Operations Section since 2001.

The Operations Section consists of 22 staff in three units: the Accounting and Business Operations Unit, the OFP Contracts and Grants Unit, and the MCAH Contracts and Grants Unit.

> Administration Section

The Administration Section undertakes various activities associated with contract management, allocation and matched funding of MCAH programs; program integrity and enrollment activities associated with the Family PACT Program; special projects and administrative activities associated with more than fifteen MCAH/OFP programs, including bill analysis and regulation development; policies and procedure development; administrative activities related to management analysis, personnel, training, and procurement; and information technology management, including website maintenance, local area network support, and management of servers, hardware, software, and inventory.

Linda LaCoursiere is Chief of the Administration Section.

The Section consists of 25 staff and three units: Allocation and Matched Funding Unit, Special Projects and Administrative Support Unit, and Information Technology Unit.

***//2008/ Effective March 2007, Fred Chow is Chief of the Administration Section. //2008//***

> Clinical Services and Quality Improvement Utilization Management Section

The Clinical Services and Quality Improvement Utilization Management Section consists of the Clinical Services Unit and is responsible for the administration and support of the Family Planning Access Care and Treatment (Family PACT) Medicaid Waiver Demonstration Project. The Section consists of a staff of seven.

Amy Krawiec, MD is the Chief of the Clinical Services and Quality Improvement Utilization Management Section, a position she has held since March 2005.

*//2007/ In January 2006 Amy Krawiec, MD, was replaced by Laurie Werner, MD, as Section Chief. //2007//*

***//2008/ In May 2006 Laurie Werner, MD, was replaced by John Mikanda, MD, MPH, as Section Chief. The Section now has nine staff positions. //2008//***

> Teen Pregnancy Prevention Section

The Teen Pregnancy Prevention Section (eight staff) consists of four grant programs (Community Challenge Grant, Information & Education, Male Involvement, and Teen Smart) to reduce the incidence of teen pregnancies. The program serves approximately 460,000 teens and parent participants through nearly 200 grants and contracts annually. Martha Torres-Montoya, MSPH, is the Section Chief; she has over twenty-five years experience in family planning, teen pregnancy prevention, and multilingual/multicultural health education programs.

***//2008/ The Teen Pregnancy Prevention Section now has nine staff positions. //2008//***

> Domestic Violence (DV) Program

For the DV program, FY 2005-06 marked the beginning of the first year of a five-year grant cycle and consolidation of the shelter, prevention and unserved/underserved (U/U) grants. Under the guidance of the Agency Secretary, MCAH/OFP is providing all 94 shelters with Shelter, Prevention and U/U funding. The two technical assistance training support contracts will continue. The Program consists of seven staff positions and is managed byCarolynn Michaels, MBA.

***//2008/ The Program now consists of six staff positions and is managed by Stephanie Roberson, MSW. There are currently three technical assistance and training contracts to assist shelters in serving specific U/U populations; disabled and developmentally disabled, those with mental health and substance abuse issues, and the lesbian, bisexual, gay, transgendered and questioning population. //2008//***

*//2008/*

> California Birth Defects Monitoring Program

By act of the California State Legislature, the California Birth Defects Monitoring Program (CBDMP) moved from Prevention Services to the MCAH/OFP Branch in January 2007. CBDMP, operated jointly by CDPH and the March of Dimes, conducts research and surveillance of birth defects and maintains a birth defect registry.

Effective July 2007, the Chief of the CBDMP Section is Marcia Ehinger, MD.

*//2008/*

***An attachment is included in this section.***

## D. Other MCH Capacity

Information about the MCAH/OFP Branch is provided in Section III C (Organizational Structure) above. Information about the CMS Branch is provided below.

The CCS program is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 5, Sections 123800-123995. The Genetically Handicapped Persons Program (GHPP), which provides services to individuals with certain genetic conditions, is authorized by the Health and Safety Code Division 106, Part 5, Chapter 2, Article 1, Sections 125125-125191. The CHDP program, California's preventive healthcare program for children, is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 6, Sections 124025-124110 and by Division 103, Part 3, Chapter 1, Article 1, Section 104395. The Newborn Hearing Screening Program is authorized by the Health and Safety Code Division 106, Part 2, Chapter 3, Article 5, Section 123975 and Article 6.5 (commencing with Section 124115).

### > Children's Medical Services (CMS) Branch

Marian Dalsey, MD, MPH is the Branch Chief, a position she has held since July 2006. She had been the Acting Branch Chief since April 2004. Dr. Dalsey is a Board-certified pediatrician with a Medical Degree from the University of Illinois College of Medicine, and a Master's of Public Health degree from the University of Illinois School of Public Health. She has held positions in healthcare administration and policy development at the local level in California and Illinois and with Medi-Cal and CMS at CDHS. Harvey Fry is the Assistant Branch Chief, a position he has held since January 2005.

//2007/ The CMS Branch was reorganized in 2005. The Branch is composed of the following five sections: Program Development, Regional Operations, Statewide Programs, Program Support, and Information Technology. //2007//

### > Program Development Section (PDS)

PDS is responsible for the development and implementation of program policy, regulations, and procedures for the programs administered by the Branch and for provision of statewide consultation in a variety of professional health disciplines.

//2007/ Marian Dalsey, M.D., M.P.H., Board-certified pediatrician and Branch Chief, is also Acting Chief of this section, a position she has held since 2002. PDS has 20 positions. //2007//

**//2008/ Chester J. Randle, Jr. M.D. became the Chief of the Program Development Section in August 2006. He is Board certified in Pediatric Critical Care Medicine. Dr. Randle has a Medical Degree from the Stanford School of Medicine and has held positions in healthcare administration as a Medical Director of a Community Health Care Center in Illinois, and as a Director of Pediatric Critical Care Services at a University based teaching hospital in California. He has also served as a Medical Consultant at a local CCS program. PDS has 19 positions. //2008//**

The PDS Section consists of two units: the Program Policy and Analysis Unit and the State Consultation Unit.

The Program Policy and Analysis Unit is responsible for development and implementation of program policy, regulations, and procedures for all programs administered by the Branch. Unit staff develop provider standards for CCS; develop policies and procedures to assist in the implementation of Medi-Cal Managed Care and the Healthy Families program; review and approve/deny all requests for organ transplants for children covered by CCS and Medi-Cal; and

provide pediatric consultation to Medi-Cal and other CDHS programs. The unit is also responsible for research and program analysis functions and development and implementation of a pharmaceutical rebate program for CCS and GHPP.

***/2008/ The Program Policy and Analysis Unit has added two research analyst positions to increase the research and program analysis capacity of the Program Development Section. //2008//***

The Statewide Consultation Unit staff provide expertise in the disciplines of medicine, nursing, social work, nutrition, dentistry, dental hygiene, health education, and physical therapy and participate in the evaluation and monitoring of county CCS and local CHDP programs for compliance with federal and state regulations and local policies and procedures. Staff in the unit are also responsible for ensuring that all providers who deliver services to children are qualified and in good standing with the appropriate board under the Department of Consumer Affairs and for assisting with on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures.

#### Regional Operations Section (ROS)

ROS is composed of three CMS regional offices located in Sacramento, San Francisco, and Los Angeles. The section provides case management services for CCS-eligible clients residing in dependent counties (those with populations of less than 200,000). Case management services include, but are not limited to, determination of medical eligibility and authorizations for services, resolution of financial appeals, determination of eligibility for Medical Therapy Unit services, and program consultation/technical assistance. The ROS consultant staff are responsible for review and approval of Early and Periodic Screening, Diagnosis, and Treatment Supplemental Services requests statewide.

Regional office professional staff also have oversight responsibilities for local CCS and CHDP programs, including evaluating and monitoring county CCS and local CHDP programs for compliance with federal and State regulations and local policies and procedures. Oversight responsibilities include, but are not limited to, program development, review and approval of annual budgets and workplans, and provision of technical assistance and program consultation.

Staff in the regional offices are responsible for coordinating and facilitating on-site reviews of hospitals, special care centers, neonatal and pediatric intensive care units, and medical therapy units for compliance with established program standards, policies, and procedures and for certifying outpatient rehabilitation centers located within CCS medical therapy units.

/2007/ Maurice Robertson is the ROS Section Chief, a position he has held since March 2005. He has held management positions in both health care and social services programs at the county and state level over his 30 years of government service. ROS has 49 positions. //2007//

***/2008/ ROS now has 52 positions. //2008//***

#### > Statewide Programs Section (SPS)

The Statewide Programs Section is responsible for administration of specialty programs with statewide responsibilities.

/2007/ Joleen Heider is the Section Chief of SPS as of May 2005. She has an MS in Biology, a BS in Dietetics and is a registered dietitian. She has been in state service for eleven years, with her last position as a HPM II with the MCAH Branch overseeing the Domestic Violence Program.

SPS has 27 positions. //2007//

There are three units within the section: Specialty Programs, Hearing and Audiology Services, and the Genetically Handicapped Persons Program (GHPP).

/2007/ The Specialty Programs Unit is responsible for implementation and monitoring of specialty programs under the purview of the CMS Branch such as the Health Care Program for Children in Foster Care, the High Risk Infant Follow-up Program, and a bioterrorism project entitled, "Caring for California's Children Project." Staff in the unit are responsible for collaboration efforts with local programs in implementation activities and for ensuring that providers, hospitals, Special Care Centers, other State programs, local agencies, community-based organizations, and the general public are informed and assisted in the process of providing services to eligible populations. //2007//

/2007/ The Hearing and Audiology Services Unit is responsible for implementation and monitoring of the Newborn Hearing Screening Program (NHSP) and for providing consultation/technical assistance to providers and local programs regarding program benefits. Staff in the unit (1) monitor contracts with NHSP Hearing Coordination Centers providing follow-up testing and treatment services to infants with suspected hearing loss; (2) evaluate and certify school audiometrists; and (3) support the training of CHDP providers to perform hearing testing in schools. //2007//

**/2008/ The Hearing and Audiology Services Unit develops and implements NHSP and CCS policy relating to hearing services. Monitoring and quality assurance activities are conducted with NHSP contractors and CCS providers. //2008//**

/2007/ GHPP provides all medical and administrative case management services for approximately 1550 clients statewide with serious, often life threatening, genetic conditions (e.g., hemophilia, cystic fibrosis, sickle cell anemia). //2007//

> Program Support Section (PSS)

PSS is composed of three units and has responsibility for a variety of activities in support of Branch operations. The Section Chief of PSS is Erin M. Whitsell. She has held this position since 2003. /2007/ There are currently 27 positions in this Section. //2007//

**/2008/ There are currently 24 positions in this Section. //2008//**

The Administration Unit is responsible for fiscal, personnel, contracting, purchasing, and business services for the Branch. Staff in the unit review, approve, and monitor CCS county programs and CHDP county/city budgets; resolve county budgeting/invoicing issues; develop and implement administrative and fiscal procedures for new programs administered by the Branch; develop and manage contracts and interagency agreements; process contract and county expenditure invoices; and maintain personnel and business services transactions for all CMS Branch staff. Unit staff also develop and participate in training programs for State and county program staff relating to the above areas of responsibility.

The Provider Services Unit is responsible for enrolling providers for the CCS, CHDP, and GHPP programs and acts as a liaison between CMS Branch programs, their providers, the Medi-Cal Payment Systems Division, and the State fiscal intermediary, Electronic Data Systems (EDS). The PSU works with individual providers, hospitals, and CCS/GHPP Special Care Centers to resolve provider reimbursement issues.

**/2008/ Staff in the Provider Services Unit also develop and conduct provider training to individual and group health care providers, hospitals, special care centers, clinics, etc. in**

***statewide formal training seminars. //2008//***

The Clerical Support Unit provides general clerical support services to CMS Branch management and staff. The unit is responsible for completion of complex typing assignments, formatting of proposals, regulations, program standards, reports, research papers, etc. The Clerical Support Unit also assists in organizing and filing all program documents; responds to telephone calls, faxes, and e-mails; disseminates program information to State staff, local agencies, the general public, and various other organizations; coordinates meetings; and makes travel arrangements for Branch staff.

> Information Technology Section (ITS)

ITS is responsible for all aspects of information technology support for the CMS Branch and CMS Net, the Branch's automated case management system. This includes CMS Branch office products, CMS Net network support, CMS Net operations, and CMS Net Help Desk operation. The section provides consultation to the State Health and Human Services Agency Data Center regarding county LAN/WAN connectivity and is responsible for corrections and modifications to CMS Net application. William White has been the Section Chief since 2003.

***//2008/ The CMS Net system is used by the county and State Regional CCS offices to manage the health care of approximately 170,000 children. //2008//***

The section is divided into two units: Information Systems and Information Technology. There are 11 state staff, two student assistants, and 12 contract staff.

***//2008/ There are now 14 state staff and 10 contract staff. //2008//***

***An attachment is included in this section.***

## **E. State Agency Coordination**

The MCAH/OFP and CMS Branches coordinate with several other departments and offices, both within and outside of CDHS, on programs related to Title V. In addition, MCAH/OFP and CMS Branches work with various universities and professional organizations on programs and projects related to Title V.

Inter- and intra-agency collaboration are vital for meeting the needs of all children and particularly CSHCN. MCAH/OFP and CMS have numerous collaborative relationships with state and local public health agencies, in both the public and private sectors, as well as working relationships with organizations such as local foundations, medical professional associations, coalitions and children's advocacy groups.

CPQCC is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals (including MCAH/OFP, CMS, and other branches of CDHS), and business groups. It is working to develop an effective perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels.

*//2007/* MCAH/OFP has received a multi-year grant beginning in 2003 from the federal Health Resources and Services Administration (HRSA) for the State Early Childhood Comprehensive Systems (SECCS) project, which focuses on interagency collaboration and coordination. The goal is to provide state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically healthy and ready for kindergarten. The project coordinates a myriad of health-related programs at the state and local levels, including: CDHS, Department of Mental Health (DMH), Department of Social Services (DSS), Department of Education (CDE), Department of Developmental Services (DDS), First 5 California, Managed

Risk Medical Insurance Board (MRMIB); organizations such as the American Academy of Pediatrics, Family Voices of California, March of Dimes, Easter Seals, Interagency Coordinating Council for Children with Disabilities; and representatives of faith-based organizations (e.g., California Council of Churches). The project is now in the implementation phase. //2007//

The State Interagency Team (SIT) is a high-level collaborative effort to provide better coordination of services and strategies for children and families in California. The State agencies represented on the SIT (at the deputy director level) include DSS, CDHS, DMH, CDE, DDS, the Department of Alcohol and Drug Programs, and the Department of Employment Development, as well as the Attorney General's Office, the First 5 California Children and Families Commission, and the California Workforce Investment Board. The Team promotes the alignment of planning, funding and policy development across state agencies to build community capacity, maximize funding, remove regulatory barriers, ensure accountability, promote strength-based practices, and share information and data. The CMS Branch was participating on SIT, but since April 2004, the MCAH Branch is representing CDHS on SIT.

#### Department of Education (CDE)

The MCAH/OFP Branch collaborates with CDE on the SECCS grant initiative to ensure a coordinated approach to early childhood health programs to help California's children be healthy and ready for school.

The MCAH/OFP Branch works closely with CDE and the Sexually Transmitted Disease (STD) Control Branch in improving the sexual health of youth in California. A larger stakeholder group including members of the Office of AIDS, DSS, and other CDHS programs are also participating to determine important cross-cutting issues for future and continued collaboration.

The CMS Branch is working with CDE (1) to assure that all infants with hearing loss identified through the NHSP are referred to Early Start and (2) in partnership on the Maternal and Child Health Bureau grant for improving services for early identification and intervention of hearing loss.

//2007/ The CCS Medical Therapy Program (MTP) is working with CDE through its CDE liaison on interagency coordination. The interagency agreement was renewed in 2005. The MTP continues working together with CDE on the structuring of new and remodeled school-based Medical Therapy Units. //2007//

#### Department of Developmental Services (DDS)

//2007/ CCS and Medi-Cal provide medical services to eligible infants and toddlers who are receiving services through the Early Start Program. Through CMS participation on the Interagency Coordinating Council and Health Services Committee, CMS maintains ongoing communication with DDS. In addition some CCS clients also receive Regional Center Services and coordination with their delivery of care occurs between CCS and DDS. //2007//

The MCAH/OFP Branch collaborates with the Early Start program at DDS on the planning and implementation activities of the SECCS grant.

#### Department of Social Services (DSS)/Children in Foster Care

//2007/ The Health Care Program for Children in Foster Care (HCPCFC) is a collaboration between DSS and CMS to improve access to and oversight of health care for children and youth in out-of-home placement or foster care settings. The HCPCFC, administered locally by the CHDP program, works closely with local foster care programs to coordinate preventive and

specialty health services for children and youth in this population. The CMS Branch has initiated a performance measure to evaluate the effectiveness of HCPCFC case management. Data collection for the Performance Measure has been a challenge, but a solution is being addressed that should result in a statewide database in a few years. //2007//

***/2008/ The DSS Child Welfare Services/Case Management System is undergoing a major overhaul. It will take approximately five years to complete this new database system. The HCPCFC Executive Subcommittee is currently consulting with DSS on the redesign of the Health and Education Passport document utilized for foster children within this system. The intent is to make it a more user-friendly document, not only for the Public Health Nurses, but also for all others that may need to input data, i.e. social workers, probation officers, etc. //2008//***

#### Managed Risk Medical Insurance Board (MRMIB)

The CMS Branch and MRMIB are working cooperatively to coordinate quarterly meetings throughout the state for the medical plans. A separate meeting is coordinated with the dental plans as CCS dental and orthodontic services are carved out. Ad hoc subcommittees composed of members from CCS and MRMIB have successfully worked together on provider training and solving program issues.

#### Childhood Lead Poisoning Prevention Branch (CLPP)

The CMS Branch, through CHDP, provides lead screenings for children. The CCS program covers the cost of the evaluation and treatment of serious lead poisoning cases. Because of concerns about inadequate identification of low income children with lead poisoning, the CHDP program and CLPP have developed a new approach to lead screening that considers all low income children to be at risk and requires blood lead screening in this population.

*/2007/ The MCAH/OFP and CMS Branches participate in the statewide planning process led by CLPP to eliminate childhood lead poisoning in order to meet the Healthy People 2010 goal to eliminate blood lead levels of concern in young children. A federal interagency strategy and objectives have been developed. //2007//*

#### Immunization Branch (IZ)

*/2007/ The CMS Branch collaborates with the IZ Branch and its Vaccines for Children (VFC) program by providing vaccinations through the CHDP program. The CMS and IZ Branches have recently collaborated on the following vaccine coverage or modifications to coverage by VFC/CHDP: tetanus, diphtheria and acellular pertussis (Tdap) vaccine; FluMist; meningococcal conjugate; measles, mumps, rubella, and varicella; hepatitis A, and rotavirus vaccines. //2007//*

***/2008/ In addition to working together on expanding varicella vaccine to a second dose for children 12 months through 12 years and on policy for human papillomavirus (HPV) vaccine, CMS and IZ Branches have worked with Medi-Cal on understanding one another's procedures and, where possible, streamlining processes involved in enabling providers to be reimbursed for vaccines. //2008//***

#### Sexually Transmitted Disease (STD) Control Branch

The MCAH/OFP Branch works closely with CDE and the STD Control Branch in improving the sexual health of youth in California. A larger stakeholder group, including members of the Office

of AIDS, Department of Social Services, and other CDHS programs, are also participating to determine important cross-cutting issues for future and continued collaboration.

#### Medi-Cal Managed Care Division (MCMC)

Memoranda of Understanding (MOUs) between county health plans, CHDP and CCS are mandated by CDHS. Each local program coordinates with the plans and maps out a procedure for working together. Ad hoc subcommittees composed of members from CCS and the MCMC plans have successfully worked together on provider training and solving program issues. Liaison activity continues with individual plans and with MCMC on system, policy, care coordination, and education issues.

The MCAH/OFP Branch collaborates with the MCMC Division on their project to improve the rate of preventive health care visits by adolescents. The MCAH/OFP Branch and the CMS Branch collaborate with MCMC on their Interagency Work Group for the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP) in MCMC Project. The project aims to develop and implement a model for changing provider practice as the basis for broader collaborative quality improvement efforts. ***//2008/ BEST-PCP ended in March 2007. //2008//***

#### Epidemiology and Prevention for Injury Control Branch (EPIC)

The MCAH/OFP Branch collaborates with the EPIC Branch on injury prevention activities, including local training programs. The two Branches have had several meetings on areas of joint interest, including SIDS and the Child Death Review Team. Other areas of collaboration include: SAFE-KIDS California Advisory Committee, the Strategic Coalition on Traffic Safety, and the Battered Women Shelter Program.

#### Birth Defects Monitoring Program

Coordination between MCAH/OFP and the California Birth Defects Monitoring Program (CBDMP) is essential to California's efforts to reduce birth defects. CBDMP is recognized worldwide for the quality and scope of its birth defects surveillance data and for the quality of its research to identify causes of birth defects. For example, CBDMP discovered that folic acid taken at the time of conception prevents several types of birth defects. Title V funds are used to partially fund birth defects surveillance in five California counties. Additionally, Title V funds are supporting the development and on-going maintenance of the CBDMP website, which has been a fundamental tool for communicating the results of birth defects research and raising awareness about the issue of birth defects.

***//2008/ By act of the California State Legislature, the California Birth Defects Monitoring Program (CBDMP) was moved from the CDHS Prevention Services Branch to the MCAH/OFP Branch in January 2007. The 2006 legislation expands capacity to discover causes, develop prevention strategies, and increase surveillance of birth defects and genetic diseases throughout the State. //2008//***

#### Office of Audits and Investigations

The MCAH/OFP Branch works closely with the CDHS Audits and Investigations Division to ensure the integrity of MCAH/OFP programs.

## Primary Care and Family Health Division (PCFH)

In addition to the MCAH/OFP and CMS Branches, there are three other branches in the PCFH Division of CDHS: Genetic Disease Branch (GDB), Primary and Rural Health Care Systems Branch (including the Indian Health Program), and WIC. MCAH/OFP and CMS work closely with all of these offices.

***//2008/ In the reorganization of CDHS into two departments effective July 2007, the CMS Branch will be in the Department of Health Care Services, and the other three Branches (MCAH/OFP, GDB, and WIC) will be in the California Department of Public Health (CDPH). In the organizational structure of the new CDPH, there will not be a PCFH Division; the MCAH/OFP, GDB, and WIC Branches will be in the Center for Family Health. //2008//***

## Genetic Disease Branch (GDB)

CCS provides services for conditions identified on newborn screening tests and develops standards for and approves Metabolic, Endocrine, and Sickle Cell Special Care Centers (SCCs) where these children are treated. The MCAH/OFP Branch is working with GDB on a campaign to educate women about pre-pregnancy folate use.

GDB services are provided by private providers under contract for newborn, prenatal, and Tay Sachs screenings. GDB enforces quality standards via contract requirements or by regulations; in addition to the screening program, GDB also monitors quality standards for Rh testing, genetic counseling and mandated laboratory reporting of cytogenetics. GDB also engages in research projects to develop new or improved tests.

*//2007/ The Newborn Screening Program of the GDB expanded in 2005 to include newborn screening for congenital adrenal hyperplasia and other inborn errors of metabolism. The CMS Branch is working closely with the GDB through the development of policy and procedures to ensure that infants with abnormal screening results receive expeditious diagnostic evaluations and treatment services as needed in Endocrine, Metabolic, and Sickle Cell SCCs throughout the state. //2007//*

***//2008/ The CMS Branch participates in both the Endocrine and Genetic Specialty statewide meetings during the year. At these meetings CCS issues are discussed and solutions are proposed. As the NBS Program expands to include Cystic Fibrosis and Biotinidase Deficiency testing beginning August 2007, the CMS Branch will be working with GDB to ensure that infants with abnormal screening results for these disorders receive expeditious diagnostic evaluations and treatment services as needed. //2008//***

## Women, Infants & Children (WIC) Supplemental Nutrition Branch

The MCAH/OFP and CMS Branches collaborate with WIC in a variety of areas including: the improvement of prenatal care, linkages between MCAH/OFP and WIC data files, obesity prevention, oral health, childhood injury prevention, and breastfeeding.

***//2008/ Another area of collaboration is ensuring children's access to healthcare by referring families to CHDP when they are not enrolled in healthcare. //2008//***

Staff from the MCAH/OFP, CMS, and WIC Branches meet quarterly for nutrition coordination meetings. The CMS Branch ensures that the PedNSS data are available to WIC local agencies and assists WIC agencies with data interpretation.

***//2008/ WIC now has the PedNSS link on their home webpage for local programs to access***

*when developing their annual nutrition education plans. //2008//*

*/2008 /WIC participates in bimonthly meetings of the CHDP Nutrition Subcommittee workgroup.  
//2008//*

### **Universities**

***The MCAH/OFP and CMS Branches work closely with public health and other departments of several campuses of the University of California and other universities in California. These include the National Adolescent Health Information Center and the Bixby Center for Reproductive Health Research & Policy at UC San Francisco (UCSF), Stanford University (on CPQCC issues), and the Center for Injury Prevention Policy and Practice at San Diego State University. The MCAH/OFP Branch contracts with the UCSF Family Health Outcomes Project (FHOP) to provide consultation and training to local MCAH jurisdictions in monitoring and updating of their local five year plan, data collection, identification of data sources, data analysis and survey development. The CMS Branch contracted this year with UCSF FHOP for consultation, data analysis, and stakeholder meetings and interviews for the Title V Needs Assessment. The MCAH/OFP Branch also collaborates with UCSF to conduct, analyze, and report on the Maternal and Infant Health Assessment Survey.***

***Through the Advanced Practice Nursing (APN) Program, the MCAH/OFP Branch provides funds to nine universities in California to maintain accredited advanced and midlevel nursing programs. Participating universities provide clinical preceptorships in medically underserved areas and provide the MCAH/OFP Branch with program evaluation data. /2008/ There are now eight APN programs. One university hospital terminated its contract. //2008//***

The CMS Branch has two contracts with San Diego State University (SDSU) Institute for Public Health (IPH) which began in FY 2005-06. One contract is to analyze CCS/Healthy Families expenditures and determine how they compare to the expenditures for the other CCS subgroups. The IPH is analyzing the expenditures for the period from 2000 through 2005, during which time per capita health care expenditures almost doubled. ***/2008/ The SDSU IPH has now completed the data analysis, and final report will be completed in the coming year. //2008//***

The second contract involves development of a Quality Improvement Initiative for CCS eligible clients. CMS and SDSU IPH are planning to facilitate two quality improvement collaboratives at the children's hospitals and university medical centers. One initiative will be focused on inpatient care with the goal of reducing nosocomial infections in the NICU and the second on improving the outpatient care for children with either Type 1 or Type 2 diabetes. The collaborative will focus on using already existing tool kits to decrease neonatal nosocomial infections and applying clinical process for improvements to care of children with diabetes. Each NICU and SCC will be evaluating its own progress over time.

***/2008/ CMS, SDSU IPH, and the California Children's Hospital Association have implemented the Neonatal Quality Improvement Initiative (NQI) with 13 hospitals throughout the state. The focus of the initiative is to reduce catheter-associated blood stream infections in the NICU. Each facility collected baseline data, by birthweight category, and reviewed the toolkit on preventing nosocomial infections that has been developed by the California Perinatal Quality Care Collaborative. Each site selected areas of neonatal care that they wanted to address in their units, such as handwashing, closed line systems, etc. With the NQI ending its initial term, the group is discussing whether to continue focus on blood stream infections, change focus to another area (such as ventilator-associated infections), or to disseminate the current best practices to other CCS-approved NICUs. //2008//***

California District of the American Academy of Pediatrics (AAP)

/2007/ The CMS Branch has collaborated with the AAP in developing guidelines for local CCS programs regarding the definition of a "medical home" and authorization of pediatricians and other primary care providers to provide these services for CSHCN. An AAP representative participates on the Stakeholder Group for the Title V Needs Assessment for CSHCN and for the strategic planning process. //2007//

***/2008/ Additional partnering activities will be initiated with the upcoming expansion of the Newborn Hearing Screening Program (NHSP). //2008//***

Four AAP Chapter Champions for Newborn Hearing Screening participate in local and statewide forums and conferences educating hospitals, pediatricians, families, and service providers about newborn hearing screening and the need for linkage with a medical home. ***/2008/ There are quarterly conference calls with the state NHSP staff. The Chapter Champions were instrumental in the passage of the 2006 NHSP expansion legislation. One of the Chapter Champions participates on the California team for the National Initiative for Children's Healthcare Quality learning collaborative to improve the rate of lost-to-follow-up from the NHSP. //2008//***

California Association of Neonatologists (CAN) and Stanford University

/2007/ The CMS and MCAH/OFP Branches are working with these groups on a perinatal and neonatal morbidity and mortality reporting system that is providing valuable information regarding quality of care and will serve as a basis for quality improvement in participating hospitals (CPQCC). Approximately 80 percent of CCS-approved NICUs are submitting their CCS data through CPQCC for CY 2005 with the anticipation that all 114 CCS-approved NICUs will submit their CCS data for CY 2006 through CPQCC. CCS continues to work with CAN, and, through representation by CAN members on the CMS NICU Technical Advisory Committee and representation of CMS on the CAN Executive Board, there is ongoing dialogue on issues of concern. //2007//

***/2008/ The CMS and MCAH/OFP Branch relationships with CAN and Stanford continue to strengthen. The CMS Branch participates in CAN/District IX Meetings and both Branches are expanding their collaboration with Stanford with regard to improving statewide perinatal, maternal and neonatal quality care. All but one of 118 CCS-approved NICUs are submitting CY 2006 data through CPQCC. //2008//***

Children's Specialty Care Coalition

The Children's Specialty Care Coalition is an organization of pediatric specialty and subspecialty providers practicing at CCS approved tertiary hospitals and SCCs.

/2007/ The CMS Branch works closely with the organization as part of the Title V Strategic Planning process; in identification and resolution of programmatic issues; in assisting with the successful adoption and use of the web-based CCS authorization system; and advocating for services for all children. //2007//

***/2008/ Representation from the Children's Specialty Care Coalition continues at stakeholder meetings for the Title V strategic planning and implementation process. The Coalition was one of the sponsors of the CCS Best Practices Conference 2006. CCS staff and staff involved with CCS from children's hospitals, physician offices, and SCCs came together to learn new ways to improve business practices related to CCS and identify and***

***discuss issues, particularly pertaining to authorizations and claims. //2008//***

There have also been ongoing discussions on ways to increase the number of qualified providers participating in the CCS program.

California Conference of Local Health Officers (CCLHO)

CMS works with this association on issues related to county program operations for CSHCN, preventive health services for children, and the CMS Net Data system. MCAH/OFP Branch leadership participates in ongoing activities and committees of the CCLHO.

California Children's Hospital Association (CCHA)

*//2007/ The Children's Hospitals are vital providers of services to children in the CCS program. The CMS Branch works closely with the hospitals as part of the Title V Strategic Planning Process; in development of a Quality Improvement Initiative; in assisting with the successful adoption and use of the web-based based CCS authorization system; and advocating for services for all children. //2007//*

The CMS Branch has collaborated with CCHA and the California Medical Assistance Commission (CMAC) on developing hospital payment and policy for inhaled nitric oxide therapy in neonates and for botulism immune globulin.

***//2008/ In collaboration with the CCHA, the CMS Branch is sponsoring a Neonatal Quality Improvement Initiative. The eight children's hospitals, four University of California Hospitals and Sutter Memorial Hospital are participating in a nine-month effort to reduce catheter-acquired blood stream infections. //2008//***

Other Professional Organizations

The CMS Branch collaborates with the California Dental Association, the California Association of Orthodontists, the Oral Health Access Council, the California Orthopedic Surgeons Association, the California Association of Home Health Agencies, and the Hemophilia Council and Foundations to improve working relationships, recruit providers, and address barriers to access to services.

*//2007/ The CMS Branch also collaborates with the California Association of Ophthalmologists to improve recruitment of providers and to address barriers to access to services. //2007//*

***//2008/ The CMS Branch is working collaboratively with the California Association of Medical Products Suppliers to identify best practices for access to medical supplies and durable medical equipment for CCS clients who are discharged from inpatient hospital settings. //2008//***

***//2008/ The CMS Branch is working collaboratively with the Children's Hospice and Palliative Care Coalition in the development of a federal Medicaid waiver to allow CCS clients to access 'hospice-like' services while still receiving treatment services for their eligible conditions. There are 60 members of the stakeholder group providing input into the waiver design and development and include representatives from the Children's Hospitals, University of California hospitals, Children's Specialty Care Coalition, hospices and home health agencies. //2008//***

## Managed Care Plans

There is ongoing collaboration between CMS and the California HealthCare Foundation, Family Voices and the Children's Regional Integrated Service System (CRISS) on the following projects: 1) CSHCN medical home project, and 2) statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans.

## F. Health Systems Capacity Indicators

### Introduction

This section covers the following Health Systems Capacity Indicators for California:

- 1) Rate of asthma hospitalizations among children (age < 5 years);
- 2) Percent of Medicaid enrolled children (age < one year) who received at least one EPSDT health assessment;
- 3) Percent of SCHIP enrolled children (age < one year) who received at least one EPSDT health assessment;
- 4) Percent of women (age 15-44) with a live birth whose observed to expected prenatal visits were greater than or equal to 80 percent on the Kotelchuck Index;
- 5) Comparison of health system capacity indicators for Medicaid and non-Medicaid populations;
- 6) Percent of poverty for eligibility in Medicaid and SCHIP Programs for infants, children, and pregnant women;
- 7) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program, and Percent of EPSDT eligible children (age 6-9 years) who received any dental services;
- 8) Percent of SSI beneficiaries (age < 16 years) who received rehabilitative services from the State CSHCN Program; and
- 9) Data capacity, including general MCH data capacity and capacity for monitoring adolescent tobacco use.

Please note that in California, the Medicaid Program is called Medi-Cal; the State Children's Health Insurance Program (SCHIP) is called Healthy Families; the Early and Periodic Screening component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program is called the Child Health and Disability Prevention (CHDP) Program.

**Health Systems Capacity Indicator 01:** *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	34.7	32.6	30.6	24.6	24.6
Numerator	8639	8286	7905	6458	
Denominator	2492753	2539962	2582390	2630401	
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005

**Notes - 2005**

Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2005. Primary diagnoses of each discharge abstract were tabulated, secondary diagnoses were not included. Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

**Notes - 2004**

Numerator: State of California, Office of Statewide Health Planning and Development, Patient Discharge Data (OSHPD-PDD), January 1-December 31, 2004. Primary diagnoses of each discharge abstract were tabulated, secondary diagnoses were not included. Denominator: Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

**Narrative:**

Health System Capacity Indicator 01 (HSCI-1) is the rate per 10,000 for asthma hospitalizations among children less than five years old. The child asthma hospitalization rate decreased to 24.6 in 2005, down from 30.6 in 2004, 32.6 in 2003, and 34.7 in 2002. This contrasts with national increases in asthma prevalence between 1980 and 2002 for children and adults [43, 44]. Based on primary diagnoses codes in 2005 hospital discharge data, California has achieved the Healthy People 2010 objective of reducing the rate to 25 per 10,000.

Changes in this indicator may involve many factors not discernible from hospitalization data alone. National guidelines for asthma prevention emphasize that asthma is an inflammatory disorder of complex etiology involving interaction between genetic heritability, environmental exposures, and immunology across the life course. [45]

Efforts to address child asthma in the state are guided by the California Public Health Initiative sponsored by the CDPH Chronic Disease Control Branch. As stated on its internet home page, "The mission of the California Asthma Public Health Initiative (CAPI) is to improve the quality of life for all children and adults with asthma through implementation of effective programs and policies in asthma education, management, and prevention. CAPI seeks to reduce preventable asthma morbidity and mortality, and to eliminate disparities in asthma practices and outcomes through coordinated approaches and partnerships with communities, state and local organizations, health care providers, health departments, foundations, and academic institutions." [46] Recent accomplishments of the CAPI are:

- 1) Maintaining a state web site linking information about various asthma programs within state government. [47]
- 2) Supporting the California Interagency Asthma Interest Group (CIAIG) which promotes collaboration and cooperation among state agencies and programs related to asthma.

- 3) Promoting guidelines for management of asthma in California schools.
- 4) Creating training materials on asthma care for child care providers.
- 5) As of January 2007, funding 18 local agencies under the program entitled, Best Practices in Childhood Asthma: Community-Level Effective Interventions for Reducing and Eliminating Asthma Morbidity and Disparities in Children (BPCA). Goals of the program are to improve the quality of clinical care, reduce asthma morbidity, and reduce/eliminate asthma health disparities for California children ages 0 through 18. BPCA seeks to apply key elements of two successful demonstration projects: the Childhood Asthma Initiative funded by First 5 California, and California Asthma among the School Aged funded by the California Endowment. BPCA is funded by an appropriation from the Cigarette and Tobacco Products Surtax Fund (Proposition 99). Agencies funded are local government, academic institutions, or private health agencies in urban and rural regions of the state. The program will continue through June 30, 2008. [48]
- 6) Convening the Asthma Disparities Summit held February 6, 2007, in Berkeley, California. [49]
- 7) Drafting an updated Strategic Plan for Asthma in California for 2007-2012. [50]

**Health Systems Capacity Indicator 02:** *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	66.2	67.3	66.3	73.7	73.7
Numerator	315811	339207	418190	455151	
Denominator	476809	504371	630754	617571	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2006**

Manual indicator for 2006 is based on 2005.

**Notes - 2005**

This measure is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP service in the reporting year.

Source is CHDP program data and State Medi-Cal claims files.

Numerator is the number of children under one year of age enrolled in Medi-Cal who received at least one CHDP service in FY 2004 -2005

Denominator is the unduplicated number of children under one year of age enrolled in Medi-Cal in FY 2004-2005.

**Notes - 2004**

This measure is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP service in the reporting year.

Source is CHDP program data and State Medi-Cal claims files.

Numerator is the number of children under one year of age enrolled in Medi-Cal who received at least one CHDP service in FY 2003 -2004

Denominator is the unduplicated number of children under one year of age enrolled in Medi-Cal in FY 2003-2004.

**Narrative:**

Health Systems Capacity Indicator 02 (HSCI-02) is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP health assessment in the reporting year. In FY 2004-05, HSCI 02 was 73.7 percent, an 11 percent increase from FY 2003-04 (66.3 percent). The denominator, unduplicated Medi-Cal enrolled children less the one year of age (617,571 for FY 2004-05), has decreased by 2 percent since FY 2003-04. The increase in this indicator is most likely due to Gateway and infant deeming.

The Memoranda of Understanding between MCMC plans and local CHDP programs continues. Each local CHDP program coordinates with MCMC plans to develop a procedure for working together. CDHS provides technical assistance to local CHDP programs and MCMC plans to resolve problem areas. The CHDP program provides outreach to providers and children and their families (such as health fairs). The CMS Branch has been collaborating with the California Medical Home Project and the LA Medical Home Project. LA County CCS is working with LA Care MCMC Plan for better coordination of care by the medical home.

Quarterly meetings between CHDP programs and MCMC plans are occurring in some counties and less frequently in other counties. Though funding for the CA Medical Home Project has ended and therefore this specific ongoing collaboration with MCMC plans has stopped, there have been opportunities to collaborate with MCMC through the Statewide stakeholder group (with MCMC representation) developing a strategic plan for the state priorities for CYSHCN identified through the Needs Assessment process and implementing that plan. The CMS Branch continues to collaborate with MCMC plans on statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans.

The CHDP Gateway and infant deeming appear to be having the greatest effect on this performance measure. The California HealthCare Foundation (CHCF) has funded a study of the CHDP Gateway. Through interviews, site visits, focus groups and an analysis of program data, this project will highlight program successes, best practices and make recommendations for strengthening the Gateway two years after implementation. A final report from the CHCF is planned for release in late spring 2006.

**Health Systems Capacity Indicator 03:** *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator			0.0	0.0	0.0
Numerator			0	0	0
Denominator			1	1	1
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2006**

Data is not available for analysis.

**Notes - 2005**

Data is not available for analysis.

**Notes - 2004**

Data is not available for analysis.

**Narrative:**

Health Systems Capacity Indicator 03 (HSCI-3) is the percent of Healthy Families (HF) enrollees under one year of age who received at least one CHDP health assessment. These data are not available. HF plans do not conduct CHDP health assessments, but instead perform preventive examinations based on the American Academy of Pediatrics guidelines. The HF Program relies on the Health Plan Employer Data and Information Set (HEDIS) to evaluate the performance of the health plans.

**Health Systems Capacity Indicator 04:** *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	77.8	78.7	78.5	78.4	78.4
Numerator	396169	409931	413004	422294	
Denominator	509038	521117	526090	538752	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Source: State of California, Department of Health Services, Center for Health Statistics, 2005 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH/OFP Branch. Observations with missing values were subtracted from the denominator when calculating the percents shown.

**Notes - 2004**

Source: State of California, Department of Health Services, Center for Health Statistics, 2004 California Birth Statistical Master File. Tabulations were done by the MCAH/OFP Branch. Observations with missing values were subtracted from the denominator when calculating the percents shown.

**Narrative:**

Health Systems Capacity Indicator 04 (HSCI-4) is the percent of women (ages 15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index. The Kotelchuck Index is a measure of prenatal care utilization that includes both the mother's timing of initiation of prenatal care and the number of prenatal care visits compared to those recommended by the American College of Obstetricians

and Gynecologists.

The Kotelchuck Index showed steady improvement in prenatal care utilization in California from 1989 through 2003, but leveled off in 2004 and 2005. Seventy-eight percent (78.4 percent) of California women received adequate prenatal care in 2005, essentially unchanged from the 78.5 percent in the previous year. For purposes of comparison, the rate was 58.7 percent in 1989. [51] While much progress has been made, the 2005 rate is still considerably lower than the national Healthy People 2010 goal of 90 percent.

A review of the distribution of this indicator by race/ethnicity (2005) shows moderate disparities. It ranges from a low of 67.5 percent for American Indians to a high of 81.5 percent for Whites. Hispanics and African Americans are closer to the upper end of the range, at 76.6 and 76.4 percent, respectively.

Several strategies have been used in California to improve prenatal care utilization, including expansion of Medi-Cal eligibility criteria, improved access to Medi-Cal through presumptive and continuous eligibility, a waived assets test, and reduced application paperwork. These were accomplished in California in the late 1980s, and the improvements in the rates in the 1990s are probably at least partly attributable to these changes. Also, several state programs support improvements in adequate prenatal care through direct and indirect delivery of services and support; these include AFLP, AIIHI, BIH, CPSP, and WIC.

Statewide meetings of regional representatives in AFLP provide a forum for discussion of strategies for improving prenatal care utilization. Local programs have utilized various strategies and resources to educate community residents regarding the importance of prenatal care. Public Service Announcements and participation in radio talk shows have shown early evidence of success in Pasadena and parts of the Los Angeles Basin. Home visitation and individual follow-up of women requiring prenatal care have proven very successful in Sonoma County. Contra Costa and Los Angeles County MCAH agencies are working collaboratively with public and private agencies to identify and address health issues related to reproductive health, including prenatal care utilization.

One of the primary goals of BIH is to increase the number of African American women receiving prenatal care in the first trimester. This is accomplished by increasing community awareness of black infant morbidity and mortality through health fairs, provider coordination, media-radio, TV, billboards, and churches. Community health workers make home visit to clients to provide health education materials about black infant mortality and prematurity.

Future BIH activities in this area include working on the following:

- 1) How to identify pregnant women who are in their first trimester when this is not apparent during street outreach.
- 2) How to maintain the capacity of local sites to do community awareness activities, despite budget deficits. (Partnering with other agencies, such as the March of Dimes, is a possible short-term alternative.)
- 3) Increasing the numbers of clients seen so that at least 25 percent of African American births receive BIH services in each jurisdiction. (In order to accommodate this increase in clients, it has been necessary to reduce mother-infant services from 24 months to 12 months post birth and, in some jurisdictions, to cut some services such as public health nurse case management and parenting support for fathers.)

CPSP provides statewide guidance to obstetrical service providers regarding the importance of ensuring continuity of prenatal care for individual women while stressing the need for

comprehensive education and referral to appropriate support services. Prenatal care providers are given a financial incentive when women are first evaluated in the first trimester of pregnancy.

**Health Systems Capacity Indicator 07A:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	61.7	70.9	90.0	87.9	87.9
Numerator	2869240	3137700	3276077	3236633	
Denominator	4650840	4425540	3641413	3680740	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Numerator: All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2004-September 2005 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Medical Care Statistics Section, California Department of Health Services.

Denominator: Consists of the sum of two indicators: (1) An estimate of uninsured children (1-21 years old) eligible for Medi-Cal. Source: 2005 California Health Interview Survey <http://www.chis.ucla.edu/main/DQ2/easy/output.asp>; (2) All persons 1 to 21 years of age who were enrolled in Medi-Cal at the end of the Federal fiscal year: September 2005 counts. Source: Medical Care Statistics Section, California Department of Health Services.

Note: Data prior to 2004 should not be compared because of the change in methodology beginning in 2004.

**Notes - 2004**

Numerator: All persons 1 to 21 years of age who received a service paid by the Medi-Cal program during the Federal fiscal year: October 2003-September 2004 (this is an unduplicated count), including both Fee-for-Service and Managed Care beneficiaries, as well as certified and uncertified beneficiaries (i.e., those who shared a cost for their care). Source: Medical Care Statistics Section, California Department of Health Services.

Denominator: Consists of the sum of two indicators: (1) An estimate of uninsured children (1-21 years old) eligible for Medi-Cal. Source: 2003 California Health Interview Survey <http://www.chis.ucla.edu/main/DQ2/geographic.asp>; (2) All persons 1 to 21 years of age who were enrolled in Medi-Cal at the end of the Federal fiscal year: September 2004 counts. Source: Medical Care Statistics Section, California Department of Health Services.

Note: A new methodology was used this year, data from previous years should not be compared.

**Narrative:**

Health Systems Capacity Indicator 07a (HSCI-7a) is the percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program. HSCI-7a (formerly National Performance Measure 14), was 87.9 percent in 2005. (The methodology for calculating this indicator has changed, and the data reported for years prior to 2004 are not comparable.)

The following barriers to service have been identified: lack of knowledge about Medi-Cal; complexity of application process; stigma associated with welfare; and fear that enrollment will adversely effect future citizenship for immigrant families.

California has made a strong commitment to reducing the number of uninsured children in California and ensuring access to healthcare services. Activities have included:

- 1) Support of streamlined Medi-Cal eligibility processes that encourage continuous coverage;
- 2) Support for MCAH/OFP programs such as AFLP, BIH, BWSP, and CPSP to screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining needed services;
- 3) Public education media campaigns and other community education efforts to encourage eligible families to obtain medical services, such as family planning, well child care, prenatal care, childhood immunizations, and dental care; and
- 4) Facilitation of the provision of Medi-Cal paid prenatal care services to adolescents by providing financial incentives to prenatal care providers.

Prior to and after launching the CHDP Gateway, many changes in policies and procedures at the state, local, and provider level have occurred. A Provider Manual and Local Program Guidance Manual are online and available to assist providers and local programs.

The CHDP local program staff serve an important role in recruiting and enrolling new providers, and assisting and encouraging established providers about the CHDP program, including the Gateway, and provision of preventive services for children from families with incomes at or below 200 percent of the FPL. The Local Program Guidance Manual helps to ensure that there is uniformity among all local programs in daily functions and the Provider Manual is an up-to-date resource for enrollment, billing, the Gateway, and all program responsibilities. Local CHDP programs and their health departments assist children and their families to access preventive health examinations through health fairs and interagency agreements with WIC and Head Start. Local CHDP staff participate on the Head Start Advisory Board.

In 2006 the CHDP Program updated their Interagency Agreement with the U.S. Department of Health And Human Services, Region IX, Administration for Children and Families, Office of Head Start, Child and Youth Development Unit. Plans are being developed to engage local CHDP and Head Start programs in training around the Interagency Agreement and its impact on local programs.

The CHDP local program staff will continue to recruit and enroll new providers and will utilize the Local Program Guidance Manual as a resource. Providers and their sites will be assessed using the new Facility and Medical Review Tools contained in the Local Program Guidance Manual. The CHDP Health Assessment Guidelines for CHDP providers are undergoing revision. Methods to provide family-centered care and culturally competent care are being interwoven throughout the manual. There will be continuing CHDP collaboration with schools, Head Start and providers in order to assist more low-income children to receive preventive exams.

**Health Systems Capacity Indicator 07B:** *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	48.1	35.5	37.8	44.2	44.2
Numerator	343183	342288	352522	353166	
Denominator	713183	964016	933287	798779	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

**Notes - 2006**

Manual indicator for 2006 is based on 2005.

**Notes - 2005**

This measure is the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Source is the revised HCFA-416 Form, element numbers 1 and 12a.

Numerator is the revised HCFA-416 Form element number 12a for FY 2005-06.

Denominator is the revised HCFA-416 Form element number 1 for FY 2005-06.

**Historical Information:**

Medical Care Statistics had been providing the numerator and denominator for this performance measure until FY 2003-04 when the numerator and denominator began being provided by Medstat using the Management Information System/Decision Support System (MIS/DSS) data base. The performance measure for FY 2004-05 can be compared with FY 2003-04, but not with prior years.

**Notes - 2004**

This measure is the percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Source is the revised HCFA-416 Form, element numbers 1 and 12a.

Numerator is the revised HCFA-416 Form element number 12a for FY 2004-05.

Denominator is the revised HCFA-416 Form element number 1 for FY 2004-05.

Medical Care Statistics had been providing the numerator and denominator for this performance measure until FY 2003-04 when the numerator and denominator began being provided by Medstat using the Management Information System/Decision Support System (MIS/DSS) data base. The performance measure for FY 2004-05 can be compared with FY 2003-04, but not with prior years.

**Narrative:**

Health Systems Capacity Indicator 07b (HSCI-7b) is the percent of EPSDT eligible children (CHDP in California) aged 6 through 9 years who received any dental services during the year. The goal of this indicator is to increase dental health services to Medi-Cal eligible children at an important stage of dental development. In FY 2005-06, HSCI-7b was 44.2 percent, up from 37.8 percent in FY 2004-05 and 35.5 percent in FY 2003-04.

Beginning in FY 2003-04, the numerator and denominator for this measure have been provided

by Medstat using the Management Information System/Decision Support System (MIS/DSS) data base. (Data from this source are not comparable to data provided for years prior to FY 2003-04.)

It is anticipated that new CHDP tools such as the two-sided full color laminated "PM 160 Dental Guide" that was distributed in 2003 to all CHDP providers will improve the quality of dental screenings and facilitate more precise referrals to a dentist. The CHDP program is making providers aware of a statewide training program to address early childhood caries through the First 5 California Initiative. CHDP is encouraging medical providers to attend one of the local trainings. Also, the CHDP program is making CHDP providers aware of the MCH website, [www.mchoralhealth.org/PediatricOH/index.htm](http://www.mchoralhealth.org/PediatricOH/index.htm), that includes seven oral health teaching modules for pediatricians; this instruction should make screening providers more cognizant of the importance of dental referrals and particularly the timeliness of these referrals.

Current activities related to this indicator include: the CHDP Gateway covers dental services for pre-enrolled children for up to two months and has increased access to dental services for this group of children; the CHDP Gateway offers the opportunity for children to apply for permanent enrollment in Medi-Cal or HF with dental services as benefits. An educational tool is being developed to train dental providers to refer children to CHDP who are already on Medi-Cal, but are not familiar with CHDP or who have not had a periodic health assessment.

The Dental Subcommittee of the CHDP Executive Committee continues to work on dental updates and revisions to the CHDP Health Assessment Guidelines and other CMS publications to broaden the knowledge-base of providers, local program staff, families, and communities. The Subcommittee has completed a final draft for a revised brochure on baby bottle tooth decay to encompass new knowledge of the parent/caregiver spreading the bacterial infection known to initiate dental caries to the child. Simple to read instructions on prevention are included along with bright colors and photographs. The Subcommittee is currently working on a portfolio of information entitled "CHDP Medical Provider Oral Health Guide" which includes such topics as transmission of bacteria, prenatal oral health, the age one dental referral, anticipatory guidance, a visual guide for screening infants and toddlers, caries risk factors assessment, fluoride varnish, xylitol, fluoride supplementation, eruption patterns and available resources. This manual, now entitled, "Oral Health Handbook and Resources for CHDP Medical Providers" will be available on CD, hardcopy, as well as a power point presentation for the counties to use to train CHDP providers. The CHDP website will also be a source for the manual.

**Health Systems Capacity Indicator 08:** *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Indicator	23.0	22.6	10.9	8.7	32.5
Numerator	20572	20940	8944	7318	27623
Denominator	89340	92790	82343	84235	85106
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

**Notes - 2006**

This measure is the percent of SSI beneficiaries through age 15 years receiving rehabilitative services through the CCS program. Source of data for the numerator is from CMS Net and CCS program data and for the denominator is from the publication: Social Security Administration Office of Policy, Children Receiving SSI.

Numerator: Children under 16 years of age enrolled in CCS with aid codes of 20 and 60 (disabled children with SSI) for FY 2005-06. Since active cases on CMS Net represent an estimated 63.6 percent of all active CCS cases for CA for FY 2005, the number with aid codes 20 and 60 from CMS Net is extrapolated for CA.

There is a large increase in the number of children with aid code 60 for FY 2005-06 which can not be explained but is more consistent with data in FY 2001-02 and FY 2002-03, and is more in line with what would be anticipated.

The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI for December, the midpoint of the current fiscal year, for children under 16 years of age. This is the first year that data have been available for children less than 16 years of age, so no comparative data for previous years are available.

#### **Notes - 2005**

This measure is the percent of SSI beneficiaries through age 15 years receiving rehabilitative services through the CCS program. Source of data for the numerator is from CMS Net and CCS program data and for the denominator is from the publication: Social Security Administration Office of Policy, Children Receiving SSI.

Numerator: Children under 16 years of age enrolled in CCS with aid codes of 20 and 60 (disabled children with SSI) for FY 2004-05. Since active cases on CMS Net represent an estimated 56.9 percent of all active CCS cases for CA for FY2004, the number with aid codes 20 and 60 from CMS Net is extrapolated for CA. Note that the CMS Net system now has the capability of identifying children through 15 years. There was a decrease in the identified number of children with aid code 60 possibly due to the fact that in September 2005, there was a change to the CMS Net system that has resulted in cleaner data regarding Medi-Cal eligibility. If this reasoning is correct, then the numerator for this measure should not decline any further in FY 2006-07.

The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI for December, the midpoint of the current fiscal year, for children under 16 years of age. This is the first year that data have been available for children less than 16 years of age, so no comparative data for previous years are available.

#### **Notes - 2004**

This measure is the percent of SSI beneficiaries through age 15 years receiving rehabilitative services through the CCS program. Source of data for the numerator is from CMS Net and CCS program data and for the denominator is from the publication: Social Security Administration Office of Policy, Children Receiving SSI.

Numerator: Children under 16 years of age enrolled in CCS with aid codes of 20 and 60 (disabled children with SSI) for FY 2003-04. Since active cases on CMS Net represent an estimated 55.1 percent of all active CCS cases for CA for FY 2003, the number with aid codes 20 and 60 from CMS Net is extrapolated for CA. Note that the CMS Net system now has the capability of identifying children through 15 years.

The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI for December, the midpoint of the current fiscal year, for children under 16 years of age. This is the first year that data have been available for children less than 16 years of age, so no comparative data for previous years are available.

#### **Narrative:**

Health Systems Capacity Indicator 08 (HSCI-8) is the percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program. HSCI-8 is 32.5 percent for FY 2006-07, compared to 8.7 percent in the previous year. The numerator, 27,623

(7,318 for FY 2005-06), is the number of children under 16 years of age estimated to have SSI and receiving rehabilitative services. The denominator, 85,106 (84,235 for FY 2005-06), is the number of SSI beneficiaries under age 16.

There have been several changes in how this indicator has been calculated over the last few years. The current methodology is as follows. The numerator is the number of children in the CMS Net system with eligibility aid codes of 20 or 60 (disabled children with SSI), most of whom will be receiving Medical Therapy Program (MTP) services. The number from CMS Net is then extrapolated to all counties. The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI for December, the midpoint of the current fiscal year, for children under 16 years of age.

The CCS MTP provides physical therapy, occupational therapy, and Medical Therapy Conference (MTC) services to children who meet specific medical eligibility criteria. The majority of children have cerebral palsy. The children eligible for the MTP do not have to meet the CCS financial requirement to receive therapy or conference services through the MTP. Services are provided in a Medical Therapy Unit (MTU), an outpatient clinic setting that is located on a public school site. Coordination of services in the MTU is under the medical management of a physician/therapy team.

CMS has introduced a web-based software program for clinical documentation of MTP services called MTU Online. By August 2006, 24 county MTPs have voluntarily adopted MTU Online for report writing. This software allows for single entry of identification data and narrative description by occupational and physical therapists and Medical Therapy Conference physicians that is compliant to Medi-Cal standards for Outpatient Rehabilitation Center certification.

Fourteen counties are actively using MTU Online as of the end of May 2007. Another five to eight counties are in the process of becoming equipped and trained to be active users. The software is version 5 and is close to being a complete electronic record. Users of MTU Online have found a decrease in the time needed for documentation of patient visits.

The CMS program introduced statewide outcome measurements for the MTP effective July 2004. Two tools developed for the MTP for program management were the (1) Functional Improvement Score (FISC), to measure the amount of functional change that a child achieves in a 6-12 month period, and the (2) Neuromotor Impairment Severity Scale (NISS), to measure the amount of neuromotor impairment for children with cerebral palsy or similar upper motor neuron conditions. The FISC was revised in 2005 (FISC II) and implemented statewide July 2005. FISC II has separated and expanded the number of functional activity items to include 20 mobility items specific for physical therapy and 20 self care items specific for occupational therapy. Data from the FISC II will be collected annually beginning July 2006. Training for establishing competency of examiners and trainers using the NISS has been completed in 32 (independent) counties as of April 2006.

July 2007 marks the first full year of collection of FISC II data. Going forward, these data will help in setting program standards and establishing new methods of allocating staff positions. More examiners and trainers have been trained using the NISS.

As in past years, the CMS Branch notes that many children who are SSI beneficiaries have mental health and developmental disabilities or delays and are not medically eligible for CCS but are eligible for other state-funded services such as regional center services.

**Health Systems Capacity Indicator 05A:** *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-	ALL

<i>system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>				<b>MEDICAID</b>	
Percent of low birth weight (< 2,500 grams)	2005	payment source from birth certificate	6.9	6.8	6.9

**Notes - 2008**

Source: State of California, Department of Health Services, Center for Health Statistics, 2005 California Birth Statistical Master File. Expected payer source for delivery was used. Infants with missing birthweight were subtracted when calculating the percentages. Infants with missing payer source are included in the Total. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

**Narrative:**

Health Systems Capacity Indicator 05a (HSCI-5a) compares Medicaid and non-Medicaid in the percent of low birth weight (<2,500 grams) babies. In California, Medicaid is called Medi-Cal. Payment source data are obtained from birth certificates. Non-Medi-Cal payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent.

The percent low birth weight babies was quite similar for Medi-Cal and non-Medi-Cal in 2005: 6.9 percent and 6.8 percent, respectively. Neither population reached the Healthy People 2010 target of 5.0 percent. There were no striking differences between Medi-Cal and non-Medi-Cal for any race/ethnic group.

MCAH/OFP programs, including CPSP, AFLP, BIH, and RPPC, work to decrease the incidence of low birth weight infants by providing at-risk women with comprehensive services including prenatal care, education, and psychosocial support.

CPSP is a voluntary program for pregnant Medi-Cal beneficiaries. There are currently more than 1,500 Medi-Cal obstetrical providers approved to provide CPSP services and approximately 165,000 women served annually. CPSP works to decrease the incidence of low birth weight infants by providing Medi-Cal eligible women with comprehensive perinatal services including obstetrical prenatal care, health education, psychosocial services, and nutrition support services. CPSP providers are eligible for an early-entry-into-care bonus and a case coordination bonus for each of their CPSP patients for whom three assessments and the initial pregnancy office visit are provided within four weeks of entry into care.

Pregnant adolescents are at increased risk of delivering low birthweight infants. A primary goal of AFLP is to improve the birth outcomes for babies born to its adolescent clients, many of whom also receive Medi-Cal services. AFLP assists and encourages pregnant adolescents to access prenatal and other necessary health care early in their pregnancy, provides nutritional counseling and works with teens to eliminate behaviors such as smoking and alcohol use which could contribute to poor birth outcomes.

African American infants are twice as likely as infants of most other racial/ethnic groups to be born at low birth weight in California. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and provides them assistance in accessing and maintaining appropriate health care and other supportive services. BIH provided services to more than 13,600 pregnant and parenting African American women, infants, and children in 2005. Many BIH clients also receive Medi-Cal services. BIH is active in 17 local health jurisdictions which account for 94 percent of the State's African American births. [52]

The MCAH/OFP and CMS Branches collaborate with the California Perinatal Quality Care Collaborative (CPQCC), which advocates for performance improvements in perinatal and

neonatal outcomes. CPQCC has more than 120 member hospitals, which account for over 90 percent of the newborns requiring critical care in California. The Perinatal Quality Improvement Panel (PQIP), a workgroup of the CPQCC, is completing a Late Pre-term Infant Toolkit to assist hospitals in the care of infants 34 to 36 6/7 weeks gestation. The toolkit is designed to enhance awareness and sensitivity to issues of transition, infection, nutrition, discharge readiness and parenting.

The fourteen Regional Perinatal Programs of California (RPPC) provide consultation to all delivery hospitals in California, using current statewide and hospital specific outcomes data to address strategies to improve risk appropriate care. The RPPCs support the implementation of clinical quality improvement strategies by collaborating with maternal and neonatal providers to address evidence-based quality improvement projects. They also disseminate current perinatal literature and provide hospitals with clinical competency standards as well as published hospital standards of care.

The MCAH/OFP and CMS Branches are collaborating with the March of Dimes on its 5-year Prematurity Campaign (2003-2007). The goal of this \$75 million campaign is to invest in research, education and community programs in order to identify the causes of prematurity and develop strategies to improve birth outcomes.

**Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births***

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2003	matching data files	5.7	4.7	5.3

**Notes - 2008**

The 2004 California Birth Cohort File is currently not available for analysis. Data using the 2003 cohort file is shown.

Source for 2003 data: State of California, Department of Health Services, Center for Health Statistics, 2003 Birth Cohort file. Expected payer source for delivery was used to compute rates. Cases with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

**Narrative:**

Health Systems Capacity Indicator 05b (HSCI-5b) compares Medi-Cal and non-Medi-Cal on the infant death rate. Payment source data are obtained from birth certificates. Non-Medi-Cal payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent.

The infant death rate was higher among Medi-Cal births (5.7 per 1,000) than among non-Medi-Cal births (4.7 per 1,000) for 2003 (most current data available). Both rates are similar to rates for the previous two years. Neither the Medi-Cal population nor the non-Medi-Cal population has achieved the Healthy People 2010 goal of 4.5, but the rate in the non-Medi-Cal population is close. The only notable difference between Medi-Cal and non-Medi-Cal by race/ethnic group was for Whites: 7.0 per 1,000 and 3.8 per 1,000, respectively.

Child Death Review Teams (CDRT), which exist in most California counties, are expanding their

capacity to make recommendations to agencies and communities about how to prevent infant deaths and to take findings to action. The Epidemiology and Prevention for Injury Control (EPIC) Branch of CDHS has done a series of trainings for CDRTs to promote the recruitment of injury prevention specialists on teams to improve their prevention recommendations.

The State Child Death Review Council has recently created a prevention committee that has begun to generate interest in prevention within CRDTs. Through their local CDRT Sutter and Kern Counties have presented media and public education campaigns addressing Shaken Baby Syndrome. The Surrendered Baby Law and remedies for unsafe sleeping environments and practices have been emphasized by CDRTs.

In response to the persistent disparity between African American and White infant mortality rates, the MCAH/OFP Branch has begun the Black Infant Health/Fetal Infant Mortality Review (BIH/FIMR). The goal of BIH/FIMR is to reduce African American fetal and infant deaths through review of these deaths at the community level. Eight BIH jurisdictions were selected for participation; all had an African American combined fetal and infant death rate above the average for the 17 BIH jurisdictions statewide, and all had a FIMR program.

BIH/FIMR uses the National FIMR model to collect more detailed information about African American fetal and infant deaths than is available from vital statistics. Data will be centrally collected and reportable at the state and county level. The program will train local FIMR coordinators and increase collaborative community involvement through BIH. A state-level BIH/FIMR team will be created to address state-level systemic issues.

The FIMR Program in Contra Costa County has integrated preconception/interconception care information into the maternal interview. The interview is one component in the spectrum of case management and family support services offered to clients following a fetal or infant death.

All MCAH programs have active and ongoing outreach to encourage pregnant women to seek early prenatal care. Outreach programs, such as Perinatal Care Guidance (PCG), provide assistance in enrolling women in a private or public health insurance program, assisting them to find a medical provider for care throughout their pregnancy, and providing follow-up to ensure continued access to care and assisting with issues or problems that arise during the perinatal period.

Several MCAH/OFP programs are focusing attention on decreasing the incidence of low birth weight within California, including CPSP, AFLP, BIH, and RPPC. For more information, see the narrative for HSCI 05a.

**Health Systems Capacity Indicator 05C:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	payment source from birth certificate	81.6	90.8	86.6

**Notes - 2008**

Source: State of California, Department of Health Services, Center for Health Statistics, 2005 California Birth Statistical Master File. Payer source for prenatal care was used. Women with missing prenatal care initiation were subtracted from the denominator when calculating the percent shown. Women with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

**Narrative:**

Health Systems Capacity Indicator 05c (HSCI-5c) compares Medi-Cal and non-Medi-Cal on first trimester prenatal care. Payment source data are obtained from birth certificates. Non-Medi-Cal payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent.

The percent of women entering prenatal care in the first trimester was lower for Medi-Cal births (81.6 percent) than for non-Medi-Cal births (90.8 percent) in 2005. This difference was noted for all race/ethnic groups, with the greatest differences for Whites (16.1 percentage points), Asians/Pacific Islanders (15.5) and American Indians (11.4). The percent of Medi-Cal births and the percent of non-Medi-Cal births that received first trimester care were down slightly from the previous year (82.0 percent and 91.2, respectively). The non-Medi-Cal population achieved the Healthy People 2010 goal of 90 percent.

One of the reasons that utilization of prenatal care in the first trimester is lower than optimal is that the number of unintended pregnancies remains high. Among low-income women surveyed in the 2002 National Survey of Family Growth, 59 percent classified their pregnancies as unintended, compared with 38 percent of women whose incomes exceeded 200 percent of the FPL. [53] Representatives from the MCAH/OFP actively participate on the Preconception Care Council of California. The Council plays a pivotal role in relaying the message of the importance of preconception care to local communities.

MCAH programs are important in identifying women in need of prenatal care at early stages in the pregnancy through community connections, community outreach, hotlines, and similar interventions. The programs are also critical in providing social support services, case management and client follow-up.

**Health Systems Capacity Indicator 05D:** *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	payment source from birth certificate	75.4	80.9	78.4

**Notes - 2008**

Source: State of California, Department of Health Services, Center for Health Statistics, 2005 California Birth Statistical Master File. Payer source for prenatal care was used. Women with missing prenatal care values were subtracted from the denominator when calculating the percent

shown. Women with missing payer source included in Total. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

**Narrative:**

Health Systems Capacity Indicator 05d (HSCI-5d) compares Medi-Cal and non-Medi-Cal on the percent of women with adequate prenatal care (Kotelchuck Index). Payment source data are obtained from birth certificates. Non-Medi-Cal payment source includes private insurance, self-pay, no charge, other government programs, and medically indigent.

The adequacy of prenatal care is measured, as in HSCI 4, as the percent of women (ages 15 through 44) with a live birth during the year whose observed to expected ratio of prenatal visits is greater than or equal to 80 percent on the Kotelchuck Index. By this measure, 75.4 percent of Medi-Cal women and 80.9 percent of non-Medi-Cal women had adequate prenatal care in 2005. The percent of Medi-Cal women with adequate prenatal care was down slightly from the previous year (75.7 percent), while the non-Medi-Cal percent was up slightly from the previous year (80.7 percent). Both groups are lower than the national Healthy People 2010 goal of 90 percent.

One of the reasons that utilization of prenatal care in the first trimester is lower than optimal is that the number of unintended pregnancies remains high. Among low-income women surveyed in the 2002 National Survey of Family Growth, 59 percent classified their pregnancies as unintended, compared with 38 percent of women whose incomes exceeded 200 percent of the FPL [54].

Representatives from the MCAH/OFP Branch actively participate on the Preconception Care Council of California. The Council plays a pivotal role in relaying the message of the importance of preconception care to local communities.

MCAH programs are important in identifying women in need of prenatal care at early stages in the pregnancy through community connections, community outreach, hotlines, and similar interventions. The programs are also critical in providing social support services, case management and client follow-up.

**Health Systems Capacity Indicator 06A:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Infants (0 to 1)	2005	200
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Infants (0 to 1)	2005	250

**Notes - 2008**

Source: State of California, Department of Health Services, Medi-Cal Eligibility Branch.

**Notes - 2008**

Source: State of California, Department of Health Services, Medi-Cal Eligibility Branch.

**Narrative:**

Health Systems Capacity Indicator 06a (HSCI-6a) compares the income eligibility requirements for Medicaid and the State Children's Health Insurance Program (SCHIP) for infants (ages 0 to 1).

In California, the SCHIP program is called Healthy Families (HF).

Infants are eligible for Medi-Cal if the family income is at or below 200 percent of the FPL. HF is more inclusive, using an eligibility level of at or below 250 percent of FPL. There have been no changes in these income eligibility requirements for several years, and no changes are anticipated in the foreseeable future.

**Health Systems Capacity Indicator 06B:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to )	2005	133 100
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Medicaid Children (Age range 1 to 19) (Age range to ) (Age range to )	2005	250

**Notes - 2008**

Source: State of California, Department of Health Services, Medi-Cal Eligibility Branch.

**Notes - 2008**

Source: State of California, Department of Health Services, Medi-Cal Eligibility Branch.

**Narrative:**

Health Systems Capacity Indicator 06b (HSCI-6b) compares the income eligibility requirements for Medicaid and SCHIP/HF for children ages 1 to 19.

Children age 1-5 are eligible for Medi-Cal if the family income is at or below 133 percent of FPL; for children age 6-19, the eligibility level is 100 percent of FPL. HF has an eligibility level of 250 percent of FPL for children age 1 - 19. There have been no changes in these income eligibility requirements for several years, and no changes are anticipated in the foreseeable future.

**Health Systems Capacity Indicator 06C:** *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL Medicaid</b>
Pregnant Women	2005	200
<b>INDICATOR #06</b> <b>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</b>	<b>YEAR</b>	<b>PERCENT OF POVERTY LEVEL SCHIP</b>
Pregnant Women		

**Notes - 2008**

Source: State of California, Department of Health Services, Medi-Cal Eligibility Branch.

**Notes - 2008**

Pregnant women are not covered by SCHIP.

**Narrative:**

Health Systems Capacity Indicator 06c (HSCI-6c) compares the income eligibility requirements for Medicaid and SCHIP/HF for pregnant women.

Pregnant women are eligible for Medi-Cal if the family income is at or below 200 percent of the FPL. Pregnant women are not eligible for HF. There have been no changes in these income eligibility requirements for several years, and no changes are anticipated in the foreseeable future.

**Health Systems Capacity Indicator 09A:** *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

<b>DATABASES OR SURVEYS</b>	<b>Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)</b>	<b>Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)</b>
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

**Notes - 2008**

**Narrative:**

Health Systems Capacity Indicator 09a (HSCI-9a) describes MCH data. There are many sources of MCH data in California, including data from birth and death certificates; hospital discharge data; and several statewide surveys, some of which are described below.

MCAH/OFP has had access to linked birth and death files since 1965. These data are used for a variety of research endeavors including assessment of fetal and infant mortality rates, sudden infant death syndrome (SIDS), maternal mortality and morbidity, and quality of care indicators. These data are provided (confidentially) to hospitals annually and are one of the primary tools for reducing fetal and infant mortality rates and improving quality of care.

MCAH/OFP also has access to hospital discharge data through the California Office of Statewide Health Planning and Development (OSHPD). OSHPD has administrative and clinical data from all licensed hospitals in California, including data on population demographics, hospital/clinic characteristics, payer source, births and deliveries, and other conditions, procedures, and injuries.

MCAH/OFP has the capacity to link birth certificate data and WIC eligibility files, as was done in 1999. Because of budgetary constraints, it has not been done since 1999. CDPH also has the capacity to link birth certificate data with newborn screening data and Medicaid data.

MCAH/OFP's Maternal and Infant Health Assessment (MIHA) survey is an annual population-based survey of women who gave birth in California. The survey is modeled after CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) and is self-administered 10-14 weeks after birth to a stratified, random sample of approximately 3,500 participating women. Strata are by maternal region of residence, race/ethnicity, and education. Surveys are available in English and Spanish. The first year of data collection was completed in 1999. Topics include intendedness of pregnancy, utilization of health care, breastfeeding, and risk behaviors before and during pregnancy, including use of folic acid supplementation and smoking during pregnancy. Birth outcomes are provided through linkage with birth certificate data. The administration of this survey is contracted out to UCSF, and UCSF staff often collaborate with MCAH/OFP staff on analysis and reporting of survey results.

The California Women's Health Survey (CWHS), conducted under the auspices of the California Office of Women's Health, is an annual, population-based, computer-assisted, random-digit dialed telephone survey in which 200 questions are answered by approximately 4,000 women. The survey is anonymous and is conducted in English and Spanish. Topics include health insurance status, family planning, sexually transmitted infections, pregnancy, mental health, and lifestyle issues such as food/nutrition and exercise. MCAH/OFP staff sit on the CWHS advisory group, contribute questions to the survey, and analyze data prepare and present findings.

The California Health Interview Survey (CHIS) is a collaborative project of CDPH, DHCS, the UCLA Center for Health Policy Research, and the Public Health Institute. CHIS is a bi-annual telephone survey of adults, adolescents, and children representative of all parts of the state. The 2001 and 2003 surveys each covered 42,000 - 55,000 households, enough to allow for statewide and some local level analysis. Questions included health insurance coverage, alcohol and tobacco use, asthma, diabetes, mental health, oral health, overweight and obesity, and lifestyle issues, including food/nutrition and exercise. MCAH/OFP staff sit on several CHIS Technical Advisory Groups, helping to develop topic areas and survey questions, and analyzing survey data.

The MCAH/OFP Branch also collects and maintains data on its various programs, including AFLP, BIH, CDAPP, CPSP, FIMR, and SIDS. Data elements vary by program, but generally cover number of clients served, client socio-demographics, number of home visits, and utilization of services. Program files can usually be linked to birth and/or death files.

**Health Systems Capacity Indicator 09B:** *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

<b>DATA SOURCES</b>	<b>Does your state participate in the YRBS survey? (Select 1 - 3)</b>	<b>Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)</b>
Youth Risk Behavior Survey (YRBS)	1	No
California Student Survey	3	No
California Health Interview Survey	3	Yes

**Notes - 2008**

**Narrative:**

HSCI 9b is data capacity for adolescent tobacco use. The two main sources, from which MCAH/OFP obtains data on adolescent tobacco use, are the California Health Interview Survey (CHIS) and the California Student Tobacco Survey (CSTS).

According to the 2005 CHIS survey, 6.5 percent of California youth age 12-17 years old smoked in the past 30 days. CHIS is a random digit dial telephone survey that is conducted every two years. It is the largest state health survey, with over 43,000 California households surveyed in 2003.

The 2004 CSTS results show that 3.9 percent and 13.2 percent of middle- and high-schoolers, respectively, reported smoking in the past 30 days. CSTS, funded by the CDHS Tobacco Control Section (TCS), is a statewide school-based survey of 6th to 12th graders conducted every other school year. ***/2008/ Youth smoking prevalence increased to 6.1 percent for middle-schoolers and and 15.4 percent for high-schoolers, based on the 2006 CSTS. //2008//***

Other sources of data on adolescent tobacco use include: the California Schools Survey (CSS), which is primarily used for local assessments; the California Tobacco Survey (CTS), a phone survey conducted approximately every three years, which assesses tobacco-related attitudes, beliefs, and media exposure; the Youth Tobacco Purchasing Survey (YTPS); and the Behavioral Risk Factor Surveillance (BRFS) Survey, which includes data on exposure to secondhand smoke.

The C-STATS website (<http://www.cstats.info/>) provides an archive of California tobacco statistics at the state and county levels. It includes data on many tobacco-related indicators for youth, including smoking prevalence; tobacco use; attitudes and beliefs about smoking, second-hand smoke, and smoking prevention; media exposure; and perceptions of the tobacco industry.

## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

#### Performance Reporting

*/2007/*

California's Title V performance reporting currently includes a total of twenty-eight measures: eighteen national performance measures (NPM) mandated by HRSA and ten additional measures chosen by the state. In FY 2005-2006, the state performance measures (SPM) were reviewed and updated based on the needs and priorities identified in the 2005 Needs Assessment.

The ten SPM in this report, which are based on the 2005 Five Year Needs Assessment, include the following:

SPM 01: The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home;

SPM 02: The ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists;

SPM 03: The percent of women, aged 18-44 years, who reported 14 or more "not good" mental health days in the past 30 days ("frequent mental distress");

SPM 04: The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy;

SPM 05: The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries;

SPM 06: The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System;

SPM 07: The percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral;

SPM 08: The percent of births resulting from an unintended pregnancy;

SPM 09: The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition; and

SPM 10: The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.

*//2007//*

The national and state performance measures cover the four levels of the MCH pyramid: Direct Health Care Services, Enabling Services, Population-Based Services, and Infrastructure Building Services. For a discussion of specific programs associated with each performance measure, please refer to Sections IV C (NPMs) and IV D (SPMs). Figures 4a and 4b (Performance Measures Summary Sheet) show where the state's many activities fit on the MCH pyramid.

Data on performance measures are included in two parts of this report - on the data forms and in the narrative. Please refer to the Attachment for information on the development of the annual

objectives for the performance measures.

***An attachment is included in this section.***

## **B. State Priorities**

### State Priorities

The 2005 five-year needs assessment identified ten priorities for maternal, child, and adolescent health in California. The priorities encompass all levels of the MCH health services pyramid and in some cases span pyramid levels. The ten priorities for Title V activities in California are:

- > Enhance preconception care and work toward eliminating disparities in infant and maternal morbidity and mortality.
- > Promote healthy lifestyle practices among MCAH populations and reduce the rate of overweight children and adolescents.
- > Promote responsible sexual behavior in order to decrease the rate of teenage pregnancy and sexually transmitted infections.
- > Improve mental health and decrease substance abuse among children, adolescents, and pregnant or parenting women.
- > Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS.
- > Improve access to medical and dental services, including the reduction of disparities.
- > Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists, and nutritionists.
- > Increase the number of family-centered medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.
- > Decrease unintentional and intentional injuries and violence, including family and intimate partner violence.
- > Increase breastfeeding initiation and duration.

### Relationship of Priorities, Performance Measures, and Capacity

All ten of California's priorities have one or more related national or state performance measures.

For Priority 1 (Enhance preconception care and work toward eliminating disparities in infant and maternal morbidity and mortality), there are five related performance measures:

- > NPM 01 (The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition[s] mandated by their State-sponsored newborn screening programs);
- > NPM 15 (Percentage of women who smoke in the last three months of pregnancy);
- > NPM 17 (Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates);
- > NPM 18 (Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester); and

> SPM 06 (The incidence of neural tube defects [NTDs] per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System).

For Priority 2 (Promote healthy lifestyle practices among MCAH populations and reduce the rate of overweight children and adolescents), there are two related performance measures:

- > NPM 14 (Percentage of children, ages 2 to 5 years, receiving WIC services that have a Body Mass Index [BMI] at or above the 85th percentile); and
- > SPM 09 (The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition).

For Priority 3 (Promote responsible sexual behavior in order to decrease the rate of teenage pregnancy and sexually transmitted infections), there are two related performance measures:

- > NPM 08 (The rate of birth [per 1,000] for teenagers aged 15 through 17 years); and
- > SPM 08 (The percent of births resulting from an unintended pregnancy).

For Priority 4 (Improve mental health and decrease substance abuse among children, adolescents, and pregnant or parenting women), there are three related performance measures:

- > NPM 16 (The rate [per 100,000] of suicide deaths among youths 15-19);
- > SPM 03 (The percent of women, aged 18-44 years, who reported 14 or more "not good" mental health days in the past 30 days); and
- > SPM 04 (The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy).

For Priority 5 (Coordinate to develop and implement a system of timely referral between mental health, developmental services, social services, special education services and CCS), there are five related performance measures:

- > NPM 02 (The percent of CSHCN age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive);
- > NPM 03 (The percent of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home);
- > NPM 05 (Percent of CSHCN age 0 to 18 whose families report the community-based service systems are organized so they can use them easily);
- > SPM 01 (The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home); and
- > SPM 07 (The percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral).

For Priority 6 (Improve access to medical and dental services, including the reduction of disparities), there are nine related performance measures:

- > NPM 01 (The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition[s] mandated by their State-sponsored newborn screening programs);
- > NPM 04 (The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need);
- > NPM 07 (Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B);
- > NPM 09 (Percent of third grade children who have received protective sealants on at least one permanent molar tooth);
- > NPM 12 (Percent of newborns who have been screened for hearing before hospital discharge);
- > NPM 13 (Percent of children without health insurance);
- > NPM 17 (Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates);
- > NPM 18 (Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester); and
- > SPM 07 (The percent of newly referred clients to the CCS program whose cases are opened

within 30 days of referral).

For Priority 7 (Expand the number of qualified providers participating in the CCS program, e.g., medical specialists, audiologists, occupational and physical therapists, and nutritionists), there are six related performance measures:

- > NPM 03 (The percent of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home);
- > NPM 04 (The percent of CSHCN age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need);
- > NPM 05 (Percent of CSHCN age 0 to 18 whose families report the community-based service systems are organized so they can use them easily);
- > NPM 06 (The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life);
- > SPM 01 (The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home); and
- > SPM 02 (The ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists).

For Priority 8 (Increase the number of family-centered medical homes for CSHCN and the number/percent of CCS children who have a designated medical home), there are three related performance measures:

- > NPM 02 (The percent of CSHCN age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive);
- > NPM 03 (The percent of CSHCN age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home); and
- > SPM 01 (The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home).

For Priority 9 (Decrease unintentional and intentional injuries and violence, including family and intimate partner violence), there are four related performance measures:

- > NPM 10 (The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children);
- > NPM 16 (The rate [per 100,000] of suicide deaths among youths 15-19);
- > SPM 05 (The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries); and
- > SPM 10 (The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months).

For Priority 10 (Increase breastfeeding initiation and duration), there is one related performance measure:

- > NPM 11 (The percent of mothers who breastfeed their infants at 6 months of age).

## Parent and Community Involvement

CDHS recognizes parent and community involvement as critical to the development of responsive, family centered, and community based systems of care. While this has been a long-standing state priority, MCAH/OFP and CMS are making special efforts this year, in accordance with the federal Title V Reviewers' recommendations in August 2004, to strengthen existing partnerships among families, communities and policymakers and to provide more information about those partnerships in this report.

Parent and community input has been solicited and incorporated into the Title V Five Year Needs Assessment. Counties obtained parent and community input via surveys, focus groups, stakeholder groups, and direct participation in the needs assessment process. Twenty-seven local MCAH health jurisdictions reported collecting survey data from more than 2,000 clients,

parents and other family members. Sixteen counties reported having conducted focus groups. Eight counties reported that clients, family members, or community representatives actively participated in their needs assessment process.

An excellent example of client/family input at the local level is the Young Mothers Advisory Council (YMAC) of San Mateo County, a project of the San Mateo County Adolescent Family Life Program. The mission of YMAC is to improve the quality of life for pregnant and parenting teens and their families by influencing public policy at various levels through a council of teen parents.

The 17 local BIH agencies have community advisory boards composed of former clients and community leaders as well as health professionals and agency representatives. The advisory boards identify gaps and barriers to services for African Americans and provide input for needs assessment, program planning, and community awareness events. Some community advisory boards, such as The Black Infant Health Leadership Coalition in Fresno and the Black Women's Health Task Force in Pasadena, also partner with local churches and community agencies to provide information and education to providers and the community about racial health disparities.

The State Early Childhood Comprehensive Systems Project (SECCS) is another example of parental involvement in program planning and implementation. SECCS, funded by HRSA, provides state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically healthy and ready for kindergarten. The project coordinates a myriad of health-related programs at the state and local levels,. Parent input is obtained through focus groups, individual interviews, and inclusion on the Steering Committee. Three members of the SECCS Steering Committee are parents of children with special healthcare needs.

Pediatric Special Care Centers (SCCs) and hospitals that treat CSHCN must meet specific criteria for provision of family-centered care (FCC). During the hospital or SCC review, the following are assessed: the level of parental involvement in treatment decision making; sharing of reports with families; the degree of parent/patient involvement in advisory committees that set policies and procedures; and availability of healthy sibling and parent visiting. As part of the review process of the SCC or hospital, the CMS Branch sends a follow-up report to the facility with FCC recommendations.

The CCS program facilitates FCC services for families of CSHCN. CCS staffing standards allow a parent liaison position in each county CCS program to enable FCC. County CCS programs assist families in accessing authorized services. Many families live long distances from the site of appropriate pediatric specialty and subspecialty care. The program provides reimbursement for travel expenses (gas, bus tickets, taxis), meals for extended stays, and motel rooms for families when there are extended hospital stays.

/2007/ The Children's Regional Integrated Service Systems (CRISS), which is comprised of fourteen CCS county programs, has an FCC Work Group that meets bimonthly. Among other activities, this Group plans, develops and sponsors an annual conference. The annual conference for fall 2005 was "What Happens at 18? Conservatorship and Other Legal Rights for the CCS Client." Youth and their parents, educators working on transition teams, Regional Center staff, CCS staff, family support agency staff, parent leaders, and public agency staff participated. //2007//

***/2008/The Annual Criss Conference for fall 2006, "Negotiating Multiple Transition Hurdles, One at a Time!," featured a youth/family, professional panel presentation focusing on such transitions as moving from the label of delay to disability, active to inactive CCS status, and dependent to independent skills. //2008//***

/2007/ CHLA, UCLA Child and Family Health Program, LA Partnership for Special Needs Children, CRISS, CCS, and CMS Branch partnered on a conference entitled "Family-Centered Strategies for Effective Transition for Youth with Special Health Care Needs: A training for

Providers and Families" in April 2006 in Los Angeles. //2007//

***/2008/ CHLA, UCLA Child and Family Health Program, LA Partnership for Special Needs Children, CRISS, CCD, and CMS Branch collaborated on a conference entitled, "Care Coordinating Services for Children with Special Health Care Needs in the Community" in February 2007. Experts in the field provided information to agency staff, providers, and parents about the system of care for CSHCN, and ways to coordinate services between and among programs and providers. In addition, hands-on breakout sessions were held to address use of parent notebooks, family resource centers, and CMS Net. //2008//***

***/2008/ The LA Partnership for Special Needs Children (LAPSNC) is expanding to include other entities in Southern California. Their first meeting was held in September 2006 with Children's Hospital San Diego, Children's Hospital Orange County, Loma Linda and UC Irvine. Their second meeting in February 2007 included representatives from Orange, San Diego, Riverside and San Bernadino Counties, including children's hospitals, CCS Programs, regional centers, and health plans, for a total of 25 people. //2008//***

/2007/ Participants in the CRISS FCC Work Group have developed a parent notebook with the assistance of families and agencies such as MCHB, the Partnership Health Plan Parent Resource Network, Parents Helping Parents. Planning has begun for trainings on the use of the parent notebook through family resource centers, medical therapy units, and special care centers. //2007//

***/2008/ Train-the-trainer on the use of the notebook is currently being planned for 100 participants and will target school nurses, regional centers, hospitals, MTUs, foster parents, family resource center staff, etc. //2008//***

/2007/ The CMS Branch has been directing a Champions for Progress Center Incentive Award and has convened a group of key stakeholders, with past investments in and knowledge of the system of care for CSHCN and their families. This group, which includes family representation, has met monthly for approximately eight months to develop a strategic plan to address the CSHCN Title V performance measures from the National Survey and three new state performance measures. //2007//

/2007/ The project has built on existing coalitions and projects, and past efforts to develop a long-term, strategic plan for serving CSHCN; and it has identified resources within California to carry out the activities defined in the strategic plan. A monitoring and evaluation strategy is being developed to assure continued improvement and progress toward achievement of the performance measures for CSHCN. //2007//

***/2008/ The Champions for Progress Center Incentive Award has ended, and a federal MCHB grant has been awarded to USC UCEDD at CHLA in collaboration with CRISS and FVC for a 3-year project to implement integrated community systems of care for CSHCN. The Champions stakeholder group is meeting quarterly to review and comment on implementation progress through June 2008. //2008//***

/2007/ Work is in progress to develop a statewide Youth Advisory Group (ages 14-24 years) to provide guidance on design, implementation and evaluation of transition activities for CMS and other agencies involved in transition issues for adolescence. //2007//

***/2008/ The Youth Advisory Group, now named California Kids as Self Advocates (KASA) Youth Panel (plus an adult facilitator), is creating a survey to assess California youth aged 14-24 who have chronic medical issues or disabilities. Their goal is to assess how youth feel about how their medical needs are being met and what they know about the transition from pediatric to adult medical care. The panel has had four meetings, and the draft survey was developed in the last meeting and is now being reviewed. This has brought***

*new experiences, such as decision-making, consensus-building, and critical thinking, to the fourteen panel members. //2008//*

### C. National Performance Measures

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	99	99	99	99.5	100
Annual Indicator	98.7	99.5	100.0	99.2	99.2
Numerator	376	397	391	478	
Denominator	381	399	391	482	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	99.5	99.8	100	100	100

#### Notes - 2006

A manual indicator is reported for 2006 based on 2005.

#### Notes - 2005

Source: State of California, Department of Health Services, Genetic Disease Branch, 2005 Newborn Screening Records. These data reflect screening for the following six conditions: PKU, congenital hypothyroidism, galactosemia, sickle cell, CAH, and tandem mass spectrometry. Data from previous years pertain to only the first four conditions. Screening for the last two conditions began in July 2005.

#### Notes - 2004

Source: State of California, Department of Health Services, Genetic Disease Branch, 2004 Newborn Screening Records.

#### a. Last Year's Accomplishments

California has effectively achieved universal coverage for newborn screening for genetic, metabolic and hematological disorders. The rate for California in 2005 was 100 percent for the four conditions for which screening was performed January-December. The percent receiving timely follow-up to definitive diagnosis and clinical management was 100 percent for these four conditions. Two new sets of screens were performed July 7 through December, the pilot phase of their testing. These were (1) screening for congenital adrenal hyperplasia (CAH), and (2) tandem mass spectrometry screening (MSMS) for inborn errors of metabolism other than PKU. The percent receiving timely follow-up was 93 percent for CAH and 97 percent for MSMS non-PKU, bringing the overall timely follow-up rate for all six screens to 99.2 percent. (Of cases that were ascertained from the new screens, 100 percent received timely follow-up. The lower percents cited are due to including two cases for each screening type that were diagnosed later and treated later because their screening results were falsely negative.)

The Genetic Disease Branch (GDB) conducts two large screening programs -- prenatal and neonatal -- for the prevention, detection and/or treatment of genetic and congenital disorders that can be detected and prevented or treated prenatally or neonatally. Services include counseling, testing, and educational materials for patients, as well as public information and professional education. Genetic screening is a statutorily mandated service available to all pregnant women (prenatal screening) and newborns (newborn screening).

The expanded Alpha Fetoprotein (AFP) Program is a prenatal screening program for the detection of open neural tube defects, abdominal wall defects, Smith-Lemli-Opitz Syndrome, and chromosomal anomalies. Women with positive screening tests are referred to State-approved Prenatal Diagnosis Centers under contract with GDB. Services offered at these Centers include genetic counseling, high-resolution ultrasound, and amniocentesis.

All the conditions for which the NBS program screens, including over 40 metabolic disorders, endocrine disorders, and hemoglobinopathies, are CCS-eligible; and GDB and CMS have been collaborating to ensure that infants identified with abnormal metabolic screening results from the current and expanded testing receive prompt diagnostic evaluations at one of the CCS-approved Metabolic Special Care Centers (SCC) in the state. The county CCS programs have expedited GDB referrals, so that infants with suspected metabolic illness can be identified and treated promptly in order to maximize prevention of premature death or serious disabilities. The guidelines for diagnostic follow-up and treatment of the disorders for which screening is newly in place (the 40 additional metabolic disorders and congenital adrenal hyperplasia) have continued to be reviewed. The CMS Branch has participated at GDB meetings in the ongoing review and assessment of the current expanded program and in the evaluation and development of further expansion of the program to include cystic fibrosis and biotinidase deficiency disorders.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Genetic Disease Branch (GDB) screens for genetic and congenital disorders, including testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.			X	
2. The GDB ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them.				X
3. The GDB fosters informed participation in its programs through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.			X	
4. The GDB and CMS collaborate to ensure that infants identified with abnormal screening results receive prompt diagnostic evaluations at one of the CCS-approved Metabolic Special Care Centers (SCC) in the state.		X		
5. GDB's Newborn Screening Program is preparing for its expansion to include Cystic Fibrosis and Biotinidase Deficiency, to begin by August 1, 2007.				X
6. The Expanded AFP Screening Program is adding a fourth marker, Inhibin, in July, 2007, to its current triple marker prenatal screening. This addition will increase the identification of pregnancies at risk for Down's Syndrome.				X
7.				
8.				
9.				

10.				
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**b. Current Activities**

The GDB screens for genetic and congenital disorders, including testing, follow-up and early diagnosis, in order to prevent adverse outcomes and minimize clinical effects. The GDB ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them. The GDB fosters informed participation in its programs through a combination of patient, professional, and public education, as well as accurate, up-to-date information and counseling.

As the GDB develops and implements the NBS expansion to include cystic fibrosis and biotinidase deficiency disorder testing beginning July, 2007, the CMS Branch is working with GDB on policy and procedures to ensure that infants with abnormal screening results for these disorders receive expeditious diagnostic evaluations and treatment services as needed.

**c. Plan for the Coming Year**

GDB will continue to provide prenatal and newborn screening and follow-up services, as well as services related to patient/parent education and counseling, public information and professional education, (e.g., Hemoglobin Trait Carrier Follow-up Program, Maternal PKU Program, GeneHELP Resource Center and the Sickle cell Counselor Training and Certification Program). State and local agencies -- including GDB, the CMS Branch, CCS-approved SCCs, GDB NBS Contract Liaisons and other NBS Program staff local County CCS programs, and Area Service Center Project Directors and Medical Consultants -- are working collaboratively to ensure that newborns identified with positive screening reports are quickly evaluated, diagnosed, and appropriately treated, and that families are informed and supported throughout the process.

Collaborative work will continue among GDB, the NBS program staff, Area Service Center Project Directors, and the CMS Branch to develop policy and procedures to ensure that newborns identified with positive screening reports for cystic fibrosis and biotinidase deficiency are evaluated and diagnosed in a timely manner, and appropriately treated. The CMS Branch will continue to participate in both the Endocrine and Genetic Specialty statewide meetings during the year. At these meetings CCS issues regarding newborn screening will be discussed and solutions proposed for potential actions by the CMS Branch in collaboration with GDB.

GDB will continue its research studies toward the possibility of screening for additional preventable and treatable genetic and congenital disorders.

The Expanded AFP Prenatal Screening Program is planning to add a fourth marker, Inhibin, to the triple marker screening that now includes AFP, hCG, and uE3. This addition will increase the likelihood of identifying pregnancies at risk for Down's Syndrome, as well as decreasing the false positive rate. This program expansion is currently planned for July 2007.

There are also plans to expand the California Prenatal Screening Program further in 2008 by offering first trimester screening in addition to second trimester screening, to allow for earlier risk assessment for chromosomal abnormalities.

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective		48.5	49.5	50.5	51.5

Annual Indicator	47.6	47.6	47.6	47.6	47.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	52.5	53.5	53.5	53.5	53.5

**Notes - 2006**

The 2006 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2005**

The 2005 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2004**

The 2004 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families partner in decision-making at all levels and are satisfied with the services they receive.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**a. Last Year's Accomplishments**

NPM 02 is one of five measures (see also NPM 03, 04, 05, and 06) taken from the National Survey of CSHCN. Based on the 2000-2002 survey, 47.6 percent of CSHCN age 0 to 18 have families partnering in decision making at all levels and are satisfied with the services they receive.

The most recent National Survey of CSHCN, which was conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics between October 2000 and April 2002, identified approximately 750 children with special needs in each state. A second survey is currently being conducted, and findings will be available in the fall of 2007.

Accomplishments related to this measure over the past year include:

- 1) The CMS Branch, working with its collaborative partners and a stakeholder group (including parents), has completed a strategic plan for the state priorities for CYSHCN identified through the Needs Assessment process. Family partnership and satisfaction have been important parts of the strategy matrix.

2) CHLA, UCLA Child and Family Health Program, LA Partnership for Special Needs Children, CRISS, CCS, and CMS Branch partnered on a conference entitled, "Family-Centered Strategies for Effective Transition for Youth with Special Health Care Needs: A training for Providers and Families" held April 28, 2006 in Los Angeles.

3) The CRISS FCC Work Group continued to meet bimonthly and county member representatives reported on their FCC activities, shared ideas and resources, and coordinated conferences, trainings and activities.

4) The FCC Work Group monitored FCC and transition activities, parent liaison services, and medical home projects.

5) The FCC Work Group provided technical assistance for CCS administrators for hiring or contracting a parent liaison.

6) County CCS programs reported on family participation in the CCS program.

7) There has been collaboration among counties and among counties and agencies to provide workshops, resource fairs, and conferences for families; these collaborations included parents and families in the planning and development.

8) Family members participated on advisory committees or task forces in many counties, and became involved in in-service training of CCS staff and providers.

9) The CRISS FCC Work Group reviewed the FCC survey sent out 2005 to CCS programs and family resource centers.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CMS and stakeholders are working family partnership and satisfaction into the strategic plan for the state priorities identified through the Needs Assessment process and implementing the plan.				X
2. Family Voices and CMS are working together to enhance services for families of CYSHCN and identify for involvement parent mentor/support groups not currently represented in the planning activities.		X		
3. Children's Regional Integrated Service Systems (CRISS) which comprises 14 CCS county programs has a Family-Centered Care (FCC) Work Group that meets bimonthly to plan an annual conference, workshops, resource fairs, and address issues regarding FCC.				X
4. The CMS Branch will be reviewing the analyzed results of the FCC Survey regarding statewide CCS program family-centered care.		X		
5. CCS programs are partnering with Family Resource Centers in their areas.		X		
6. CCS is partnering in planning 2 regional educational FCC conferences in 2008 (Northern and Southern California) for CCS administrators, medical, nurse and social work consultants, parent health liaison/leaders, and therapists.		X		
7. The CMS Branch established a performance measure for family participation in the CCS program and counties continue to				X

evaluate their programs using this performance measure.				
8. The FCC Work Group is providing technical assistance for CCS administrators for hiring or contracting a parent liaison.				X
9. Counties and agencies are collaborating to provide workshops, resource fairs, and conferences for families; these collaborations include parents and families in their planning and development.		X		
10.				

**b. Current Activities**

Current activities around this measure include:

1) A Federal MCHB grant was officially awarded to the USC's University Center for Excellence in Developmental Disabilities (UCEDD) at Children's Hospital LA (CHLA) for collaboration with CRISS, CMS Branch, and FVCA for a 3-year project to implement integrated community systems of care for CSHCN. The strategic plan for CYSHCN, developed by the stakeholder group from the Champions grant, will be implemented in the 14 CCS County regions (involved with CRISS) and in Los Angeles. Implementing strategies around family partnership and satisfaction will be part of the process. There are 25-30 stakeholders consistently participating in these monthly meetings.

2) The FCC Work Group will continue to meet bimonthly, monitoring FCC and transition activities, parent liaison services, and medical home projects, as well as providing resources and support for all counties in attaining parent liaison services.

3) County CCS programs continue to evaluate their programs for family participation in the CCS program.

4) The CRISS Project and Family Voices of California (FVCA) presented a workshop in English and Spanish on "Negotiating Multiple Transition Hurdles, One at a Time" on November 3, 2006 in Oakland for nurses, physicians, CCS staff, Regional Center service coordinators, and youth and families.

5) The CMS Branch received the analyzed results of the FCC survey regarding statewide CCS program family-centered care.

**c. Plan for the Coming Year**

1) The Champions stakeholder group for the MCAH grant implementing integrated community systems of care for CSHCN will meet on a quarterly basis to review and comment on implementation progress through June 2008.

2) The CRISS FCC Work Group will be planning and developing an annual conference for the fall of 2007.

3) The CMS Branch will be reviewing the analyzed results of the FCC survey regarding statewide CCS program family-centered care.

4) The FCC Work Group will continue to meet bimonthly, monitoring FCC and transition activities, parent liaison services, and medical home projects, as well as providing resources and support for all counties in attaining parent liaison services.

5) County CCS programs will continue to evaluate their programs for family participation in the CCS program.

6) There will again be two regional educational conferences in 2007, one each in Northern and

Southern California that will include education on FCC topics for all CCS administrators, medical consultants, nurse consultants, social work consultants, parent health liaison/leaders, and therapists; conference planning will draw on the expertise of family support organizations, CCS programs, and providers; the conference presentations will model parent-professional collaboration.

7) Collaborative workshops, conferences, and resource fairs will continue to occur.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective		45.5	46.5	48	50
Annual Indicator	44.7	44.7	44.7	44.7	44.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	51	52	53	54	54

**Notes - 2006**

The data reported in 2002 have pre-populated the data for 2006 for this performance measure and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2005**

The data reported in 2002 have pre-populated the data for 2005 for this performance measure and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2004**

The data reported in 2002 have pre-populated the data for 2004 for this performance measure and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN in the State age 0 to 18 years who receive coordinated, ongoing, comprehensive care within a medical home.

Source of Data is Centers for Disease Control and Prevention, National Center for Health

Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**a. Last Year's Accomplishments**

NPM 03 is from the National CSHCN Survey. Based on the 2000-2002 survey, 44.7 percent of the CSHCN in California receive coordinated, ongoing, comprehensive care within a medical home.

The most recent National Survey of CSHCN, which was conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics between October 2000 and April 2002, identified approximately 750 children with special needs in each state. A second survey is currently being conducted, and findings will be available in the fall of 2007.

CCS collaborated with CHLA and the California Epilepsy Foundation on a grant from HRSA, "Improving Access to Care for Children and Youth with Epilepsy in California". The overall goal of the proposed project was to improve access to health and other services and supports related to epilepsy by facilitating the development of state-wide community-based interagency models of comprehensive, family-centered, culturally-effective care and state-wide standards of care. This collaboration is an effort to achieve early detection, diagnosis and best-practices treatment for children and youth (0-18) with epilepsy in California, especially those residing in medically underserved areas, as well as to eradicate the often-associated stigma through increasing public awareness and understanding of the disorder.

Other activities include:

- 1) County CCS programs assessed whether CCS eligible children have a documented medical home and looked at ways to improve this.
- 2) Work was finalized on the state strategies for increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.
- 3) Worked on addressing a policy letter for the medical home for CCS clients.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CMS and stakeholders are working on the state strategies for increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home and an implementation plan.				X
2. CCS is a collaborative partner with Children's Hospital LA (CHLA) for a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA, particularly in a medical home setting.		X		
3. County CCS programs are assessing whether CCS eligible children have a documented medical home and looking at ways to improve this.				X
4. Work continues developing policy for CCS regarding the medical home for CCS clients, authorization of the medical home, including phone consultation and care coordination.				X
5.				
6.				
7.				
8.				

9.				
10.				

**b. Current Activities**

- 1) Collaborating with CHLA on the grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in California.
- 2) Work continues on utilizing the federal MCHB grant awarded to the USC's UCEDD at CHLA for collaboration with CRISS, CMS Branch, and FVCA to implement the strategies around increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.
- 3) Work continues on a policy letter for CCS regarding the medical home for CCS clients, particularly authorization of the medical home and ramifications of this authorization.
- 4) Evaluation continues by county CCS programs to determine if children in the CCS program have a medical home and how to improve on this part of a performance measure regarding effective case management.

**c. Plan for the Coming Year**

Plans for the coming year include:

- 1) Continue to Collaborate with CHLA on the grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in California.
- 2) Continue to work with USC's UCEDD at CHLA in collaboration with CRISS, CMS Branch, and FVCA to implement the strategies around increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.
- 3) Continue to develop a policy letter for CCS regarding the medical home for CCS clients, particularly authorization of the medical home, including phone consultation for care coordination, billing codes, and ramifications of this authorization.
- 4) Continue evaluation by county CCS programs to determine if children in the CCS program have a medical home and how to improve performance regarding effective case management.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective		60.5	62.5	64.5	65.5
Annual Indicator	59.3	59.3	59.3	59.3	59.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>

Annual Performance Objective	68.5	70.5	70.5	70.5	70.5
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**Notes - 2006**

The 2006 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2005**

The 2005 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2004**

The 2004 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families have adequate private and/or public insurance to pay for the services they need.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**a. Last Year's Accomplishments**

NPM 04 is from the CSHCN Survey and is related to population-based services. For the 2000-2002 survey, 59.3 percent of families of CSHCN age 0 to 18 years in California had adequate private and/or public insurance to pay for the services they needed.

The most recent National Survey of CSHCN, which was conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics between October 2000 and April 2002, identified approximately 750 children with special needs in each state. A second survey is currently being conducted, and findings will be available in the fall of 2007.

The CMS Branch determines whether CCS eligible children had access to private health coverage utilizing CDHS' Other Health Coverage (OHC) file. When the CMS Branch learned that a child had coverage not shown on the OHC file, it added this information to the file.

The state stakeholder group finalized strategies to improve insurance coverage for CYSHCN.

CHDP programs and providers identified and "deemed" certain infants under one year of age as eligible for ongoing, full-scope, no cost Medi-Cal at the time of a CHDP Health Assessment.

The CMS Branch continued to work with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work continues to utilize the Federal MCHB grant awarded to		X		

the USC's UCEDD at CHLA for collaboration with CRISS, CMS Branch, and FVCA to implement the strategies around improving insurance coverage for CYSHCN.				
2. The CMS Branch continues to determine whether CCS eligible children have access to private health coverage utilizing CDHS' Other Health Coverage (OHC) file.		X		
3. CHDP programs and providers are identifying and "deeming" certain infants under one year of age as eligible for ongoing, full-scope, no cost Medi-Cal at the time of a CHDP Health Assessment.		X		
4. The CMS Branch continues to work with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program.		X		
5. The California HealthCare Foundation (CHCF) has funded a study of the CHDP Gateway and CMS will review the findings of this report and determine any actions to take.		X		
6. The Branch will continue to implement the CHDP Gateway and identify CCS eligible children through the Gateway process.		X		
7.				
8.				
9.				
10.				

**b. Current Activities**

Work to utilize the federal MCHB grant continues. The grant was awarded to the USC's UCEDD at CHLA for collaboration with CRISS, CMS Branch, and FVCA to implement the strategies around improving insurance coverage for CYSHCN.

The CMS Branch continues to work with HF and the AIM program to facilitate enrollment of eligible infants into HF and those with CCS eligible conditions into the CCS program. The Branch continues to update the OHC file as health coverage information is obtained. The Branch continues to implement the CHDP Gateway and identify CCS eligible children through the Gateway process.

**c. Plan for the Coming Year**

- 1) Develop strategies to refer children enrolled in CCS to all sources of available insurance, including Healthy Families, county Health Kids programs, Kaiser Permanente (KP) Care for Kids, and Medicaid waiver programs as appropriate.
- 2) Promote CMS participation in health care financing discussions at all levels of state government.
- 3) Link state and local CCS programs and other agencies serving CSHCN with funded outreach programs and projects promoting insurance coverage for children (e.g. Governor's coverage initiatives, other campaigns).
- 4) Review existing Medicaid waivers and consider opportunities for expansion to include additional youth, e.g. for Medi-Cal "deeming" for additional youth with special health care needs (YSHCN).

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective		67	68	69	70
Annual Indicator	65.9	65.9	65.9	65.9	65.9
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	71	72	72	72	72

**Notes - 2006**

The 2006 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2005**

The 2005 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**Notes - 2004**

The 2004 indicator is pre-populated from 2002 and is based on the State estimates from SLAITS.

This measure is the percent of CSHCN age 0 to 18 years whose families report the community-based service systems are organized so they can use them easily.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

**a. Last Year's Accomplishments**

NPM 05 is a National CSHCN Survey measure and is the percent of CSHCN age 0 to 18 years whose families report that community-based service systems are organized so they can use them easily. For California in 2000-2002, the result was 65.9 percent.

The most recent National Survey of CSHCN, which was conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics between October 2000 and April 2002, identified approximately 750 children with special needs in each state. A second survey is currently being conducted, and findings will be available in the fall of 2007.

- 1) Family members participated on CCS advisory committees and task forces.

2) CHDP, HCPCFC, and CCS programs reported on a performance measure demonstrating that they provide effective case management.

3) Family members of CSHCN participated in in-service training for CCS staff in order to provide the family perspective of the CCS program.

4) CCS collaborated with CHLA and the CA Epilepsy Foundation on a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA; the overall goal of the project is to improve access to health and other services and supports related to epilepsy by facilitating the development of state-wide community-based interagency models of comprehensive, family-centered, culturally-effective care and state-wide standards of care.

5) The LA Partnership for Special needs Children and a CCS stakeholder group, focused on increasing awareness of the need to screen and when appropriate to refer CCS eligible children for mental health problems.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work continues utilizing the Federal MCHB grant awarded to the USC's UCEDD at CHLA for collaboration with CRISS, CMS Branch, and FVCA to implement the strategies around coordination of services and education of families for CYSHCN.		X		
2. The CMS Branch has continued collaboration with FVCA, parent representatives, and diverse parent groups through the Interagency Coordinating Council for Early Start.				X
3. CHDP, HCPCFC, and CCS programs continue reporting on a performance measure evaluating whether they are providing effective case management.				X
4. The LA Partnership for Special needs Children, a CCS stakeholder group, has been focusing on increasing awareness of the need to screen and when appropriate to refer CCS eligible children for mental health problems.		X		
5. CCS is collaborating with CHLA and the CA Epilepsy Foundation on a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA.		X		
6. The FCC Work Group continues to meet bimonthly, and county member representatives will report on their FCC activities, share ideas and resources, and coordinate conferences, trainings and activities.				X
7. Children's Medical Services Branch and the Medi-Cal program are collaborating together to devise a pediatric palliative care program.				X
8. A Palliative Care Stakeholders workgroup is meeting to strategize the implementation of a pediatric palliative care model.				X
9.				
10.				

**b. Current Activities**

Current activities include:

1) Work utilizing the federal MCHB grant awarded to the USC's UCEDD at CHLA for collaboration with CRISS, CMS Branch, and FVCA to implement the strategies around coordination of services and education of families for CYSHCN continues.

2) CHDP, HCPCFC, and CCS programs continue reporting on a performance measure demonstrating that they provide effective case management; results will be compared with future years.

3) The CMS Branch continues to evaluate collaborative relationships with other departments, agencies, and organizations.

4) The FCC Work Group continues to meet bimonthly; county member representatives report on their FCC activities, share ideas and resources, and coordinate conferences, trainings and activities.

5) CCS continues to collaborate with CHLA and the California Epilepsy Foundation on the HRSA grant identified for "Improving Access to Care for Children and Youth with Epilepsy in California."

6) Children's Medical Services Branch and the Medi-Cal program are collaborating together to devise a pediatric palliative care program.

7) A Palliative Care Stakeholders workgroup has had a series of meetings to strategize and obtain input for the development and implementation of a pediatric palliative care model.

**c. Plan for the Coming Year**

Plans for the coming year include:

1) Local CCS offices will conduct regional meetings with family organizations to improve consistency in inter-county interpretation of state laws/regulations/CCS program benefits and eligibility.

2) Create universal consent forms with parents to facilitate information sharing among agencies.

3) Develop tools such as a hard copy and/or electronic health record and child health notebooks, to assist families in tracking medical care.

4) Provide education to families, youth and all providers to help them know how services are organized.

5) A pediatric palliative care waiver application to the federal Centers for Medicare and Medicaid Services (CMS) will be submitted by January 1, 2008.

6) CCS will be accepting County CCS offices to establish pilot pediatric care programs.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					5.8
Annual Indicator	5.8	5.8	5.8	5.8	5.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	5.8	5.8	5.8	5.8	5.8

**Notes - 2006**

The data reported in 2002 have pre-populated the data for 2006 for this performance measure.

This measure is the percent of youth with special health care needs in the country who receive the services necessary to make transitions to all aspects of adult life.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

**Notes - 2005**

The data reported in 2002 have pre-populated the data for 2005 for this performance measure.

This measure is the percent of youth with special health care needs in the country who receive the services necessary to make transitions to all aspects of adult life.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

**Notes - 2004**

The data reported in 2002 have pre-populated the data for 2004 for this performance measure.

This measure is the percent of youth with special health care needs in the country who receive the services necessary to make transitions to all aspects of adult life.

Source of Data is Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001.

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

**a. Last Year's Accomplishments**

NPM 06 is a National CSHCN Survey measure and is the percentage of youth who received the services necessary to make transitions to all aspects of adult life. Due to small sample sizes, the relative standard error for every state except Maine was greater than 30 percent, so the national average is reported, which is 5.8 percent.

These data are from the most recent National Survey of CSHCN, which was conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics between October 2000 and April 2002. A second survey is currently being conducted, and findings will be available in the fall of 2007.

1) CHLA, UCLA Child and Family Health Program, LA Partnership for Special Needs Children, CRISS, CCS, and the CMS Branch collaborated on a conference entitled "Family-Centered Strategies for Effective Transition for Youth with Special Health Care Needs: A Training for Providers and Families" held April 2006 in Los Angeles. Experts in the field provided information to agency staff, providers, youth and their families about the system of care for transitioning

youth, transition resources, and strategies for assisting youth and their families.

2) At the bimonthly meetings of the Family-Centered Care (FCC) Work Group, county CCS programs reported on transition activities. A matrix of transition activities of each of the 14 counties represented was maintained and updated.

3) Through the Champions for Progress grant, the state stakeholder group discussed strategies to address ways to develop an effective coordinated transition process for CYSHCN.

4) CCS social work consultants continued to meet quarterly and discuss transition issues.

5) CRISS conducted a statewide survey to assess CCS program FCC and transition activities. 52 of 58 counties responded.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Counties continue to be involved in planning and implementing transition strategies.				X
2. The FCC Work Group continues to monitor transition activities in the 14 CRISS counties.		X		
3. The CMS Branch received analyzed County data from the CRISS statewide survey regarding statewide CCS program FCC.				X
4. The CMS Branch will reconvene a Transition Workgroup in late Summer or early Fall 2007 with the purpose of providing guidance to the CMS Branch in developing program policy.				X
5. CCS social work consultants continue to meet on transition issues.		X		
6. State CCS staff will continue to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.		X		
7.				
8.				
9.				
10.				

**b. Current Activities**

Current activities include:

1) The FCC Work Group continues to monitor transition activities in the 14 CRISS counties.

2) CCS social work consultants continue to meet on transition issues.

3) Counties continue to be involved in planning and implementing transition strategies.

4) State CCS staff continues to instruct CCS-approved SCCs and those newly applying for approval on the importance and methods of integrating transition planning into patient care beginning at age 14 years.

5) The CMS Branch received analyzed County data from the CRISS statewide survey regarding statewide CCS program FCC.

**c. Plan for the Coming Year**

- 1) All current activities will continue in the coming year.
- 2) Some counties have Transition Task Forces hosted by their county Developmental Disabilities Council (e.g. Alameda, Contra Costa). Some of these agencies will be hosting transition fairs and other activities to support this population.
- 3) The CRISS-FCC Work Group will continue to report on the many local activities around improving transition services and local activities will continue.
- 4) The Statewide Youth Advisory Council, under the auspices of Family Voices of California, will be creating a transition activity calendar and developing a survey on adult health care providers and identifying needs of young adults with disabilities. The Work Group will be considering creating a training tape demonstrating effective ways to get answers to the transition checklist.
- 5) The CMS Branch will reconvene a Transition Workgroup in late Summer or early Fall 2007 with the purpose of providing guidance to the CMS Branch in developing program policy.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	75.4	75.8	75.8	78	82
Annual Indicator	75.8	77.4	81.3	77.9	77.9
Numerator	427631	400715	417804	410274	
Denominator	564157	517719	513904	526667	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	78.4	78.9	79.4	79.9	80.4

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Source of percent immunized: Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area, US, National Immunization Survey, 2005. Available at:

[http://www.cdc.gov/nip/coverage/nis/05/tab02\\_antigen\\_iap.xls](http://www.cdc.gov/nip/coverage/nis/05/tab02_antigen_iap.xls) Last accessed on February 7, 2007. Data for the 4:3:1:3:3 series used.

Denominator: The number of two-year olds in the given year is from the Department of Finance figures, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

## **Notes - 2004**

Source of percent immunized: Estimated Vaccination Coverage with Individual Vaccines and Selected Vaccination Series Among Children 19-35 Months of Age by State and Immunization Action Plan Area, US, National Immunization Survey, 2005. Available at:

[http://www.cdc.gov/nip/coverage/nis/04/tab02\\_antigen\\_iap.xls](http://www.cdc.gov/nip/coverage/nis/04/tab02_antigen_iap.xls) Last accessed on January 24, 2006. Data for the 4:3:1:3:3 series used.

Denominator: The number of two-year olds in the given year is from the Department of Finance figures, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

Data for 2002 based upon 4:3:1:3 immunization schedule. Data for 2003-2005 based upon 4:3:1:3:3 immunization schedule.

### **a. Last Year's Accomplishments**

NPM 07, the percentage of 19 to 35 month olds in California who completed the full schedule of age-appropriate immunizations, was 77.9 percent in 2005, down from 81.3 percent in 2004. California is just below the Healthy People 2010 objective of 80 percent. (The standard for calculating age-appropriate immunizations changed in 2003 from the 4-3-1-3 schedule used in previous years to the 4-3-1-3-3 schedule. The data points for 2003 - 2005 are therefore not comparable to the data reported for previous years.)

The 4-3-1-3-3 schedule consists of four or more doses of diphtheria and tetanus toxoid and pertussis vaccine/diphtheria and tetanus toxoid (DPT/DT); three or more doses of poliovirus vaccine; one or more doses of measles-containing vaccine (MCV); three or more doses of Haemophilus influenza type b vaccine (Hib); and three or more doses of Hepatitis B vaccine (Hep B).

To promote childhood immunization, the CHDP program assures access to vaccines that are required for school entry and has issued provider information notices that contain updated information on the vaccines covered by the CHDP program. CHDP also maintains access to vaccines that are indicated in some high risk children, reimbursing medical providers for vaccine purchase when these vaccines are not supplied by the federal Vaccines for Children (VFC) program.

Efforts to improve immunization rates have been made through CHDP, Medi-Cal, Healthy Families, Healthy Start, the Health Insurance Plan of California (HIPC), the Access for Infants and Mothers Program (AIM), and the Immunization (IZ) Branch.

During the past year, the CMS Branch collaborated with the IZ Branch on the following vaccine coverage or modifications to coverage by VFC/CHDP: pentavalent rotavirus vaccine, quadrivalent human papillomavirus vaccine (HPV), varicella vaccine, and influenza vaccine.

California has been working to improve regional immunization registries, creating a state hub to link all the regions, and unifying the statewide system for identifying pockets of need and developing adequate interventions. There are nine regional immunization registries, covering 53 of 58 California counties. Efforts are underway to improve the electronic exchange of information on patients moving between regions and jurisdictions and also on allowing schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries. It is anticipated that by 2009, immunization information will be securely and rapidly transferred throughout the state.

The CMS and IZ Branches are collaborating on Program and Provider letters for pentavalent rotavirus vaccine, influenza vaccine for all healthy children aged 6 to 59 months who are at high risk for complications from influenza, and the human papilloma virus vaccine.

The IZ Branch holds collaborative coordination meetings three-times a year with the CMS

Branch; Medi-Cal Branches, including Medi-Cal Managed Care; and Healthy Families. This is a collaborative effort to inform all involved agencies about ACIP/VFC decisions and to streamline the process for providing new immunizations as benefits for CHDP and Medi-Cal.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCAH/OFP and CMS Branches advocate for eligible children to join Medi-Cal or HF, both of which cover immunization.		X		
2. Healthy Start (HS), the Health Insurance Plan of California (HIPC), and Access for Infants and Mothers (AIM) provide health care access, including immunizations, for children.		X		
3. Health promotion for adequate immunizations is also done through the CHDP Gateway and AFLP, BIH, and CPSP.			X	
4. Nine regional immunization registries, covering 53 of 58 California counties, provide the foundation for a centralized system of maintaining immunization records.				X
5. Based on data from the regional immunization registries, pockets of need are identified, and interventions are developed.				X
6. Efforts are underway to improve the electronic exchange of information for patients moving between regions, and to allow schools, childcare centers, Medi-Cal, WIC, and Cal-WORKS to link into regional registries.				X
7. The CMS and IZ Branches are currently collaborating on providing pentavalent rotavirus vaccine to infants 6-32 weeks of age.			X	
8. The CMS and IZ Branches are collaborating on providing the quadrivalent human papilloma virus vaccine to females aged 11 to 12 years.			X	
9.				
10.				

**b. Current Activities**

The CMS Branch and Medi-Cal Program are encouraging providers to deliver needed services, particularly immunizations, during the CHDP Gateway / pre-enrollment period.

The MCAH/OFP and CMS Branches advocate for families to enroll in Medi-Cal or HF. With more children having access to primary and preventive care, the number of children receiving immunizations should increase. Local MCAH/OFP programs, including AFLP and BIH, continue to assess the immunization status of adolescent and women clients and their children on a periodic schedule, and to promote the importance of maintaining up-to-date immunizations by assisting program clients to access ongoing preventive care.

The CMS and IZ Branches are currently collaborating on providing the quadrivalent human papilloma virus vaccine to females aged 11 to 12 years. Vaccination can be started as early as 9 years of age and is also recommended for females aged 13 to 26 who have not been previously vaccinated or who have not completed the full series.

The three-times-yearly collaborative coordination meetings continue with the IZ Branch, CMS Branch, Medi-Cal Branches and Healthy Families. ACIP decisions from the February Meetings are under discussion.

**c. Plan for the Coming Year**

The CMS and IZ Branches will work together to make providers aware of vaccine shortages and other immunization-related issues of importance. Through the CMS Branch and the CHDP Executive Committee, local CHDP programs will be kept informed on all immunization issues.

The CMS Branch will continue to collaborate with the IZ Branch in its work on California's statewide immunization registry.

The MCAH/OFP Branch will be working with the IZ Branch in its roll-out of the new adolescent immunizations over the next couple years.

The CMS and IZ Branches will be collaborating on the new combination vaccine, Pentacel™ (Hib, DTaP, IPV) once it is FDA and VFC approved.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	23.5	22.3	21.9	20	20.1
Annual Indicator	22.4	21.1	20.6	20.3	20.3
Numerator	16660	16193	16263	16740	
Denominator	745239	766755	790821	822674	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	20	19.7	19.4	19.1	18.8

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Numerator: State of California, Department of Health Services, Center for Health Statistics, 2005 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004. Tabulations were done by the MCAH/OFP Branch.

**Notes - 2004**

Numerator: State of California, Department of Health Services, Center for Health Statistics, 2004 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004. Tabulations were done by the MCAH/OFP Branch.

**a. Last Year's Accomplishments**

Reducing the adolescent birth rate is one of California's highest health priorities. Between 1987 and 1994, the birth rate among 15-17 year olds increased from 34 to 45 births per 1,000 women. Since 1994, the rate has fallen steadily, down to 26.6 in 2000, and down further to 20.3 in 2005.

Racial and ethnic differences in the adolescent birth rate persist. In 2005, Asians had the lowest birth rate for women 15-17 years old (5.4 births per 1,000 women), followed by Whites (6.8) Pacific Islanders (12.5), American Indians (13.1) and African Americans (17.9). Hispanic adolescents had a birth rate of 35.5 (more than five times higher than the rates for Asians and Whites).

The MCAH/OFP Branch supports several teen pregnancy prevention programs. The Adolescent Family Life Program (AFLP) utilizes a case management and mentoring model to assess and address the risks and resources of adolescent clients and their children related to pregnancy prevention, birth outcomes, child health and safety, access to health insurance, appropriate utilization of health care, and enhancing the psychosocial and economic well-being of the adolescent family.

Office of Family Planning (OFP) programs include the Family Planning, Access, Care, and Treatment Program (Family PACT); the Teen Smart Outreach (TSO) Program; the Community Challenge Grant (CCG) Program; the Male Involvement Program (MIP); and the Information and Education Program (I&E).

In addition to the CDPH teen pregnancy prevention programs, DSS operates the Cal Learn program, and CDE funds 140 school districts and county offices of education to operate the California School Age Families Education (Cal-SAFE) program. Cal Learn assists pregnant/parenting teens to attend and graduate from high school as well as provides case management services according to AFLP standards. Cal-SAFE is designed to increase the availability of support services necessary for enrolled expectant/parenting students to improve academic achievement and parenting skills.

In February 2007, the MCAH/OFP Branch released a report on the Adolescent Family Life Program. The report contains a history and description of the program; information about providers and funding, including fiscal challenges; a profile of female clients; and a discussion of process and outcome indicators, including early prenatal care, birthweight, repeat births and contraceptive use, educational continuation, and service referrals. It also includes some client stories.

To promote integration among HIV, STD, and teen pregnancy prevention programs, the CDC's Division of Adolescent and School Health (DASH) sponsored three national stakeholder meetings between 2003 and 2005. In 2005 California's representatives to those meetings convened an ad hoc work group, named the Adolescent Sexual Health Workgroup (ASHWG), to further integration efforts in California. ASHWG is comprised of program managers from MCAH/OFP, the STD Control Branch, the Office of AIDS, the CA Department of Education, and private partners.

ASHWG is working in two priority areas: Data Integration and Core Competencies. The ASHWG Data Integration Subcommittee has achieved agreement among its state agency partners on generating STD, HIV, and birth data with the same age, racial/ethnicity, and gender categories. State-level tables have been generated for 2000-2004. The Subcommittee is still working to resolve confidentiality issues regarding small cell sizes for syphilis, gonorrhea, and HIV/AIDS data in age and race/ethnic categories.

ASHWG has drafted language on Core Competencies for adolescent sexual health providers. They cover basic knowledge, attributes, abilities and skills and are intended to apply to all staff and professionals who interact with youth, including health clinic workers, test counselors, case managers, clinicians, classroom teachers, community educators, and health outreach workers. The Core Competencies are intended as a interdisciplinary guide that can be used in multiple ways, including recruiting and hiring Staff, staff development and training, self assessment performance appraisal, curriculum development, and quality assurance in program

implementation. Feedback from potential users is being incorporated, and the Core Competencies are being finalized.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP provides case management services to pregnant and/or parenting teens to improve birth outcomes and prevent additional pregnancies.		X		
2. The Family PACT Program provides reproductive health services, education, and counseling to 300,000 adolescents annually, including comprehensive clinical exams and access to contraception.	X			
3. The Community Challenge Grant Program funds 117 community agencies and serves approximately 200,000 teens annually.		X		
4. The Teen Smart Outreach program does outreach to teens and offers in-depth counseling related to sexual and contraceptive concerns of adolescents who access family planning services through the Family PACT program.		X		
5. The Information and Education program provides community-based educational services on teen pregnancy prevention.			X	
6. The Male Involvement Program provides community-based educational services which promote the involvement of young men in the prevention of teen pregnancy and unintended fatherhood.			X	
7. The Cal-SAFE program, which operates in 140 school districts, promotes teen pregnancy prevention.			X	
8. MCAH/OFP collaborates with other key stakeholders at the state level, including the Dept of Education, the Office of AIDS, and the STD Control Branch, to better coordinate efforts in HIV, STD, and teen pregnancy prevention.			X	
9. MCAH/OFP and key stakeholders collaborate on data integration to generate STD, HIV, and birth data for 2000-2004.				X
10. MCAH/OFP and key stakeholders collaborate on Core Competencies, a document intended as an interdisciplinary guide for staff and professionals who work on adolescent sexual health issues.				X

**b. Current Activities**

AFLP provides case management services to pregnant and/or parenting teens, serving about 18,000 teens annually.

The Family PACT Program provides family planning services, testing and treatment of STDs, education and counseling for low-income Californians. Family PACT serves 1.7 million clients a year, including 350,000 adolescents. Family PACT continues efforts in the areas of client outreach; provider recruitment, training, and technical assistance; and the addition of new FDA-approved contraceptive methods to the benefits package.

CCG promotes community-based partnerships to develop effective local teen pregnancy prevention programs, to promote responsible parenting, and to involve fathers in the economic, social, and emotional support of their children. CCG funds 117 community agencies and serves about 200,000 teens annually.

MIP promotes the involvement of young men in the prevention of teen pregnancy and unintended fatherhood. MIP funds 21 agencies and serves about 25,000 adolescent boys and young adult males annually. OFP Information and Education (I&E) projects operate in 27 community agencies and serve about 75,000 youth in grades 6 to 12 annually. I&E projects and Male Involvement Programs are currently developing strategies to increase access to Family PACT services.

OFP contracts with the UCSF Bixby Center for Reproductive Health Research & Policy to provide program monitoring and evaluation services for the Family PACT, TSO, CCG, MIP and I&E programs.

**c. Plan for the Coming Year**

In spite of the considerable success in the reduction of teen birth rates in recent years, teen pregnancy prevention will continue to be a major issue for California, given the demographics of California's youth population.

AFLP, Family PACT, TSO, CCG, MIP and I&E will continue their teen pregnancy prevention efforts. TSO, CCG, MIP and I&E Programs now require clinical services linkages, i.e., they must demonstrate formal referral mechanisms and collaboration with one or more Family PACT providers. They are currently working to develop and implement teen specific strategies to increase access to Family PACT services.

The recently implemented increase in permissible case load for AFLP case managers from 40 to 50 clients per month is designed to continue to make AFLP services available by lowering program costs due to local budget concerns. As these increased case loads are implemented, it will result in less staff time available per client.

ASHWG will continue to promote integration among HIV, STD, and teen pregnancy prevention programs in CDPH and CDE. The ASHWG Data Integration Subcommittee will work on further refinement of the standard data tables, including addressing the issues of confidentiality and small cell size. The Subcommittee is also investigating the possibilities for integration of youth sexual behavior data.

Once the Core Competencies for adolescent sexual health providers have been finalized, ASHWG will begin work on dissemination. Using the Competencies as a framework, ASHWG will also pursue opportunities for joint training between agencies.

The MCAH/OFP Epidemiology and Evaluation Section will produce a Teen Birth Rate Resource, which will include detailed maps and tables of teen birth rates by race/ethnicity, for targeting of teen pregnancy prevention efforts.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	19.5	19.9	20.2	31	27.6
Annual Indicator	19.7	31.0	27.6	27.6	27.6
Numerator	230010	157000	132808	130064	
Denominator	1167565	506000	481280	471246	
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	27.6	27.6	27.6	27.6	27.6

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005

**Notes - 2005**

Source of the percent of third grade children with sealants: Dental Health Foundation, California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade Children. <http://www.dentalhealthfoundation.org/topics/public/index.shtml>. Based on the weighted results from a completed survey of a representative sample of elementary schools in California, 2005. Dental sealant information is based on a one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Territorial Dental Directors.

Denominator: State of California, Department of Education 3rd graders in 2005-2006 school year (<http://data1.cde.ca.gov/dataquest/>). Numerators are estimates derived by multiplying the percentage of 3rd graders with identified dental sealants as determined by the 2005 Oral Health Needs Assessment of Children.

**Notes - 2004**

Source of the percent of third grade children with sealants: Dental Health Foundation, California Smile Survey: An Oral Health Assessment of California's Kindergarten and 3rd Grade Children. <http://www.dentalhealthfoundation.org/topics/public/index.shtml>. Based on the weighted results from a completed survey of a representative sample of elementary schools in California, 2005. Dental sealant information is based on a one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Territorial Dental Directors.

Denominator: State of California, Department of Education 3rd graders in 2005 (<http://data1.cde.ca.gov/dataquest/>). Numerators are estimates derived by multiplying the percentage of 3rd graders with identified dental sealants by the denominator.

**a. Last Year's Accomplishments**

Children's access to preventive dental services is assessed in relation to the percent of third grade children who have received protective sealants on at least one permanent molar tooth. The percent with sealant in California is estimated to be 27.6 percent in 2006. The Healthy People 2010 objective is 50 percent.

The numerator for this performance measure is from the Oral Health Needs Assessment (OHNA), a survey of a representative sample of elementary schools in California in 2005-2006. Dental sealant information is based on a one-minute, non-invasive oral health screening of all third graders in selected schools. The CA Office of Oral Health (OOH) partnered with the MCAH/OFP Branch and the Dental Health Foundation to conduct the OHNA.

Medi-Cal and Healthy Families provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children. CHDP provides dental screenings for over 1.8 million children a year.

The OOH contracts with the UCSF School of Dentistry to oversee the California Children's Dental Disease Prevention Program (CDDPP), which serves more than 300,000 preschool and

elementary school children annually. The CDDPP includes the screening/application of dental sealants to children in grades 2-5 as well as other activities such as oral health education in the classroom, fluoride supplements/mouth rinse and plaque control. A parent education component provides training to the parents of pre-school children about oral disease prevention strategies and the importance of nutrition to oral health.

MCAH/OFP, CMS, Medi-Cal and OOH are members of the CA Oral Health Access Council (OHAC). The OHAC is a diverse panel of oral health stakeholders that are working together to improve the oral health status of the state's traditionally underserved populations. The Dental Health Foundation and the CA Primary Care Association serve as co-facilitators of OHAC.

MCAH/OFP, CMS, Medi-Cal and OOH are also members of the CDHS Oral Health Work Group. The Work Group assists in the coordination of state oral health activities and serves as a clearinghouse for member organizations. In addition, MCAH/OFP, OOH and Medi-Cal are members of the CHDP Dental Subcommittee and the Head Start Oral Health Work Group.

The MCAH/OFP Branch has contracted with UCSF School of Dentistry for a dental hygienist to serve as the MCAH/OFP Oral Health Policy Consultant to meet the growing demand for technical assistance at both the state and local levels. Current oral health information has been distributed among Branch program staff as well as local jurisdictions. Several presentations were given to local health advocacy groups on maintaining good oral health during pregnancy and the prevention of early childhood caries.

The State First 5 Commission has listed oral health for children aged 0-5 years as one of its five priorities. The First 5 Oral Health Initiative includes a \$7 million Early Childhood Oral Health Education and Training Project. Training for medical and dental health care providers started in 2004 and will continue through this final year of the grant. Several counties have also allocated First 5 funds for services related to oral health. WIC began oral health education for staff and child care providers based on this First 5 curriculum.

Beginning in June 2006 the application of fluoride varnish by doctors and nurses was added as a reimbursable Medi-Cal benefit for children younger than six years of age. Because many dentists are not willing to see children this young, medical providers offer the best hope for preventing and controlling tooth decay through the application of fluoride varnish.

The CMS Branch continued various activities to encourage orthodontists and dentists to accept more CCS children into their practices. The CCS program worked on increasing access to dental/orthodontic care for CCS clients, including preserving/expanding the provider network and reducing turnaround time on provider reimbursement.

The CHDP Dental Subcommittee recommends dental referrals beginning at one year of age. The CHDP Dental Subcommittee completed an Oral Health for Infants and Toddlers Provider Training Manual entitled "Oral Health Handbook and Resources for CHDP Medical Providers". The manual contains instruction on performing dental exams on young children and was provided via hard copy and CD to five CHDP local county programs for field testing.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Medi-Cal and HF provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children.		X		
2. CHDP provides dental screenings for over 1.8 million children a year and is developing an Oral Health for Infants and Toddlers Provider Training Manual for county programs.		X		

3. The CMS Branch is undertaking activities to encourage orthodontists and dentists to accept more CCS children into their practices, including more rapid reimbursement.		X		
4. The CDDPP provides dental sealants screening/application to more than 300,000 school children and oral health education in the classroom. CDDPP includes a parent education component.		X		
5. MCAH/OFP, with key stakeholders (e.g. Medi-Cal, State First 5 Commission, CMS and APPP), is implementing the “State Team Action Plan” to increase integration of oral health into existing MCAH/OFP Branch programs.				X
6. The MCAH/OFP Branch has contracted with UCSF School of Dentistry for a dental hygienist to serve as the Branch’s Oral health Policy Consultant to provide technical assistance at the state and local levels.				X
7. Beginning in 2007, children are required to receive a dental check-up within 12 months of their enrollment into kindergarten or first grade, whichever is their first year of public school.				X
8. MCAH local jurisdictions are working with medical, dental and education providers in community dental health advisory boards to promote preventive oral health practices and provide fluoride varnish applications.				X
9. Sierra Health Foundation, in partnership with CDDPP and UCSF, is awarding \$1 million in grants over 3 years to new and existing CDDPP school-based oral health preventive service programs.				X
10. The CA Dental Association Foundation is expanding its pediatric Oral Health ACCESS Program (PCHAP) by offering pediatric dentistry training to 300 dentists statewide to increase their skills to treat young children.				X

**b. Current Activities**

Beginning in 2007, California law requires children receive a dental check-up within the last 12 months and up to May 31 of their first year in public school (kindergarten or first grade). The goal of this program is to establish a dental home for every child. The program will identify children who need further examination and dental treatment, and barriers to receiving care.

MCAH/OFP continues to meet monthly with key stakeholders (e.g. Medi-Cal, First 5, CMS and AAP) to develop and implement the California State Action Plan as part of the Best Practices for Oral Health Access initiative. This plan will increase the integration of oral health into existing MCAH/OFP programs.

Five MCAH programs have a dental coordinator on staff. Other jurisdictions rely on their local CDDPP and/or CHDP coordinators to integrate oral health outreach programs into MCAH target populations. Local agencies, such as Head Start, First 5, CHDP and WIC, work to incorporate screenings, provide fluoride varnish applications, and promote preventive oral health practices to pregnant women, new parents and children. MCAH case management programs, such as CPSP, BIH, and AFLP, enroll women and their families into Medi-Cal and Healthy Families and provide them with necessary dental referrals.

**c. Plan for the Coming Year**

State and county programs will continue to promote oral health, but the state will not be able to fully address NPM 09 until appropriate funds are allocated for sealant promotion, placement, and continuous surveillance of prevalence. As a result of the low prevalence of sealant use demonstrated by the Oral Health Needs Assessment, the California Dental Association is

planning an educational initiative for dentists to encourage more widespread use of sealants.

In partnership with CDDPP and the UCSF School of Dentistry, Sierra Health Foundation's brightSMILES Program is awarding up to \$1 million in grants over a 3 year period to new and existing CDDPP school-based oral health preventive service programs. Applications have been submitted and are currently being reviewed.

The CA Dental Association Foundation is expanding its Pediatric Oral Health ACCESS Program (POHAP) by offering a comprehensive pediatric dentistry training program to 300 dentists statewide. Enhancing general dentists' skills and comfort levels to treat young children, including those with special health care needs, further increases access to the MCAH population.

Given that dental decay is the most common chronic childhood disease, MCAH/OFP has identified increasing access to dental services as one of its priorities. MCAH/OFP will encourage jurisdictions to strengthen strategies to increase the number of children receiving preventive dental services. MCAH is also developing oral health indicators to measure results of jurisdiction oral health activities.

Oral health educational materials (in English and Spanish) that address early childhood dental decay prevention for mothers and young children will continue to be distributed through MCAH/OFP programs. Other health programs within and outside the state have also requested CDPH materials.

As a member of the California State Action Plan, MCAH/OFP staff will be participating in a number of activities over the coming year, including:

- 1) Enumerating CDPH programs providing health services to children and families that do and do not have an identifiable oral health component.
- 2) Convening an expert advisory panel to review oral health content of existing programs and make evidence-based content recommendations, including defining what the minimum oral health content of each program should be and metrics that will allow measuring program changes over time.
- 3) Prioritizing programs needing new or revised oral health content and developing new or revised content for them with consultation from the expert advisory panel.
- 4) Establishing a procedure for periodic review of oral health content of programs to assure it is current with the latest science.
- 5) Assisting local MCAH programs to include measures of oral health status and resources in local needs assessments, include oral health activities in local work plans, develop oral health-related outcomes measures, and integrate oral health with other local MCAH programs.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	2.8	2.6	2.6	2.9	3
Annual Indicator	2.9	3.6	3.1	3.2	3.2
Numerator	227	289	250	257	
Denominator	7905059	7960784	7951488	7930829	

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	3.1	3	2.9	2.9	2.8

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Source Data: Numerator: State of California, Department of Health Services, Center for Health Statistics, 2005 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 296-306). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch. Data are provisional due to the need for the Center for Health Statistics to verify the Cause of Death coding for approximately 1% of total California deaths reported in the 2005 Death Statistical Master File.

**Notes - 2004**

Source: Numerator: State of California, Department of Health Services, Center for Health Statistics, 2004 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 296-306). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

**a. Last Year's Accomplishments**

California motor vehicle death rates for children aged 0-14 declined from 5.4 deaths per 100,000 in 1990 to 2.9 in 2000. Between 2000 and 2002, the rate was relatively stable, fluctuating between 2.9 and 3.1. In 2003 the motor vehicle death rate jumped to 3.6, then returned to 3.1 in 2004 and increased slightly to 3.2 in 2005.

There is little variation in this measure by race/ethnicity. The rate is lowest for Whites at 2.6 per 100,000, followed by 3.9 for Hispanics, and 4.1 for African Americans. (Other race/ethnic groups had too few deaths due to motor vehicle accidents to be included in the comparison.)

The Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University is a resource center on child and adolescent injury prevention. Under a contract with MCAH/OFP, CIPPP has 1) provided technical assistance to local health jurisdictions, 2) organized an annual statewide childhood injury prevention conference, 3) held a bi-monthly injury prevention teleconference with injury prevention professionals, and 4) provided local jurisdictions with regular reviews of the current injury prevention literature.

Due to Title V budget cuts in FFY 2005-06, funding for the MCAH/OFP contract with CIPPP was reduced. The reduction eliminated funding for the annual statewide conference and the bimonthly injury prevention teleconferences, as well as reducing the level of technical assistance provided to local health jurisdictions.

The MCAH/OFP Branch provides funding to local health jurisdictions (58 counties and three cities) in support of local efforts to promote maternal and child health; local jurisdictions may use this funding for child injury prevention, among other projects. The Branch has been allocating

additional funding for local childhood injury prevention programs in five counties in three-year cycles. However, this funding, specifically for childhood injury prevention, will be discontinued after June 2007. Counties are expected to continue to address childhood injury prevention issues with their general funding allotment. Counties have also received grants from the Office of Traffic Safety, which have enabled them to expand childhood injury prevention programs.

Many local health jurisdictions participate in Safe Kids coalitions. Safe Kids is a worldwide network of local groups whose mission is to prevent accidental childhood injury. They bring together health and safety experts, educators, foundations, corporate sponsors, governments and volunteers to educate and protect families. Safe Kids Coalitions identify and target the injury problems most prevalent in their local areas. They plan and implement strategies to address those problems by: 1) calling attention to the problem, through media and public awareness activities, 2) advocating for engineering improvements and enhanced safety legislation and enforcement, 3) providing educational programs for children and families, and 4) distributing lifesaving safety devices to families in need.

To raise funds to support child injury and abuse prevention programs, the State sells personalized auto license plates, called "Kid's Plates". Kid's Plates feature a heart, hand, star, or plus sign. The proceeds fund child injury prevention efforts, including bicycle safety, motor vehicle occupant protection, and pedestrian safety, as well as other child injury and abuse prevention programs. The Kid's Plates Program provides a wide range of technical assistance to help foster effective regional and local injury prevention efforts and funds grants for training and equipment. CIPPP is the Kid's Plate program administrator for the EPIC Branch.

Other activities California has undertaken to reduce motor vehicle deaths among children include: Increased enforcement of drinking and driving laws; passenger restraint laws; graduated driver licensing; public education campaigns addressing the risks of drinking while driving; and vehicle safety improvements.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Local MCAH/OFP funded programs participating in the SAFE KIDS Coalitions implement traffic safety training, child passenger safety checks and safety seat distribution, and bicycle helmet education programs.			X	
2. AFLP and CPSP provide educational materials on use of car seats and child injury prevention.			X	
3. To raise funds to support child injury and abuse prevention programs, the State sells special car license plates, called Kid's Plates.		X		
4. The Epidemiology and Prevention for Injury Control (EPIC) Branch maintains an up-to-date list of locally operated child passenger safety seat programs for use by traffic courts, community agencies, hospitals and clinics.		X		
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Local health jurisdictions participate in Safe Kids Coalitions, child passenger safety checks, child passenger safety seat distribution and training, and bicycle helmet educational programs.

AFLP and CPSP provide educational materials on use of car seats and child injury prevention.

CIPPP provides technical assistance to local health jurisdictions in developing, implementing and evaluating injury prevention programs. Since the 2006 reduction in the MCAH/OFP contract with CIPPP, Center staff continue to provide data updates and technical assistance to local health jurisdictions, but in a reduced capacity.

The MCAH/OFP Branch collaborates with the CDPH Epidemiology and Prevention for Injury Control (EPIC) Branch on child injury prevention activities. EPIC's Vehicle Occupant Safety Program (VOSP) works to strengthen and expand California's child passenger safety infrastructure. VOSP promotes resource sharing and capacity building among California's state and local Child Passenger Safety agencies and provides professional development opportunities, technical assistance and training resources. An updated statewide list of current locally operated child passenger safety seat programs for use by traffic courts, community agencies, hospitals and clinics is available online at <http://www.dhs.ca.gov/ps/cdic/epic>.

The MCAH/OFP Branch continues to work with Safe Kids California Advisory Committee, the Statewide Coalition on Traffic Safety, and the Child Death Review Council.

### c. Plan for the Coming Year

The current activities of the MCAH/OFP Branch, CIPPP and local health jurisdictions will be continued.

The MCAH/OFP Branch will continue to work on the Statewide Coalition on Traffic Safety (SCOTS). SCOTS is a task force containing representatives from more than 20 state and national agencies including the CDPH MCAH/OFP and EPIC Branches, the California Highway Patrol (CHP), the California Office of Traffic Safety, the California Alcohol and Beverage Control, the California Department of Education (CDE), and the California Department of Transportation (CalTrans).

The SCOTS task force was established to unite traffic safety stakeholders throughout the state to engage interagency public and private partnerships to employ diverse evidence based interventions to reduce motor vehicle fatalities in California. The MCAH/OFP Branch's participation in SCOTS has led to an increased awareness among California's motor vehicle injury stakeholders regarding the rise of fatal motor vehicle injuries in California's adolescent and young adult populations and has led the task force to adopt this particular indicator as a priority area.

As an active partner in the SCOTS coalition, the MCAH/OFP Branch has assisted in motor vehicle related injury control efforts for children by establishing common statewide goals and priorities; strengthening injury prevention and control partnerships; sharing data, knowledge and resources; avoiding redundant activities; and leveraging existing resources, including funds, people and leadership attention, toward common objectives.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					69.6

Annual Indicator			69.1	70.2	70.2
Numerator			361762	369404	
Denominator			523322	526361	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	71	71.5	72	72.5	73

**Notes - 2006**

Source: 2005 Maternal and Infant Health Assessment Survey (MIHA), Maternal, Child and Adolescent Health/Office of Family Planning Branch, California Department of Health Services. Numerator: The number of women who delivered a live birth and who reported any breastfeeding at 2 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they breastfed at 2 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

**Notes - 2005**

Percent of mothers breastfeeding at 2 months of age reported. Six month breastfeeding data not available. Source: State of California, Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch, 2004 Maternal and Infant Health Assessment. Survey data weighted to population of mothers who delivered live infants in survey year. Tabulations were done by the MCAH/OFP Branch.

**a. Last Year's Accomplishments**

Performance Measure 11 was revised in 2006 from the percentage of mothers who breastfeed their infants at hospital discharge to the percentage of mothers who breastfeed their infants at six months of age. Data on breastfeeding at age six months are currently not available for California. The closest currently available data are for breastfeeding at two months of age.

The percentage of California mothers who breastfeed their infants at two months of age is 70.2 percent for 2005. (Data for this performance measure come from California's Maternal and Infant Health Assessment survey, a survey of postpartum mothers that is modeled after the PRAMS.)

There are notable racial/ethnic disparities on this measure. In 2005, US-born Asian women had nearly the same percentage of breastfeeding (75.6) as White women (75.5) and foreign-born Asian women (75.4), followed by foreign-born Latina women (72.8), African American women (62.4), and women of other race/ethnic groups (61.2). Groups that were below the state rate include US-born Latinas (54.9) and Native American women (49.1).

Last year's accomplishments include:

- 1) A Model Hospital Breastfeeding Policy Toolkit has been completed and placed on the MCAH/OFP website. The Branch is offering and providing technical assistance to hospital staff using the toolkit at labor and delivery hospitals to improve hospital lactation policies, including the use of quality assurance indicators.
- 2) MCAH/OFP staff provided technical assistance to other partners, such as the Medi-Cal Managed Care Quality Improvement meeting, Office of Women's Health workplace breastfeeding support group, United States Breastfeeding subcommittee, obesity conference, and Medi-Cal breastfeeding benefits workgroup.

- 3) New material added on the breastfeeding page of the MCAH/OFP website includes: resources on African American Breastfeeding, Emergency Preparedness: Infant and Young Child Care and Feeding, Employed/Working Mothers' Breastfeeding Resources, Medications and Breastfeeding, and Family Planning and Contraception During Breastfeeding.
- 4) The CDPH breastfeeding report was finalized by the Breastfeeding Promotion Committee in March 2007 with plans to print and disseminate in fall 2007.
- 5) MCAH/OFP continues to send annual hospital breastfeeding rates, resources, and technical support to all labor and delivery hospitals' CEOs and Directors of Nursing.
- 6) Statewide breastfeeding surveillance mapping has been completed. Special attention was given to areas with low breastfeeding rates. The maps and findings will be printed in the 2007 CDPH Breastfeeding Report. The report highlights recommendations from the California Breastfeeding Promotion Advisory Committee. CDPH, including MCAH/OFP, has begun writing a strategic plan addressing the recommendations of the Breastfeeding Promotion Advisory Committee.
- 7) In 2005, only 42 percent of California newborns were exclusively breastfed in the early post-partum period. Disparities in exclusive breastfeeding rates were found to be lowest for Hispanics (31 percent), African Americans (32 percent), and Pacific Islanders (33 percent), which are well below the rate for whites (64 percent) and the recommended Healthy People 2010 goal of 75 percent.
- 8) The MCAH/OFP Lactation Consultant has been collaborating with a WIC Branch Lactation Consultant to develop and provide lactation trainings to the Black Infant Health Program.
- 9) The MCAH/OFP nutritionist is the alternate for the Association of State and Territorial Public Health Nutrition Directors on the United States Breastfeeding Promotion Committee. She was able to participate at their last two meetings and is an active member of the Workplace subcommittee.
- 10) MCAH/OFP staff are participating on the Office of Women's Health Breastfeeding Supportive Workplaces Committee. Their interest is to provide lactation support for women working in low wage jobs.
- 11) MCAH/OFP staff surveyed women utilizing the East End lactation rooms and are providing feedback to upper management.
- 12) Starting in spring 2006 a new breastfeeding message was included in the Genetic Disease Branch preconception booklet given with marriage licenses.
- 13) The pre-pregnancy Body Mass Index (BMI) of mothers in California was analyzed in relationship to their breastfeeding initiation and duration using 2000-2003 Maternal Infant Health Assessment (MIHA) data. A journal article has been drafted and will be submitted to the Journal of Human Lactation.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The AFLP, Cal-SAFE, and Cal-Learn promote breastfeeding among adolescent mothers, an age group that is less likely to breastfeed.		X		
2. The CDAPP promotes breastfeeding as beneficial for both		X		

mother and child in reducing the risk for diabetes.				
3. BIH collaborates with local breastfeeding coalitions to promote breastfeeding in several counties. WIC has conducted peer counseling training at various local BIH sites.		X		
4. The MCAH/OFP and CMS Branches are participating on the CDPH Obesity Prevention Group; breastfeeding promotion is one of the interventions for childhood obesity prevention.				X
5. MCAH/OFP Branch staff help promote local breastfeeding coalitions, including working with a team from the University of California at Davis (UCD) to organize CA Breastfeeding Coalition meetings.				X
6. MCAH/OFP and WIC Branches collaborate on many breastfeeding promotion activities; such as sharing data on breastfeeding, and convening the State Breastfeeding Promotion Advisory Committee.				X
7. The MCAH/OFP Branch and RPPC are providing toolkits and technical assistance to staff at labor and delivery hospitals to improve hospital lactation policies.		X		
8. MCAH/OFP staff maintain Branch website information on advocacy groups, hospital-specific data on breastfeeding at hospital discharge, MCAH reports, and model hospital breastfeeding policies.				X
9. CDAPP coordinators are updating Sweet Success Guidelines for care, which should be released by early 2008. The guidelines include the types of birth control that are most suitable for breastfeeding mothers with diabetes.				X
10. MCAH and OFP staff are standardizing information provided to mothers about birth control and breastfeeding, as well as to hospitals about which birth control methods are compatible with in-hospital breastfeeding initiation.				X

**b. Current Activities**

The MCAH/OFP and WIC Branches collaborate on many breastfeeding promotions and share data on breastfeeding. For example, WIC has designed and is providing lactation training to home visitors and other BIH staff in order to address disparities in African American lactation rates.

BIH, CDAPP, AFLP, Cal-SAFE, and Cal-Learn continue to promote exclusive breastfeeding among their constituencies. BIH promotes breastfeeding among African American women, and has collaborated with local breastfeeding coalitions that promote breastfeeding in several counties. CDAPP promotes breastfeeding as beneficial in reducing the risk for diabetes, and has added a chapter on breastfeeding to its Guidelines for Care for women with gestational diabetes and those taking insulin while breastfeeding. AFLP, Cal-SAFE, and Cal-Learn encourage breastfeeding among teen mothers, who are less likely to breastfeed.

March of Dimes and RPPC hosted the Seventh Annual Conference for Preventing Prematurity, Birth Defects and Infant Mortality Meeting in January 2007. Two keynote presentations emphasized the importance of breastfeeding as infants' first immunization, particularly for NICU babies, and also breastfeeding as nutritional support for perinatal disaster preparedness.

CDAPP trainings for providers include emphasis on breastfeeding. At an affiliate training in Loma Linda in January 2007, emphasis was given to breastfeeding as an aid to maintaining and improving glycemic control for diabetic mothers.

**c. Plan for the Coming Year**

Plans for the coming year include the following:

- 1) CPSP's "Steps to Take" breastfeeding pages will be updated with materials developed by WIC and the National Breastfeeding Campaign to encourage labor and delivery options that promote, protect and support breastfeeding families.
- 2) The WIC and MCAH/OFP Branches will promote the use of training programs directed at African American and Hispanic women to develop community-based lactation support, promote community referrals to home visiting programs, and encourage those interested in becoming breastfeeding peer counselors.
- 3) The Programs, Policy, and Epidemiology & Evaluation Sections of the MCAH/OFP Branch will coordinate with OFP so that information: 1) given to mothers about birth control methods is correct and does not become a barrier to breastfeeding, and 2) is provided to hospitals about birth control methods initiated at the hospital which may impede breastfeeding.
- 4) CDAPP coordinators are currently in the process of updating Sweet Success Guidelines for Care which should be released by early 2008. The guidelines will emphasize types of birth control for diabetic mothers that do not negatively affect glycemic control or interfere with breastfeeding.
- 5) CDAPP Coordinators are developing a web based PowerPoint presentation for women entitled "Breastfeeding after a Pregnancy with Diabetes: How to have a Sweet Success".
- 6) The MCAH/OFP Branch shares information with its programs during World Breastfeeding Week held August 1-8 every year. MCAH/OFP will send out emails to all county and CBO affiliates encouraging their participation in the celebration. The theme for 2007 is "Breastfeeding: The 1st Hour - Save ONE million babies."
- 7) RPPC coordinators will expand their focus on technical assistance and promulgating quality assurance measures to assess each client's breastfeeding success during her hospital stay. Evaluation of their effectiveness will be based on improving exclusive hospital breastfeeding rates.
- 8) Lactation technical assistance, material development and trainings will continue for the MCAH/OFP programs, especially for CPSP, AFLP, RPPC, CDAPP, OFP and BIH.
- 9) Through the Women's Health Action Learning Collaborative in Los Angeles County, the MCAH/OFP Branch and the Nutrition Network Worksite Program are developing a breastfeeding and weight educational piece to be made available across the state.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	40	60	70	70	75
Annual Indicator	52.2	56.2	68.6	75.0	75
Numerator	276646	304469	374096	411162	
Denominator	530203	541760	545329	548216	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	75	85	90	95	95

**Notes - 2006**

Manual indicator is provided based on FY 2005 results.

**Notes - 2005**

Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.

Source: Numerator and denominator data are from the State of California, Department of Health Services, Office of Vital Records, birth certificate data.

Numerator: Number of newborns who have been screened for hearing before discharge for FY 2005.

Denominator: Number of live births by occurrence in California in FY 2005.

**Notes - 2004**

Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge.

Source: Numerator and denominator data are from the State of California, Department of Health Services, Office of Vital Records, birth certificate data.

Numerator: Number of newborns who have been screened for hearing before discharge for FY 2004.

Denominator: Number of live births by occurrence in California in FY 2004.

**a. Last Year's Accomplishments**

NPM 12 is the percent of newborns who have been screened for hearing loss before hospital discharge. Current California legislation only provides authority to implement the Newborn Hearing Screening Program (NHSP) in the 180 hospitals approved by the CCS program. The number of infants who received hearing screening prior to hospital discharge is based on NHSP program data that was reported from the hospitals to the Hearing Coordination Centers (HCC). This does not include any estimate of screening that may be occurring in non-CCS approved hospitals that do not report to the NHSP.

Based on information reported by the individual Hearing Coordination Centers (HCCs) for Calendar Year (CY) 2005, 411,162 infants, or 75 percent of all California newborns, received newborn hearing screening prior to hospital discharge. This was an increase of 10 percent from FY 2004-05 and meets the objective of 75 percent. The infants screened in CY 2005 comprise 98 percent of the target population of infants born in CCS-approved hospitals.

DHCS only receives aggregate data reports from HCCs on a quarterly basis. This has affected the program's ability to accurately report the number of infants who receive screening, those who need follow-up, those identified with hearing loss, and those who have entered early intervention services.

Accomplishments in the past year include:

- 1) One training session for community audiologists was provided on amplification and ongoing audiologic management of infants with hearing loss. This was a two-part training with a 6-week on-line component and a three-day on-site workshop. There were thirty-six participants in the course and the workshop was held in May 2006.

- 2) The Best Practices report from the Deaf and Hard of Hearing Early Intervention Workgroup has received final approval by the California Department of Education and been released.
- 3) Local early intervention providers have been trained in the Learn to Talk Around the Clock and the Ski-Hi parent-infant curricula.
- 4) The California NHSP presented a breakout session on the successful HCC model for assuring follow-up from newborn hearing screening at the national Early Hearing Detection and Intervention Conference in Washington DC in February 2006.
- 5) Due to a change in management at the South Eastern California HCC, the NHSP staff performed an on-site program review in March 2006, including interactive chart review and technical assistance.
- 6) A Request for Proposals was initiated to procure a statewide NHSP data management service.
- 7) The NHSP and the California Department of Education submitted a grant application to MCHB to fund parent support for families of infants identified with hearing loss through the NHSP. The application was approved and funded.
- 8) Orientation, training, and technical assistance was provided to the new Bay Area/Coastal HCC contractor to assure continuity of services to infants and hospitals in that region.
- 9) The CMS Branch provided technical assistance and consultation support to HCCs.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CMS Branch will continue participation on Parent Mentor Advisory Council, formerly the Deaf and Hard of Hearing Early Intervention Workgroup, to assist in the implementation of the parent support grant from MCHB.		X		
2. Activities to procure a statewide data management service for the NHSP will continue.		X		
3. Technical assistance and consultation support will continue for all HCCs.		X		
4. The CMS Branch will ensure that all general acute hospitals with licensed perinatal services will participate in the NHSP expansion, effective January 2008.			X	
5. The CMS Branch is revising the NHSP inpatient and outpatient screening provider standards to accommodate the program expansion.				X
6. The CMS Branch is planning regional meetings with staff of the non-CCS approved hospitals to introduce them to the NHSP and the certification process.		X		
7. The CMS Branch collaborates with the California Speech Language Pathology and Audiology Board addressing standards of audiology practice, reporting issues and produces an Audiology Bulletin with timely information about issues of interest to pediatri				X
8. The CMS Branch continues to work with Medi-Cal and its fiscal intermediary to address issues affecting access to				X

outpatient hearing screening and audiology services.				
9.				
10.				

**b. Current Activities**

Current activities include:

- 1) New legislation passed expanding the NHSP to all general acute care hospitals with licensed perinatal services, effective January 2008.
- 2) The CMS Branch is revising the NHSP inpatient and outpatient screening provider standards to accommodate the program expansion.
- 3) The CMS Branch is developing a Request for Proposals (RFP) to incorporate the increased workload and funding for the HCCs and revising the RFP for the data management service to incorporate the program expansion.
- 4) The CMS Branch is planning regional meetings with staff of the non-CCS approved hospitals to introduce them to the NHSP and the certification process.
- 5) The CMS Branch is exploring data sharing approaches with the DDS regarding entry into the early intervention program for infants and toddlers with hearing loss.
- 6) The CMS Branch continues participation with the Deaf and Hard of Hearing Early Intervention Workgroup, the National Initiative for Children's Healthcare Quality (NICHQ) and provides on-site consultation to HCCs.
- 7) The CMS Branch collaborates with the California Speech Language Pathology and Audiology Board addressing standard of audiology practice, reporting issues, and produces an Audiology Bulletin with timely information about issues of interest to pediatric audiologists.
- 8) The CMS Branch continues to work with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing screening and audiology services.

**c. Plan for the Coming Year**

Plans for the coming year include:

- 1) The CMS Branch will continue participation on Parent Mentor Advisory Council, formerly the Deaf and Hard of Hearing Early Intervention Workgroup, to assist in the implementation of the parent support grant from MCHB.
- 2) Activities to re-procure the Hearing Coordination Centers will continue. Orientation activities will be initiated if new contractors are selected.
- 3) Activities to procure a statewide data management service for the NHSP will continue. Implementation activities will commence after contract execution.
- 4) Certification of the non-CCS approved expansion hospitals will begin.
- 5) The CMS Branch will continue participation in the NICHQ learning collaborative.
- 6) The CMS Branch will continue dialogue with the California Speech Language Pathology and Audiology Board addressing standard of audiology practice and reporting issues.
- 7) The CMS Branch plans to develop communication with the statewide audiology association

(California Academy of Audiology) regarding standards of practice and access to pediatric audiology services.

8) The CMS Branch will produce new issues of the Audiology Bulletin to address additional areas of interest to pediatric audiologists.

9) Technical assistance and consultation support will continue for all HCCs.

**Performance Measure 13: Percent of children without health insurance.**

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	16.7	15.5	15.5	12.9	13
Annual Indicator	14.3	13.1	13.1	13.6	13.6
Numerator	1513479	1317215	1323850	1443896	
Denominator	10583770	10055080	10105720	10616890	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	13.5	13.3	13.1	12.9	12.7

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Source: Estimated percent of uninsured children (age 0-18) is from the Kaiser Family Foundation analysis of the March 2005 Current Population Survey. Denominator (estimate of the number of children 18 years of age and younger): State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004. The numerator was derived by multiplying the percent uninsured by the denominator.

**Notes - 2004**

Source: Estimated percent of uninsured children (age 0-18) is from the Kaiser Family Foundation analysis of the March 2005 Current Population Survey. Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California, May 2004. The numerator was derived by multiplying the percent uninsured by the denominator.

**a. Last Year's Accomplishments**

The percent of children in California aged 0-18 who were uninsured declined from 15.7 percent in 2000 to 13.1 percent in 2004, then increased to 13.6 percent in 2005. This 13.6 percent represents almost 1.4 million children. The Healthy People 2010 objective is zero percent uninsured.

California's data for NPM 13 are for children ages 0-18 and are based on the U.S. Current

Population Survey. Estimates derived from the 2005 California Health Interview Survey (CHIS), which utilizes a different survey methodology, produce slightly lower numbers [55]. According to the 2005 CHIS, 1.1 million California children age 0 to 18 (11.3 percent) lacked health insurance coverage all or part of the year in 2005. [56]

Insurance coverage rates depend largely on three sources of coverage: job-based insurance, Medi-Cal and Healthy Families. According to the 2005 CHIS, just over half of children aged 0-18 were covered by job-based health insurance, and one-third were enrolled in California's Medi-Cal and Healthy Families programs [57]. Of California's uninsured children, 429,000 (55 percent) were eligible for enrollment in Medi-Cal or Healthy Families. Another 97,000 uninsured children were eligible for one of the 14 county-based Healthy Kids programs in 2005, but not enrolled. The remaining 219,000 uninsured children were not eligible for these public programs because of their family incomes or lived in counties without a Healthy Kids expansion program. [58]

The number of uninsured children in California could be reduced by more than half if all children eligible for public insurance programs were enrolled. In an effort to decrease the number of uninsured children, a comprehensive outreach and education campaign has been undertaken to increase enrollment in Medi-Cal and HF. Efforts to reduce administrative barriers to enrollment included a shortened joint application for both Medi-Cal and HF, the elimination of quarterly status reports under Medi-Cal, and an on-line enrollment system. Health-e-APP, a web-based HF application, became available in 2003 and has improved speed, accuracy, and consumer satisfaction with the application process.

Through the CHDP Gateway, any child under 19 years old with family income at or below 200 percent FPL (and not already in the MEDS system) is "presumed eligible" for Medi-Cal or HF and is given a temporary Medi-Cal Benefits Identification Card. With this card, a child has access to no-cost, full-scope fee-for-service Medi-Cal benefits for up to 60 days. From July 2003 through December 2006, 2.5 million children were pre-enrolled in the Gateway, and 76 percent requested a joint application for Medi-Cal and HF.

A significant share of California's uninsured, but eligible, children are served by the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Senate Bill (SB) 437, enacted in October 2006, created the WIC Gateway. The WIC Gateway allows parents and caretakers of infant and child WIC applicants to submit a simple electronic application to simultaneously obtain presumptive eligibility for Medi-Cal or Healthy Families and to apply for enrollment to either as well. By targeting locations already serving many of these uninsured children -- such as WIC agencies--and simplifying the enrollment process, the WIC Gateway has the potential for enrolling tens of thousands of uninsured children into Medi-Cal and Healthy Families.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCAH/OFP programs encourage and facilitate enrollment in Medi-Cal and HF via education and assistance efforts.			X	
2. The CMS Branch works to maximize the effectiveness of the Gateway for enrolling eligible children in Medi-Cal or HF.				X
3. CHDP provides information and materials in multiple languages for the Gateway.				X
4. CDHS and MRMIB continue to implement and support improvements in the process of eligibility determination and enrollment for Medi-Cal and HF.		X		
5. DHCS and the WIC Program will conduct a feasibility study report over the next year to determine the viability of the WIC Gateway (established through legislation in 2006) and guide its				X

development and implementation.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

MCAH/OFP programs, including AFLP, BIH, BWSP, and CPSP, encourage and facilitate enrollment in Medi-Cal and HF. Efforts are ongoing and include public awareness media campaigns and other community education efforts.

Local CHDP programs inform new providers about the Gateway and direct these providers to CHDP Gateway resources. Modifications, effective June 1, 2004, revised the Gateway pre-enrollment process allowing the Gateway transaction to identify and "deem" certain infants under one year of age as eligible for ongoing, full scope, no cost Medi-Cal at the time of a CHDP assessment. From February 2005 to December 2006, over 150,000 infants have been "deemed" eligible for full-scope, no cost Medi-Cal as a result of the modified CHDP Gateway pre-enrollment process.

State funding for Certified Application Assistants (CAA) was terminated as of July 2003, due to the state budget crisis. Some CAAs continue working on a county-funded or volunteer basis, and the State continues to provide CAA trainings. CAAs work with families in clinics, community centers, schools, and homes, helping them to navigate the complex eligibility structures of Medi-Cal and HF.

CDPH, DHCS and MRMIB, in collaboration with stakeholders, are responsible for designing, promulgating and implementing the WIC gateway to streamline and expedite health insurance enrollment for children who are served at local WIC agencies.

**c. Plan for the Coming Year**

MCAH/OFP programs, including AFLP, BIH, BWSP, and CPSP, will continue to encourage and facilitate enrollment in Medi-Cal and HF.

The CMS Branch will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and CHDP providers.

DHCS and MRMIB will continue to implement and support improvements in the process of eligibility determination and enrollment for Medi-Cal and HF.

Over the next year, DHCS and the WIC Program will conduct a feasibility study report (FSR). The FSR will determine the viability of the WIC gateway and help guide its development and implementation.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2002	2003	2004	2005	2006
Annual Performance Objective					33.7
Annual Indicator			33.8	33.7	33.7

Numerator			114071	111876	
Denominator			337488	331975	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	33.6	33.6	33.5	33.5	33.4

**Notes - 2006**

Data Source: Centers for Disease Control and Prevention, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for Calendar Year 2005. Table 16C, children age 24-59 months. Overall percent computed by summing percent of children age 24-59 months in the 85th- <95th percentile for Body Mass Index (BMI) plus the percent greater than or equal to the 95th percentile for BMI. The numerator was calculated by multiplying the denominator by this overall percent. Data available at: <http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informationnotices/2006/chdpin06E/pdf/table06C.pdf>. Last accessed on Feb 7, 2007.

In California, PedNSS data are collected from the Child Health and Disability Prevention (CHDP) Program health assessment screening appointments. The CHDP program targets low-income, high-risk children, birth through 19 years of age. CHDP data are collected in medical offices/clinics and recorded on the CHDP Confidential Screening/Billing Report form (PM 160). This form is submitted for payment and program reporting as well as serving as California's data source. These data are transmitted to the CDC for inclusion in the national PedNSS.

**Notes - 2005**

Data Source: Centers for Disease Control and Prevention, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for Calendar Year 2004. Table 16C, children age 24-59 months. Overall percent computed by summing percent of children age 24-59 months in the 85th- <95th percentile for Body Mass Index (BMI) plus the percent greater than or equal to the 95th percentile for BMI. The numerator was calculated by multiplying the denominator by this overall percent. Data available at: <http://www.dhs.ca.gov/pcfh/cms/onlinearchive/pdf/chdp/informationnotices/2005/chdpin05d/contents.htm>. Last accessed on March 28, 2006.

In California, PedNSS data are collected from the Child Health and Disability Prevention (CHDP) Program health assessment screening appointments. The CHDP program targets low-income, high-risk children, birth through 19 years of age. CHDP data are collected in medical offices/clinics and recorded on the CHDP Confidential Screening/Billing Report form (PM 160). This form is submitted for payment and program reporting as well as serving as California's data source. These data are transmitted to the CDC for inclusion in the national PedNSS.

**a. Last Year's Accomplishments**

The 2005 Pediatric Nutrition Surveillance System (PedNSS) revealed that 33.7 percent of children, ages 2 to 5 years, who received WIC services, had a BMI at or above the 85th percentile, similar to the finding of 33.8 percent in 2004.

Prevalence rates differ by race/ethnicity. For 2005, Pacific Islander children were most likely to have a BMI at or above the 85th percentile (47.7 percent), followed by American Indians/Alaska Natives (39.5 percent), Hispanics (35.5 percent), Whites (28.9 percent), African Americans (28.1 percent), Filipinos (28.5 percent) and Asians (26.3 percent).

The MCAH/OFP Branch took the lead in promoting early intervention to reduce childhood obesity. It focused on promoting optimal preconception weight and euglycemia pre-pregnancy, optimal prenatal weight gain and glycemic control in pregnancy, and breastfeeding. These concepts were included in the strategic plan for addressing obesity in California.

The CDC's three priority areas for reducing obesity (increased physical activity, reduced television viewing, and breastfeeding promotion) and the two promising areas (energy balance and five fruits and vegetables per day) have been incorporated into existing MCAH/OFP and CMS programs.

Cholesterol and fasting blood glucose screening tests for children at risk for obesity and/or cardiovascular disease were added as CHDP program benefits this past year.

Approximately 70 percent of MCAH local health jurisdictions are addressing obesity and have anti-obesity strategies; 37 percent have anti-obesity goals and objectives, and 63 percent have an obesity-related coalition. For example, Humboldt County has a North Coast Child Nutrition Task Force that provides networking opportunities for health professionals advocating for reduced obesity and improved activity for young children. Marin County provides nutrition education at a local Latino Community Center, and sponsors a Nutrition Helpline and an interactive exhibit which can be customized to different target populations.

Health departments in mid-size counties, such as Santa Barbara County, are working closely with medical providers to ensure BMI documentation by creating a follow-up system which includes referral and intervention. Health departments in larger counties, such as Santa Clara County, are meeting with local HMOs to share PedNSS data and collaborate on intervention approaches. Five counties have been chosen by The California Endowment to participate in a four-year project to demonstrate Healthy Eating and Active Communities (HEAC).

There are six Healthy Tomorrow grants in California. Topics include: school health, obesity, oral health, SCHIP and medical home. The MCAH/OFP Branch staff provide technical assistance on site visits.

Blue Cross of California and the CHDP program collaborated to provide BMI training for office medical staff including CHDP providers and their staff. One-hour BMI workshop luncheons/dinners were held from May to December 2006 throughout California. CHDP providers were encouraged to use the tools provided at the workshop to measure and document BMI in their medical offices.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Data collection from CHDP nutrition assessments for the Pediatric Nutrition Surveillance System (PedNSS) continues.		X		
2. CHDP program benefits include cholesterol and fasting blood glucose screening tests for children at risk for obesity, the complications of obesity and at risk for cardiovascular disease.			X	
3. State and local CHDP nutritionists develop and implement nutrition education, provide consultation and training to CHDP providers, and coordinate follow-up and referrals to related programs.				X
4. AFLP and the oral health programs are promoting healthy food choices and physical activity.		X		
5. BIH and CPSP promote optimal weight gain in pregnancy and breastfeeding in an effort to reduce the risk of obesity.		X		

6. BIH and AFLP promote proper nutrition by encouraging healthy eating through discussions on how to cut fat and lower calories.		X		
7. CDAPP promotes breastfeeding and optimal nutrition and provides counseling to women to encourage optimal pre-gestational weight, optimal pregnancy weight gain, and glycemic control during pregnancy.		X		
8. MCAH/OFP partners with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent overweight among infants and pre-school aged children.				X
9. MCAH/OFP and CMS Branches collaborate with the California Nutrition Network for Healthy, Active Families to promote healthy eating and a physically active lifestyle among low income Californians.				X
10.				

**b. Current Activities**

Santa Clara's Black Infant Health Program (BIH) and Kaiser Permanente developed and implemented the BIH Wellness Project (Bi-Well). Bi-Well provided participants with skills, strategies, education and resources to improve their nutritional choices and physical fitness. Bi-Well included developing partnerships with the Young Women's Christian Association (YWCA) and a non-profit wellness center to provide clients with additional exercise classes and personal fitness assessments. After 14 weeks, the participants lost weight, increased their knowledge of healthy behaviors and improved their mental health. Santa Clara is currently writing another grant to continue and expand this project.

MCAH/OFP Branch actively participated in the planning of the 2007 Childhood Obesity Conference. Many speakers addressed the need to prevent childhood obesity in the formative years by focusing on prevention during pregnancy, infancy and preschool years. MCAH/OFP facilitated conference sessions, presented two posters and showcased breastfeeding resources at a booth.

**c. Plan for the Coming Year**

The MCAH/OFP Branch continues to collaborate with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent overweight among our youngest, most vulnerable children. One such partnership is with the California Nutrition Network for Healthy, Active Families (Network) which promotes healthy eating and a physically active lifestyle among low-income Californians by using social marketing techniques.

The MCAH/OFP and CMS Branches will continue to participate on the Obesity Prevention Group (OPG), which aims to integrate obesity prevention into CDPH programs, develop an action plan, and obesity-related proposals and plans for funding opportunities.

Similar to previous years, MCAH/OFP and CMS will be a partners in planning for the 2009 California Childhood Obesity Conference.

MCAH/OFP Branch is working with Los Angeles and Sonoma counties on healthy women's weight to address the preconception period as it affects obesity. These counties are developing interventions and informational materials that can be shared with other counties.

MCAH/OFP Branch's approach to preventing overweight among children 2-5 years is to focus on modifying risk factors which are independently related to the later risk of obesity, including risk factors before pregnancy, in-utero, and in infancy.

MCAH/OFP programs, including AFLP, BIH, CDAPP and CPSP, continue to promote healthy

food choices, physical activity and breastfeeding. BIH encourages healthy eating through classes that incorporate meal planning, grocery shopping and stretching supplies. CDAPP will continue to promote breastfeeding and optimal nutrition and provide counseling to women to encourage optimal pre-gestational weight, optimal pregnancy weight gain, and glycemic control during pregnancy.

The CMS Branch continues to collect data from nutrition assessments by CHDP providers for infants, children, and adolescents. In another ongoing activity, state and local CHDP nutritionists develop and implement nutrition education, provide consultation and training to CHDP providers, and coordinate follow-up and referrals to related programs.

The MCAH/OFP Branch will be assessing MCAH resources and supporting efforts in its local health jurisdictions in the areas of policy development, coordination of services and provision of enabling services that are geared towards stemming the epidemic of obesity in children. The MCAH/OFP Branch will continue to provide nutrition, physical activity, and breastfeeding resources and intervention ideas to MCAH Action, which is the self-directed organization of the 61 California MCAH health jurisdiction directors.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					3.4
Annual Indicator			3.4	3.8	3.8
Numerator			18154	20218	
Denominator			530756	532721	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	3.7	3.6	3.5	3.4	3.3

**Notes - 2006**

Source: 2005 Maternal and Infant Health Assessment Survey, Maternal, Child and Adolescent Health/Office of Family Planning Branch, California Department of Health Services. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth that reported whether or not they smoked during pregnancy. Numerator and denominator are weighed to the representative number of resident women in the state who delivered a live birth that year.

**Notes - 2005**

Source: State of California, Department of Health Services, Maternal, Child and Adolescent Health/Office of Family Planning Branch, 2004 Maternal and Infant Health Assessment survey. Survey data weighted to population of mothers who delivered live infants in survey year. Tabulations were done by the MCAH/OFP Branch.

**a. Last Year's Accomplishments**

In 2005, 3.8 percent of women who gave birth reported smoking during the last trimester of pregnancy. Smoking during pregnancy has declined by 33 percent since 1999, when 5.7 percent of women reported smoking during the last three months of pregnancy. This trend is consistent with the continual decline in smoking among all women in California over the past two decades. Most recently, the percentage of all women in California who smoke decreased by 18 percent from 11.1 percent to 9.1 percent between 2005 and 2006. The Healthy People 2010 target is that 99 percent of pregnant women report not having smoked in the 30 days prior to the time they are asked the question. [Data on smoking during pregnancy are from the California Maternal and Infant Health Assessment (MIHA) and include women aged 15 years and older.]

Smoking prevalence during the last trimester of pregnancy differs by racial and ethnic group. White women are most likely to smoke during the last trimester (7.8 percent), followed by African American (7.0 percent) and American Indian/Other women (5.6 percent).

Efforts to reduce and prevent smoking are incorporated into MCAH/OFP programs serving pregnant women. AFLP assists pregnant teens by providing smoking exposure assessment and cessation assistance. To assist African American women, BIH employs a community-based strategy to modify high-risk behaviors including smoking, alcohol use, and drug use, while promoting healthy behaviors and improving access to healthcare services. For women accessing prenatal care through Medi-Cal, CPSP includes smoking cessation as one goal for improving maternal health and birth outcomes.

The decline of smoking in California over the last 20 years is largely attributable to the state's comprehensive tobacco control program, which has included a statewide media campaign, a cessation help line (with tailored counseling for teens and pregnant women), approximately 100 local programs across the state based in local health departments and community based organizations, and the energetic efforts of four ethnic networks. These efforts reduced California's overall cigarette consumption at twice the rate of the nation from 1988 to 2002; played an instrumental part in making almost all indoor workplaces smoke free, including restaurants and bars; and made tobacco less accessible and less socially desirable among youth and adults.

Smoking cessation is part of preconception care. In 2005, the CDC launched the Preconception Care National Health Initiative and convened the Select Panel on Preconception Care in a national summit. The Select Panel developed recommendations and action steps which were published in the Mortality and Morbidity Weekly Reports (MMWR) on April 21, 2006. Building on the impetus set by the CDC, the Preconception Care Council of California (PCCC) was organized in May 2006 with the leadership of the MCAH/OFP Branch and the CA Chapter of the March of Dimes. PCCC is composed of organizations and programs that are stakeholders and decision makers in the development of preconception care services in California.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP assess clients for smoking habits and exposure to second hand smoke and discuss the risks of smoking for the mother and baby during pregnancy and after birth.		X		
2. BIH clients receive education about smoking and health; the BIH Scope of Work includes smoking cessation to reduce low birth weights.		X		
3. CPSP guidelines assist providers and practitioners with health education, nutrition, and psychosocial intervention guidelines; handouts are also available, in English and Spanish, to educate women about smoking cessation.		X		
4. The California Preconception Care Initiative has developed a provider/patient resource packet to assist health care providers;				X

one topic covered is smoking during pregnancy.				
5. Four statewide Priority Population Partnerships addressing the African American, American Indian, Asian/Pacific Islander, and Hispanic/Latino populations conduct culturally specific educational and advocacy campaigns.		X		
6. The California Smokers' Helpline, of the California Tobacco Control Program, provides tailored counseling services for teens, adults, and pregnant women in English, Spanish, Korean, Mandarin, Cantonese, and Vietnamese.		X		
7. The Preconception Care Council of California (PCCC) was developed under the leadership of MCAH/OFP and the CA Chapter of MOD and is composed of organizations committed to creating and providing preconception care services.				X
8. The Los Angeles Collaborative to Promote Preconception/Interconception Care is implementing systematic improvement for accessible perinatal healthcare and resources over the next 2 years.				X
9. The MCAH/OFP website now includes links to the CDPH California Tobacco Control Section's tobacco prevention efforts.				X
10. CDAPP has received CDC funding to train healthcare professionals on the detrimental effects of tobacco use, including second hand smoke on diabetic pregnant women and their unborn children.				X

**b. Current Activities**

AFLP clients are assessed at entry and annually for past smoking habits, current smoking habits, and exposure to second hand smoke. Case managers discuss the risks of smoking for the mother and baby during pregnancy and after birth.

BIH clients, individually or in small groups, receive education about smoking and health. The BIH Scope of Work includes smoking cessation to reduce low birthweight rates.

CPSP guidelines "Steps to Take" assist providers and practitioners with health education, nutrition, and psychosocial intervention guidelines. "Camera ready" handouts, in English and Spanish, are available for CPSP to educate women about smoking cessation.

The CDPH Tobacco Control Section supports multiple statewide, regional, county, and community smoking cessation projects. Each of the 61 health jurisdictions involves a community coalition to engage in community mobilization to promote social norm changes and educate the public about health and tobacco use as well as tobacco industry strategies that promote tobacco use. The MCAH/OFP website now includes links to the Tobacco Control Section's tobacco prevention efforts.

The California Smokers' Helpline provides intensive tobacco cessation counseling, which includes tailored counseling for teens, adults, and pregnant women. Perinatal Services Coordinators from local MCAH health jurisdictions have consulted with educational experts at the Helpline for outreach educational materials.

**c. Plan for the Coming Year**

The Los Angeles Collaborative to Promote Preconception/Interconception Care will continue to lead a multi-phased two-year action plan "Healthy Births through Healthy Communities: A Commitment to Action" to implement systematic improvements for accessible perinatal healthcare and resources. The LA County Collaborative is comprised of the LA County MCAH Programs, LA Best Babies Network (LABBN) and the local chapter of MOD. The Collaborative has gained key commitments from healthcare leaders and community based organizations and is

promoting understanding of the importance of, and need for preconception/interconception care.

The California Smokers' Helpline will continue to provide intensive tobacco cessation counseling via the telephone and access to materials through its website. The California Tobacco Control Section will continue its seven statewide Priority Population Partnerships addressing the issue of tobacco control with California's African Americans, American Indians, Asian/Pacific Islanders, Hispanics/Latinos, labor union members, people of low socio-economic status, and the lesbian, gay, bisexual and transgender community.

The California Diabetes Program has received special funding from the CDC to present a proactive project to healthcare providers and diabetic educators. Through their "Do You CAARD?" presentation and campaign, they provide compelling information about how tobacco use, including second hand smoke, increases insulin resistance and increases diabetes-related complications. The campaign includes a gold TAKE CHARGE card to be handed out to encourage use of the California Smokers Helpline. There are plans to include this presentation at an MCAH/OFP Branch meeting later this year.

AFLP, BIH, and CPSP will continue their activities related to smoking assessment, education, and cessation support for pregnant women. Local health jurisdictions will continue their smoking cessation activities, including outreach, education, referrals, data collection, and data analysis.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	5.4	4.7	4.6	4.8	5.6
Annual Indicator	4.7	5.0	5.7	4.8	4.8
Numerator	120	131	153	132	
Denominator	2560575	2617630	2689492	2762949	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	4.7	4.7	4.6	4.6	4.5

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Source Data: Numerator: State of California, Department of Health Services, Center for Health Statistics, 2005 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 331-337). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch. Data are provisional due to the need for the Center for Health Statistics to verify the Cause of Death coding for approximately 1% of total California deaths reported in the 2005 Death Statistical Master File.

**Notes - 2004**

Source: Numerator: State of California, Department of Health Services, Center for Health Statistics, 2004 California Death Statistical Master File (ICD-10 Group Cause of Death Codes 331-337). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

**a. Last Year's Accomplishments**

The rate of suicide deaths among California youth declined between 1990 and 1998, from 9.2 to 6.3 per 100,000 youth. Between 1999 and 2005, the rate fluctuated around 5.0. In 2005, the rate was 4.8.

Suicide is one of the leading causes of death among American youth, and California is looking at ways to improve adolescent mental health. The Adolescent Health Collaborative (AHC), a broad-based, statewide group with representatives of the public and private sectors, identified the need for a comprehensive plan for addressing the health and developmental needs of California's adolescents. In response to this need, the MCAH/OFP Branch contracted with staff of NAHIC to develop a strategic plan to address adolescent health in 2001. The document provided background information and recommendations for future directions for the local adolescent health programs in California.

Due to Title V budget cuts in FY 2005-06, the contract with AHC for adolescent health improvement was eliminated; it is being reinitiated in 2008 with redirected funding.

The MCAH/OFP Branch collaborated with the Medi-Cal Managed Care (MCMC) Division on their Interagency Work Group for the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP) Project, which ended at the end of 2006. BEST-PCP focused on a discrete set of policy and structural issues at the state and county levels to facilitate meaningful change at the practice level. The project developed and implemented a model for changing provider practice as the basis for broader collaborative quality improvement efforts. The target population was age 0-3 years. By addressing the behavioral, emotional, and social health of very young children, this model has the potential for improvements in social, emotional, and mental health of children as they get older.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. AFLP providers assess adolescent clients for suicide risk and other mental health needs on an ongoing basis.		X		
2. AFLP case management strategies include both youth development and risk reduction activities and services.		X		
3. MCAH Branch works with the Adolescent Health Collaborative and other key partners to promote best practices in mental health and suicide prevention. This includes particular attention to the foster youth population.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

In California and across the country there is increasing recognition of the importance of promoting mental health and of early detection and treatment of mental health problems. MCAH/OFP programs play an important role in identifying mental health needs, intervening before mental health problems become debilitating, and facilitating access to integrated, comprehensive treatment.

The following MCAH/OFP programs include a mental health component: CPSP, BIH, AFLP, DV, CDAPP, and local MCAH programs. All include assessment and referral, and some include treatment as well.

In the fall of 2004, California voters passed the Mental Health Services Act (MHSA), which imposes a one percent tax on annual incomes in excess of \$1 million. The funds, which total about \$750 million a year, are distributed by the Department of Mental Health to counties. Distribution of the funds has now begun, and the availability of county mental health services is gradually improving. The first counties to receive MHSA grants were Stanislaus, Mendocino and Los Angeles. Grants to other local jurisdictions have followed. Services planned and/or implemented to date have focused on the needs of teens and families, and have improved the ability of local MCAH staff to match client needs to available resources.

**c. Plan for the Coming Year**

The MCAH/OFP Branch will continue to look for opportunities to incorporate positive youth development into its programs and coordinate with others in the State to work to increase the assets of our youth. The MCAH/OFP Branch will continue to work with AHC and others to promote best practices in mental health and to investigate best practices in suicide prevention. This will include particular attention to the foster youth population.

The MCAH/OFP Branch will work to maintain and improve appropriate linkages between the Department of Alcohol and Drug Programs (ADP), the Department of Mental Health (DMH), the Department of Rehabilitation, the Department of Social Services (DSS), Medi-Cal, Office of Emergency Services (domestic violence), and the Department of Health Services to address systemic barriers and create pathways to service delivery. The Branch will also continue to promote providers' screening, assessment, education, and referral to treatment and services for adolescent clients at risk of alcohol use, drug abuse, domestic violence, depression, and stress.

The MCAH/OFP Branch will continue to support and promote the incorporation of mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of the MCAH population within their boundaries. As a result of MHSA funding, it is anticipated that services for adolescent clients with mental health or behavioral health issues will expand, and that access to care will be improved.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	66.6	68.7	69.6	68.5	68.2
Annual Indicator	68.7	67.3	68.0	67.1	67.1
Numerator	3911	3970	4360	4546	
Denominator	5697	5900	6411	6770	
Check this box if you cannot report the numerator because					
1. There are fewer than 5 events over the last year,					

and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	67.2	67.5	67.8	68.1	68.4

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005 data.

**Notes - 2005**

Source: State of California, Department of Health Services, Center for Health Statistics, 2005 California Birth Statistical Master File and California Children Services, Approved Hospitals for NICUs as of Jan. 30, 2006. Tabulations, by place of occurrence, were done by the MCAH/OFP Branch.

**Notes - 2004**

Source: State of California, Department of Health Services, Center for Health Statistics, 2004 California Birth Statistical Master File and California Children Services, Approved Hospitals for NICUs (2004). Tabulations, by place of occurrence, were done by the MCAH/OFP Branch.

**a. Last Year's Accomplishments**

NPM 17, the percent of Very Low Birth Weight (VLBW) infants delivered at facilities for high-risk deliveries and neonates, increased steadily from 64.6 percent in 1998 to 68.0 percent in 2004. It decreased to 66.8 percent in 2005 and is still far short of the Healthy People 2010 objective of 90 percent.

There is some variation by race/ethnicity in the percent of VLBW infants delivered at facilities for high-risk deliveries/neonates. It is lowest for American Indians (54.8) and highest for Pacific Islanders (76.5). African Americans, Asians, Whites and Hispanics were close to the state rate (69.9, 69.4, 67.5 and 64.9, respectively).

The California figures are based on data from hospitals designated by the CCS program as Regional or Community NICU facilities. There are currently 118 CMS-approved NICUs in California. However, not all facilities providing care for VLBW infants seek certification by CCS.

The fourteen Regional Perinatal Programs of California (RPPC) provide planning and coordination to ensure that all high-risk patients are matched with the appropriate level of care. The RPPC develops communication networks, disseminates education materials, assists hospitals with data collection for quality improvement, and provides hospital linkages to California's Perinatal Transport Systems (CPeTS).

Based on information from the 2004-2005 RPPC statewide survey, the RPPC and CCS developed strategies to improve inter-hospital transport of high-risk pregnant women and newborns to hospitals with high-risk services. A tool kit, "Agreements for Provision of Perinatal and Neonatal Care: A step-by-Step Guide", was developed in 2006 to assist hospitals with transfer/transport agreements, policy development, outreach education, and review of outcome data.

Other recently completed RCCP Toolkits are: "Neonatal Hyperbilirubinemia; Screening, Assessment, Management & Prevention of Kernicterus" and "The Late Preterm Infant: Assessment, Management & Prevention of Morbidity and Mortality". These toolkits were developed by Workgroups of the Community Perinatal Network & Orange County Perinatal Council for RPPC.

The MCAH/OFP Branch has two data projects which monitor perinatal outcomes: the Improved Perinatal Outcome Data Reports (IPODR) (<http://datamch.berkeley.edu/>) and the California Perinatal Profiles (<http://perinatalprofiles.berkeley.edu/>). The IPODR website includes an annual county profile report based on California Birth/Death Vital Statistics and Hospital Discharge Data aggregated at the zip code level. The California Perinatal Profiles website provides both public (state and regional) and confidential (hospital specific) data to aid quality improvement in maternity hospitals in California.

In an effort to improve data collected from the birth certificates, RPPC and the Office of Vital Records hosted a series of regional training for birth clerks in 2006. The turnover of birth clerks makes this an ongoing need. RPPC will convene a group to produce a Birth Clerk - Birth Certificate Toolkit.

CPQCC has convened a Perinatal Transport Sub-committee to develop and implement a web-based perinatal transport data collection system. The Sub-committee includes an expert panel of providers with experience in perinatal transport to identify data elements that will provide useful information and guide perinatal transport quality improvement processes. The team has developed a new data collection tool kit, which was pilot-tested and is being implemented statewide as of January 1, 2007. The data, which will be collected and reported through CPQCC, will be valuable for transport quality improvement as well as perinatal disaster preparedness.

Beginning in May 2006, MCAH/OFP and the Emergency Preparedness Office (EPO) have been collaborating to develop a Perinatal Disaster Preparedness Plan. This project assesses existing systems and works to improve the coordination of triage for hospitalized women and newborns during disaster.

In February and March 2007, representatives from Northern and Southern CPeTS participated in emergency preparedness planning by attending "Development of Standards and Guidelines for Health Care Surge During Emergencies" lead by Pricewaterhouse/Coopers in collaboration with the EPO. Information regarding CPeTS was shared at these meetings.

CMQCC will identify and validate appropriate indicators that will be used to guide quality improvement projects for maternal, perinatal and neonatal care in California.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The fourteen Regional Perinatal Programs of CA (RPPC) provide regional planning and coordination and ensure that the needs of high-risk patients are matched with the appropriate level of care.				X
2. The CA Perinatal Transport Systems (CPeTS) assist in the referral of high-risk pregnant women and newborn infants by providing bed availability status for regional CCS approved NICUs, updated daily, on the CPeTS website.		X		
3. RPPC and CPeTS assist hospitals with data collection and quality improvement activities.				X
4. MCAH and the Emergency Preparedness Office (EPO) are collaborating to develop a Perinatal Disaster Preparedness Plan.				X
5. RPPC will work with EPO and Licensing and Certification in proposing revisions for emergency situations to some sections of Title 22 regulations.				X
6. The CPQCC reports on neonatal care for hospital/NICU members of CPQCC, providing CCS a useful and uniform				X

reporting scheme for comparative assessment of hospitals on level of care for neonates.				
7. The Improved Perinatal Outcome Data Reports (IPODR), which include county profiles and other reports, provide information on which to base health planning and allocation decisions, and evaluation of these decisions.				X
8. The California Perinatal Profiles website provides both public (state and regional) and confidential (hospital specific) data to aid continuous quality improvement to all maternity hospitals.				X
9. RPPC will convene a group to produce a Birth Clerk-Birth Certificate Tool Kit for hospitals to address the educational training needs of birth clerks due to the high turnover rate.				X
10. RPPC /CMS continue to host trainings through 2007 on a toolkit to assist hospitals with transfer/transport agreements, policy development, outreach education, and review of outcome data.				X

**b. Current Activities**

The RPPC and CPeTS continue their work in matching high-risk patients with the appropriate level of care. Bed availability for regional neonatal intensive care units, updated daily, is reported on the CPeTS website ([www.perinatal.org](http://www.perinatal.org)). CPeTS also facilitates meetings of the Regional Transport Quality Improvement Committees.

The RPPCs review all birth outcomes data, including IPODR and Perinatal Profiles data, with each hospital in their region to identify areas for improvement. RPPCs also provide technical assistance for implementation of the CPQCC toolkits to perinatal providers. The RPPCs, with the CDHS Office of Vital Statistics, convene regional meetings with local Birth Clerk and County Registrars to improve the collection of data on birth certificates.

The CMS Branch continues to collaborate with CPQCC in retrieval, analysis and development of NICU data for CCS-approved NICUs. This collaboration offers CCS a useful, uniform reporting scheme for comparative assessment of hospitals for level of care provided for neonates. All CCS-approved NICUs are now required to submit data annually to CPQCC. The number of CPQCC member hospitals has increased from 80 in May 2004 to over 120 in May 2006.

The RPPC Branch Nurse Consultant participates with representatives from EPO and Licensing and Certification to review Title 22 of the California Code of Regulations and purpose revisions specific to emergency preparedness and response.

**c. Plan for the Coming Year**

The RPPC and CPeTS will continue their work in the areas of regional planning and coordination, matching the transport of high-risk patients with the appropriate level of care, and assisting hospitals with data collection and quality improvement activities surrounding these patient transfers. RPPC will convene a workgroup to develop a Birth Clerk -- Birth Certificate Toolkit to improve the collection of data on birth certificates. Once developed, it will be disseminated to birthing hospitals across the state.

The tool kit, "Agreements for Provision of Perinatal and Neonatal Care: A Step-by-Step Guide" was completed in 2006 and is being disseminated through seven Regional Cooperative Agreement Workshops in 2007. These workshops are hosted by RPPC in collaboration with CMS.

CPSP will continue to strengthen ongoing collaboration between CPSP providers and Sweet Success, affiliates of the CDAPP, to ensure that CPSP clients, who have diabetes or who develop gestational diabetes have access to expert care in diabetes management.

The CMS Branch and CPQCC will continue to 1) respond to CPQCC membership questions, and 2) review data element selection in an effort to decrease any unnecessary data element collection for hospitals. The CMS Branch will continue to analyze CPQCC data reports for CCS-approved NICUs, addressing outliers and concerns about quality of care. The MCAH/OFP and CMS Branches will continue participation on the CPQCC Executive Committee and the Perinatal Quality Improvement Panel (PQIP). (The PQIP is an executive subcommittee of CPQCC which oversees data analysis and quality improvement efforts.)

The CMS Branch has begun and will continue collaboration with CPQCC to develop a plan to monitor outcomes of infants/children in the newly restructured High Risk Infant Follow-up program. This monitoring capability, coupled with perinatal/neonatal CPQCC data elements, will enable the Branch to assess outcomes in association with perinatal/neonatal care.

MCAH/OFP will continue to collaborate with CPQCC and CPeTS to develop an electronic data system, which allows tracking of transfers, comparisons of maternal versus neonatal transports, and monitoring of outcomes.

The RPPC Branch Nurse Consultant will work with a group from OEP and Licensing and Certification to propose revisions to sections of Title 22 regulations for responding to emergencies.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	85.9	87.4	88.4	89.4	87.1
Annual Indicator	86.5	87.3	87.1	86.6	86.6
Numerator	448955	464157	466463	470955	
Denominator	519307	531508	535633	544118	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	86.7	86.9	87.1	87.3	87.5

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005 data.

**Notes - 2005**

Source: State of California, Department of Health Services, Center for Health Statistics, 2005 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH/OFP Branch. Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

**Notes - 2004**

Source: State of California, Department of Health Services, Center for Health Statistics, 2004 California Birth Statistical Master File. Tabulations (by place of residence) were done by the

MCAH/OFP Branch. Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

**a. Last Year's Accomplishments**

Improving access to first trimester prenatal care has been a long-term MCAH/OFP priority. California made steady progress on NPM 18 between 1998 and 2003, with the rate increasing about one percentage point a year. NPM 18 was down slightly in 2004, at 87.1 percent, compared to 87.3 percent in the previous year, and decreased again slightly to 86.6 percent in 2005. The Healthy People 2010 objective is 90 percent.

Although the rate was down slightly across all racial/ethnic groups in 2005, women in two racial/ethnic groups still met or exceeded the statewide annual objective for 2005. White and Asian women were more likely to receive prenatal care in the first trimester (90.2 percent and 89.5 percent, respectively) than women who were Hispanic (84.5 percent), African American (82.9 percent), American Indian (74.9 percent), or Pacific Islander (74.1 percent).

Several strategies have been used in California to improve prenatal care utilization, including expansion of Medi-Cal eligibility criteria, improved access to Medi-Cal through presumptive and continuous eligibility, a waived assets test, and reduced application paperwork. These were accomplished in California in the late 1980s.

CPSP, AFLP, BIH, WIC, and the American Indian Infant Health Initiative (AIHI) support improvements in adequate prenatal care through direct and indirect delivery of services and support. The programs provide case management services and linkages to medical care for their target populations. CPSP provides perinatal support services to approximately 165,000 women a year, and reimbursement to the 1500 active CPSP providers is more than \$88 million/year.

The primary goal of the BIH program is to reduce barriers to care. In addition to case management, the BIH staff collaborates with obstetricians and family practitioners in activities such as "Adopt A Doctor" in Pasadena and "Doctors in the House" in Sacramento County to improve access for at risk African American pregnant women. Mentor programs such as "Sister-Friends" and the "Angel Club" in Pasadena provide support to encourage BIH clients to keep medical appointments.

The MCAH/OFP Branch works to provide ethnically diverse staff for recruiting clients into care, and local MCAH jurisdictions employ a variety of methods to target diverse populations. The MCAH program in Orange County works with Latino Health Access, a local non-profit organization, to operate the Promotores Program. Promotores are highly trained community health workers, recruited and hired from the communities where they live, who provide wellness education and act as role models for their peers. Promotores, in conjunction with public health professionals, work with pregnant Hispanic women and their families to promote early prenatal care and access to other appropriate healthcare services.

It is estimated that about 40 percent of all births in California are unintended. [59] California's Family PACT Program provides no-cost family planning services to all California residents with incomes at or below 200 percent of the federal poverty level, and, insofar as these services help to reduce the rate of unintended pregnancy, they also contribute indirectly to increased utilization of prenatal care.

In spite of efforts to increase the number of women who receive prenatal care in the first trimester, the following obstacles remain: delays due to lack of awareness of Medi-Cal Presumptive Eligibility Program, delays due to the Medi-Cal enrollment process, and high rates of unintended pregnancy.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The CPSP provides Medi-Cal eligible women with prenatal care, health education, and support services.		X		
2. The BIH program identifies pregnant and parenting African American women who are at risk for poor birth outcomes and provides them assistance in accessing and maintaining health care and other support services.		X		
3. The AFLP provides case management services to pregnant adolescents at risk of poor birth outcomes; services include nutritional and prenatal counseling and assisted referral for prenatal and other medical services.		X		
4. The AllHI serves prenatal and parenting American Indian women with direct health care services and case management services.	X			
5. The MCAH/OFP Branch works to provide ethnically diverse staff for recruiting clients into care, and local MCH jurisdictions employ a variety of methods to target diverse populations.		X		
6. The Family PACT Program provides no-cost family planning services to low-income residents; these services help to reduce the rate of unintended pregnancy, and contribute indirectly to increased utilization of prenatal care.		X		
7. The Preconception Care Council of California plays a pivotal role in relaying the message of the importance of preconception care to local communities.				X
8. Local Health Jurisdictions collaborate with schools to assure the incorporation of prenatal care essentials into curricula for local schools, nursing schools and medical residency programs.		X		
9.				
10.				

**b. Current Activities**

CPSP, AFLP, WIC, BIH, and AllHI continue to provide case management services and linkages to medical care for their target populations.

Through participation in CPSP, providers receive a bonus for each woman receiving three assessments and the initial pregnancy office visit provided within the four weeks of entry into care, and CPSP providers are eligible for payment of one additional obstetrical visit to ensure continuity of care for each CPSP patient.

The MCAH/OFP Branch is working on consolidating data (beneficiaries, paid claims, birth outcomes, and hospital discharge data) to develop baseline data on the efficacy of CPSP services.

Community Health Workers from the BIH program provide services for pregnant African American women. Through outreach, educational classes and home visits they provide assessment, education and linkage to services.

The Preconception Care Council of California is playing a pivotal role in relaying the message of the importance of preconception care to local communities.

California's Family PACT Program continues to provide no-cost family planning services to all California residents with incomes at or below 200 percent of the federal poverty level.

Local Health Jurisdictions have also collaborated with schools to assure the incorporation of

prenatal care essentials into curricula for local schools, nursing schools and medical residency programs.

**c. Plan for the Coming Year**

CPSP, AFLP, WIC, BIH, and AllHI will continue to provide case management services and linkages to medical care for their target populations.

Plans for the coming year for CPSP include continuing provider recruitment; monitoring and strengthening the utilization of CPSP's scope of benefits through provider and practitioner training, including documentation training; material development; and development of evaluative reports on the efficacy of services. In addition, CPSP is in the process of identifying the socio-demographic and medical-diagnostic characteristics of its client populations and their patterns of service utilization that will help in future program planning and administration. These activities are undertaken in an effort to ensure the availability and effectiveness of CPSP services, even in this era of budget constraints, and to achieve improvements in first trimester entry into prenatal care.

**D. State Performance Measures**

**State Performance Measure 1:** *The percent of children birth to 21 years enrolled in the CCS program who have a designated medical home.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					50
Annual Indicator				57.9	76.4
Numerator				92903	123748
Denominator				160499	162023
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	70	70	70	70	70

**Notes - 2006**

This measure is the percent of children birth to 21 years enrolled in the CCS program who have a designated medical home.

The data are from CMS Net data for 56 counties and data from local county CCS programs for the remaining 2 counties for FY 2006-07.

**Notes - 2005**

This measure is the percent of children birth to 21 years enrolled in the CCS program who have a designated medical home.

The data are from CMS Net data for 55 counties and data from local county CCS programs for the remaining 3 counties for FY 2005-06.

**a. Last Year's Accomplishments**

SPM 01 was a new California State Performance Measure in 2006.

SPM 01 is 76.4 percent in FY 2006-2007. There has been an increase of 32 percent since 2005-2006. It is believed that this increase is due to improved reporting of this indicator. County CCS programs assessed whether CCS eligible children had a documented primary care physician/medical home and worked at improving this documentation.

This measure is from a field on CMS Net for "medical home", and from a data system field for LA and Sacramento Counties (not on CMS Net). This SPM is similar to the National Performance Measure (NPM) 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. NPM 03 is from the CSHCN Survey for California and is a different population than the CCS program.

Currently the CCS program is interchanging terminology for medical home and primary care physician (PCP) in the data captured for this measure. The aim is to work on the data definition and the data collected so that ultimately the field "medical home" will reflect where the child, enrolled in the CCS program, receives comprehensive and coordinated, ongoing medical care. This is a goal for the coming years as this change will take time. As the definition is refined, the anticipation is that the percent of CCS enrollees with medical homes may actually decrease for a few years since some previously designated PCPs will not meet the criteria for providing a medical home. Also, LA County receives a direct transfer of data from Medi-Cal Managed Care plans regarding the medical home/PCP for each child. When LA County converts to CMS Net in 2007, this direct transfer will no longer occur, resulting in a decrease in the number of medical homes/PCPs reported.

The Healthy People 2010 Objective is that every child with special health care needs will receive comprehensive care in a medical home and though this is probably not attainable in this timeframe, the CCS program does have a goal to eventually reach this objective. The CMS stakeholder group for developing the strategic plan for the Title V Needs Assessment identified having a medical home for children enrolled in the CCS program as one of the top three state priorities over the next five years. The priority is to increase the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.

CCS has been collaborating with Children's Hospital Los Angeles (CHLA) and the CA Epilepsy Foundation on a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA; one of the goals of the project is to improve access to health and other services and support related to epilepsy by facilitating development of medical homes for medical care for children and youth (0-18) with epilepsy in CA, especially those residing in medically underserved areas.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to work on data definition and the data collected for the field CMS Net "medical home" field to reflect where the child receives comprehensive and coordinated, ongoing medical care.				X
2. Work continues developing policy for CCS regarding the medical home for CCS clients, authorization of the medical home, including phone consultation and care coordination.				X
3. Continue to collaborate with CHLA on the grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in California.		X		
4. Work continues on a policy letter for CCS regarding the medical home for CCS clients, particularly authorization of the medical home and ramifications of this authorization.				X
5. There will be continued evaluation by county CCS programs of whether children in the CCS program have a medical home and how to improve on this part of a performance measure regarding effective case management.				X
6.				

7.				
8.				
9.				
10.				

**b. Current Activities**

1. Collaboration continues with CHLA on the grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA.
2. Work continues on utilizing the Federal MCHB grant awarded to the USC's UCEDD at CHLA for collaboration with CRISS, CMS Branch, and FVCA to implement the strategies around increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.
3. Work continues on a policy letter for CCS regarding the medical home for CCS clients, particularly authorization of the medical home and ramifications of this authorization.
4. Evaluation continues by county CCS programs to determine if children in the CCS program have a medical home and how to improve on this part of a performance measure regarding effective case management.

**c. Plan for the Coming Year**

Plans for the coming year include:

1. Continue to collaborate with CHLA on the grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy in CA.
2. Continue to work with USC's UCEDD at CHLA in collaboration with CRISS, CMS Branch, and FVCA to implement the strategies around increasing the number of FCC medical homes for CSHCN and the number/percent of CCS children who have a designated medical home.
3. Continue to develop a policy letter for CCS regarding the medical home for CCS clients, particularly authorization of the medical home, including phone consultation for care coordination, billing codes, and ramifications of this authorization.
4. Continue evaluation by county CCS programs to determine if children in the CCS program have a medical home and how to improve performance regarding effective case management.
5. Work on identifying children with a true medical home, and not just a PCP, will begin this year.

**State Performance Measure 2:** *The ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					0
Annual Indicator				0.0	0.0
Numerator				137	130
Denominator				67267	70365
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>

Annual Performance Objective	0	0	0	0	0
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**Notes - 2006**

This measure is the ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.

The data is from CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2006-07.

The result is a ratio for 2006 of 1:475. The annual indicator for 2008 and 2009 is 1:540. The indicator for 2010 and 2011 is 1:500.

**Notes - 2005**

This measure is the ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.

The data is from CCS program listing of approved providers at Cardiac Special Care Centers and CCS ICD 9 codes for cardiac and cardiac related diagnoses for FY 2005-06.

The result is a ratio for 2005 of 1:491. This is the annual indicator for 2006, 2007, 2008; the indicator is 1:475 for 2009 and 2010.

**a. Last Year's Accomplishments**

SPM 02 is a new California State Performance Measure in 2006.

SPM 02 is 1:541 for FY 2006-07. This is the second year for this measure and there is a 5 percent decrease in the number of cardiologists and a 5 percent increase in the number of children being seen by these cardiologists. SPM 02 addresses provider capacity for the CCS program for the subspecialty of pediatric cardiologists. There are growing concerns over the shortage of pediatric subspecialty care providers throughout the state, and particularly for CSHCN with complex medical conditions. The subspecialty of pediatric cardiologists has been selected for this measure because children with diagnoses related to congenital heart disease make up the largest group of children enrolled in CCS, and because it is perceived that pediatric cardiologists are decreasing in numbers throughout the state. Some reasons for the latter include that the pool of pediatric cardiologists in the country is insufficient, and recruiting to California is difficult due to the high cost of living, lower salaries, and lower reimbursement.

The ratio for this measure was obtained by determining the number of active cases in CMS Net with any of the following cardiac ICD-9 codes: 390.0 through 429.9, 440.0 through 448.9, 745.0 through 747.9, 780.2, 785.0 through 785.3, and 786.50 through 786.51. This number (28146) was extrapolated for LA and Sacramento Counties. The assumption was then made that CCS cases represent approximately 40 percent of pediatric cardiologists' caseloads. Hence, pediatric cardiologists are responsible for an estimated 70,365 children birth to 14 years of age in California. The number of pediatric cardiologists at all the CCS approved Cardiac Special Care Centers was then determined (130) and the ratio obtained of one pediatric cardiologist per 541 children birth to 14 years of age.

Because internists specializing in cardiovascular diseases are seeing an unknown number of the children 14 years and older, the CCS children 14 to 21 years with cardiac ICD-9 codes were not included. Some pediatric cardiologists continue to see an unknown number of these children 14 years and older, making the ratio of 1:541 an underestimate of the caseload. A benchmark for this ratio has not been found in the literature.

Work was finalized on identifying the activities that will be needed over the next few years to attain the objectives for the goal of expanding the number of qualified providers participating in the CCS program.

The CMS Branch worked with the state expert committee, the CMS Cardiac Technical Advisory Committee, and its chairperson, to ascertain the best methodology for determining this performance measure.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain and strengthen the provider network for CSHCN.				X
2. Improve CCS program capacity to serve older teens and YSHCN who are transitioning to adult services.				X
3. Advocate for enhanced physician training regarding CYSHCN.		X		
4. CMS will work on a method to annually update the core team members the Pediatric Cardiac Special Care Centers so that the CMS Branch can best evaluate the numbers of pediatric subspecialty physicians in the state available to CSHCN.				X
5. Explore strategies used by other states that have successfully attracted and retained pediatric and sub-specialty providers.		X		
6. Collaborate with the AAP, Children's Specialty Care Coalition, the CCS Transition Workgroup, and other partners in order to evaluate and implement strategies to address provider capacity.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

Administer the Federal MCHB grant awarded to USC's University Center for Excellence in Developmental Disabilities (UCEDD) at CHLA for collaboration with CRISS, CMS Branch, and FVCA to implement the objectives through identified activities for the goal of expanding the number of qualified providers participating in the CCS program. Strategies used by other states to attract and retain pediatric and sub-specialty providers will be explored. Implementation plans and evaluation tools will also be developed in a collaborative method. Collaboration will continue with the state CMS expert committee and the Cardiac Technical Advisory Committee, to analyze this performance measure and to explore ways to increase provider capacity.

**c. Plan for the Coming Year**

1. CMS will work on a method to annually update the core team members of CCS approved Special Care Centers, particularly the Pediatric Cardiac Special Care Centers so that the number of active pediatric cardiologists is accurate and the CMS Branch can best evaluate the numbers of pediatric subspecialty physicians in the state available to CSHCN.
2. Continue to work with USC's University Center for Excellence in Developmental Disabilities (UCEDD) at CHLA in administering the Federal MCHB grant awarded for collaboration with CRISS, and FVCA to implement the objectives through identified activities for the goal of expanding the number of qualified providers participating in the CCS program.
3. Explore strategies used by other states to attract and retain pediatric and sub-specialty providers. Implementation plans and evaluation tools will also be developed in a collaborative method.
4. Continue to collaborate with the state CMS expert committee and the Cardiac Technical

Advisory Committee, to improve on the methodology for determining the ratio for this performance measure if possible, and to explore ways to increase provider capacity.

**State Performance Measure 3:** *The percent of women, aged 18-44 years, who reported 14 or more “not good” mental health days in the past 30 days (“frequent mental distress”).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					13.6
Annual Indicator			13.7	12.9	12.9
Numerator			941842	877547	
Denominator			6858643	6822505	
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	12.8	12.7	12.6	12.5	12.4

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Source: California Department of Health Services, California Women’s Health Survey (CWHS), 2005. Numerator: Number of women, 18-44 years of age, who reported 14 or more not good mental health days in the past 30 days. Denominator: Number of women, 18-44 years of age, reporting the number of not good mental health days. Numerator and denominator were weighted using the California Department of Finance population data for 2000 (file name Race/Ethnic Population with Age and Sex Detail, 2000-2050).

**Notes - 2004**

Source: California Department of Health Services, California Women’s Health Survey (CWHS), 2004. Numerator: Number of women, 18-44 years of age, who reported 14 or more not good mental health days in the past 30 days. Denominator: Number of women, 18-44 years of age, reporting the number of not good mental health days. Numerator and denominator were weighted using the California Department of Finance population data for 2000 (file name Race/Ethnic Population with Age and Sex Detail, 2000-2050).

**a. Last Year's Accomplishments**

SPM 03, the percent of women, aged 18-44 years, who reported 14 or more "not good" mental health days in the past 30 days, became a new California State Performance Measure in 2006.

After fluctuating between 13.7 and 15.7 percent between 1999 and 2004, SPM 03 was down to 12.9 percent in 2005, indicating a possible downward trend.

In California and across the country there is increasing recognition of the importance of promoting mental health and of early detection and treatment of mental health problems. MCAH/OFP programs play an important role in identifying mental health needs, intervening before mental health problems become debilitating, and facilitating access to integrated, comprehensive treatment.

The following MCAH/OFP programs include a mental health component: CPSP, BIH, AFLP, DV, CDAPP, and local MCAH programs. All include assessment and referral, and some include treatment as well.

In March 2006 the Black Infant Health Collaborative of Southern California met to discuss psychosocial risks, including depression, domestic violence, substance abuse, grief, and parental

attitudes toward their infant. Their conclusion was that community resources for mental health services were limited, and that this was an area of concern both then and into the future.

Since the inception of the California Mental Health Services Act (MHSA) in January 2005, implemented as a result of Proposition 63 which imposes a one percent tax on incomes in excess of \$1 million, the availability of mental health services for the MCAH population in the local health jurisdictions is gradually improving. The first counties to receive grants from the California Department of Mental Health were Stanislaus, Mendocino and Los Angeles. Grants to other LHJs have followed. While the grants are not specifically administered by MCAH programs within the counties, services planned and/or implemented to date have focused on the needs of teens and families, and have improved the ability of local MCAH staff to match client needs to available resources.

Further efforts and collaborations at the county and regional level have occurred as a result of the MHSA. Marin County had identified maternal depression as a priority area and devoted Title V augmentation funds to the issue. The county contracted with a local agency to provide a parenting support group, in-home visits and bilingual psychotherapy for women referred by the CPSP program who were experiencing postpartum depression. Marin County continued to address the mental and behavioral health needs of its citizenry, incorporating an increasing emphasis on the MCAH population into its strategic plan.

The City of Pasadena, in conjunction with a local junior college, had researched and developed a project intended to establish the Pasadena Youth Radio. The project addressed the goals of improving adolescent health and mental health by providing a venue for teens to creatively present issues of importance to them to a broad sector of the community. Lessons learned as a result of this program were incorporated into a Pasadena Strategic Plan devoted to promoting the health and well-being of its citizenry. Collaboration among diverse agencies resulted in a comprehensive approach to adolescent social and behavioral issues.

MCAH/OFP continues to inform the research and program communities by analyzing and presenting data on mental health from the California Women's Health Survey (CWHs) and from the Maternal and Infant Health Assessment survey. Early this year, the Office of Women's Health (OWH) of CDHS published a Data Point contributed by MCAH/OFP entitled "Frequent Mental Distress and Desire for Help Among California Women Experiencing Intimate Partner Violence." A similar report was presented in December, 2006 by MCAH/OFP at CDC's annual MCH-Epi conference in Atlanta. In addition, MCAH/OFP contributed the content of two sections in the forthcoming report from OWH, California Women's Health, 2007. The titles of those sections are 1) Intimate Partner Violence and Mental Health, and 2) Postpartum Depression.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCAH/OFP programs - CPSP, BIH, AFLP, DV, CDAPP, and local MCAH programs - include mental health assessment and referral, as well as treatment in some cases.		X		
2. Local MCAH staff have improved ability to match client needs to resources because of increased resource availability and program capacity due to new California Mental Health Services Act funding.		X		
3. BIH in collaboration with the Office of AIDS trains BIH Coordinators, staff, and MCAH directors in perinatal HIV/AIDS prevention, including education and counseling to overcome client emotional barriers to testing.		X		
4. MCAH/OFP reported results from the California Women's Health Survey and California's Maternal and Infant Health				X

Assessment survey at meetings and on DHS websites, covering postpartum depression and mental health issues.				
5. The behavioral/emotional findings of a forthcoming demonstration site assessment of early childhood systems of care will be applied to our current year's Early Childhood Comprehensive Systems efforts.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The following MCAH/OFP programs include a mental health component: CPSP, BIH, AFLP, DV, CDAPP, and local MCAH programs. All include assessment and referral, and some include treatment as well.

San Diego County has incorporated the use of the Edinburgh Postnatal Depression Scale for use with postpartum clients during PHN home visits; several other counties are incorporating the tool into their home visit protocols. Some CDAPP coordinators are also including the use of the Edinburgh Postnatal Depression Scale with their Sweet Success providers.

The Teenage Program in Contra Costa County has been successful in reducing the stresses and difficulties associated with adolescence, through education, peer counseling and guidance designed to empower teens to become leaders and agents for change.

The Life Course Model developed by Dr. Michael Lu at UCLA has guided many activities implemented by Contra Costa County MCAH staff; it incorporates a holistic approach to health throughout the lifespan and incorporates mental health principles as part of an overall healthy lifestyles approach to the entire lifespan of an individual.

State and local MCAH/OFP staff are working with the California Women's Mental Health Policy Council and the Department of Mental Health to develop a curriculum for training local staff to work with women experiencing DV in addition to mental health and/or substance abuse issues. This curriculum will include a mental health screening tool.

**c. Plan for the Coming Year**

General plans for the next several years include:

1. Establishing and maintaining appropriate linkages between the Department of Alcohol and Drug Programs (ADP), the Department of Mental Health (DMH), the Department of Rehabilitation, the Department of Social Services (DSS), Medi-Cal, Office of Emergency Services (domestic violence), and the Department of Health Services to address systemic barriers and create pathways to service delivery;
2. Building capacity of the provider network that delivers comprehensive perinatal services, including psychosocial assessment and reassessment each trimester and post-partum, development of a care plan, efficacious referrals, and client follow-up;
3. Collaborating with DMH, DSS, Office of Emergency Services, and Medi-Cal to enhance the Domestic Violence Program in the area of preventing and treating domestic violence and improving mental health in preconception/pregnant/parenting women;
4. Collaborating with public health entities to implement systems to identify and refer to treatment and support women who are experiencing depression during the antenatal or post-partum period;

5. Providing referrals and support for women experiencing stress related to poverty, especially for those at risk for alcohol abuse, drug abuse, or domestic violence;
6. Promoting providers' screening, assessment, education, and referral to treatment and services for women at risk of alcohol use, drug abuse, domestic violence, depression, and stress.
7. The MCAH/OFP Branch will continue to support and promote the incorporation of mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of the MCAH population within their boundaries. MHSA funding will expand access and services for clients with mental health or behavioral health issues, including women at risk for postpartum depression. Behavioral health services for adolescents have also increased within the LHJs and will continue to do so. The MCAH/OFP Branch will continue to support locally implemented activities designed to improve the overall well-being of the MCAH population.

More specific plans include:

1. Collaboration between BIH and Office of AIDS for HIV/AIDS prevention with funding from CDC to address the increasing risk of HIV/AIDS in this population. The California Training Center will develop a training curriculum and provide training to the BIH Coordinators, their MCAH Directors and BIH staff who provide direct services to the client. The training will include effective techniques in HIV education and counseling to overcome client psychological barriers to HIV/AIDS testing.
2. A demonstration site assessment of early childhood systems of care is forthcoming. The behavioral/emotional health findings will be applied to our current year's Early Childhood Comprehensive Systems efforts.

**State Performance Measure 4:** *The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					16.4
Annual Indicator			16.5	17.3	17.3
Numerator			87461	92534	
Denominator			530470	534314	
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	17.1	16.9	16.7	16.5	16.3

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Source: 2005 Maternal and Infant Health Assessment Survey, Maternal, Child and Adolescent Health/Office of Family Planning Branch, California Department of Health Services. Numerator: The number of women who delivered a live birth and who reported drinking any alcohol in the first or third trimester of pregnancy. Denominator: The number of women who delivered a live birth that reported whether or not they consumed alcohol during pregnancy. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

## **Notes - 2004**

Source: 2004 Maternal and Infant Health Assessment Survey, Maternal, Child and Adolescent Health/Office of Family Planning Branch, California Department of Health Services. Numerator: The number of women who delivered a live birth and who reported drinking any alcohol in the first or third trimester of pregnancy. Denominator: The number of women who delivered a live birth that reported whether or not they consumed alcohol during pregnancy. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

### **a. Last Year's Accomplishments**

SPM 04 was added as a State Performance Measure in 2006.

In 2005, 17.3 percent of women who gave birth reported drinking any alcohol in the first or last trimester of pregnancy, up slightly from the previous year. The Healthy People 2010 target is that 94 percent of pregnant women report no drinking in the 30 days prior to the time the question is asked. [Data for SPM 04 are from the California Maternal and Infant Health Assessment (MIHA) and include women aged 15 years and older.]

Mothers who reported drinking during the first or last trimester of pregnancy differed by racial and ethnic group. White and American Indian/Other women were most likely to drink any alcohol (28.6 percent), followed by African American (15.5 percent) and Latina (10.9 percent) women. Asian/Pacific Islander women were least likely to report drinking in the first or last trimester of pregnancy (9.4 percent).

An estimated 4,460 to 6,050 babies with Fetal Alcohol Spectrum Disorder (FASD) are born each year in California. [60, 61] FASD describes the range of effects that can occur in an individual whose mother used alcohol during pregnancy. These effects may include physical, cognitive, behavioral and/or learning difficulties with lifelong implications. Nationally, FASD is the most common form of preventable brain injury in infants.

The MCAH/OFP Branch seeks to improve birth outcomes for women at risk of alcohol use or abuse, including screening and referral for treatment services. Community-based prevention programs, including AFLP, BIH, CPSP, DV, and CDAPP educate clients about FASD, identify mothers at high risk, and refer them for alcohol treatment services.

Over the past year, the MCAH/OFP Branch has taken a leading role in promoting preconception health and healthcare. Reduction of alcohol use by women of reproductive age is a key feature of preconception care. The Preconception Care Council of California (PCCC) was organized in May 2006 with the leadership of the MCAH/OFP Branch and the CA Chapter of MOD to develop a comprehensive statewide plan of action that promotes preconception care in California.

The California Preconception Care Initiative has developed a provider/patient resource packet to assist health care providers. Use of alcohol is one of the covered topics. In addition to the packet, clinical information is being disseminated through the Internet, regional conferences, DVD, and audio presentations. Plans are currently in place to update the packet.

The MCAH/OFP and CMS Branches are collaborating with MOD on the Alcohol and Pregnancy Campaign to increase knowledge and awareness about consequences of substance use during pregnancy.

The 4 P's Plus is a nationally-recognized screening tool developed by Dr. Ira Chasnoff that helps medical staff identify women who may be at risk and need additional evaluations by certified alcohol and drug counselors. Dr. Chasnoff came to Sacramento in February 2006 to present an update on his 4 P's Plus program to MCAH/OFP Branch staff, local MCAH directors, and staff of other state agencies. He described educational resources for communities, how to raise awareness, and interventions useful for preventing FASD and its consequences.

The MCAH/OFP Branch conducted a survey of local MCAH directors from April to July 2006 to assess the availability and format of local MCAH data on prenatal substance abuse. A report on the survey results was completed in September 2006.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community-based prevention and support programs, including AFLP, BIH, CPSP, DV, and CDAPP, educate clients about the dangers of alcohol use during pregnancy and refer high-risk women for alcohol treatment services.		X		
2. The MCAH/OFP and CMS Branches collaborate on the March of Dimes Alcohol and Pregnancy Campaign to increase knowledge and awareness about consequences of substance use during pregnancy.				X
3. The MCAH/OFP Branch participates in the Statewide FASD Task Force, which meets quarterly and consists of representatives from state agencies and local communities.				X
4. Results of a MCAH/OFP Branch survey of local MCAH directors to assess the availability and forms of local MCAH data on prenatal substance abuse showed that 21 of the 46 local health jurisdictions use the 4-Ps Plus model.				X
5. Fresno County uses federal Healthy Start funds to identify and provide support services to women at high risk for alcohol use during pregnancy.		X		
6. Butte County received funds from their local First 5 to receive training directly from Dr. Chasnoff and to organize the First Chance Coalition for Alcohol and Drug Free Babies.				X
7. The California Preconception Care Initiative is updating the provider/patient resource packet it provides to health care providers. Alcohol use is one of the covered topics.				X
8. In addition to the preconception care packet, clinical information is being disseminated through the Internet, regional conferences, DVD, and audio presentations.				X
9.				
10.				

**b. Current Activities**

Many local health jurisdictions are active in FASD prevention and over 20 use Dr. Chasnoff's 4-P's Plus screening tools. Several counties also use county specific strategies, coalitions and programs designed to address the issue of perinatal substance abuse and FASD. Strategies include incorporating substance abuse avoidance education into preconception care, school-based clinics, school curricula and community education opportunities. Counties have partnered with medical care providers and developed assessment tools that incorporate provisions for referral to locally available treatment and guidance facilities.

The MCAH/OFP Branch participates in the Statewide FASD Task Force. The Task Force meets quarterly and consists of representatives from state agencies and local communities. A five-year Strategic Plan to advance the prevention and treatment of FASD was approved in 2005, to be carried out by 2010.

The CA Department of Alcohol and Drug Programs (ADP) in collaboration with CDPH formed the State Epidemiologic Outcomes Workgroup (SEOW). MCAH/OFP participated with ADP to provide

data to help assess the prevalence and consequences of alcohol and drug use during pregnancy. The SEOW is evaluating the usefulness of these data sources in terms of providing meaningful and timely indicators of substance use and consequences.

**c. Plan for the Coming Year**

The MCAH/OFP Branch, MCAH programs, and local health jurisdictions will continue and expand current efforts to reduce and eliminate the consumption of alcohol during pregnancy.

Local health jurisdictions will work on developing and strengthening coalitions with public and private agencies, healthcare providers, and public representatives at the local level to determine how best to identify women at risk and how to develop appropriate referral sources. Barriers will be identified and addressed. Many local health jurisdictions are focusing on alcohol use during pregnancy in their educational presentations to healthcare providers and other interest groups.

The MCAH/OFP Branch will continue to participate in the Statewide FASD Task Force. Activities of the 2005-2010 Strategic Plan include efforts to improve data collection, improve public awareness, sustain an effective statewide task force, establish a statewide FASD Registry, and establish a public policy agenda.

**State Performance Measure 5:** *The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	16	20.7	20.7	19.5	18.2
Annual Indicator	20.1	19.7	18.4	16.8	16.8
Numerator	515	516	494	467	
Denominator	2560575	2617630	2689492	2778214	
Is the Data Provisional or Final?				Provisional	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	16.6	16.4	16.2	16	15.8

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Source Data: Numerator: State of California, Department of Health Services, Center for Health Statistics, 2005 Death Statistical Master File (ICD-10 Group Cause of Death Codes 296-306). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch. Data are provisional due to the need for the Center for Health Statistics to verify the Cause of Death coding for approximately 1% of total California deaths reported in the 2005 Death Statistical Master File.

**Notes - 2004**

Source: Numerator: State of California, Department of Health Services, Center for Health Statistics, 2004 Death Statistical Master File (ICD-10 Group Cause of Death Codes 296-306). Denominator: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, California. May 2004. Tabulations (by place of residence) were done by the MCAH/OFP Branch.

### **a. Last Year's Accomplishments**

The rate of motor vehicle deaths among 15-19 year olds declined significantly between 1990 and 2000, falling from 27.3 to 12.9 per 100,000. After increases in 2001 and 2002 (to 17.3 and 20.1, respectively), the rate declined slightly in each subsequent year to 16.8 in 2005. (Denominators are based on the number of adolescents, not the number of miles driven.)

The highest rates of adolescent motor vehicle deaths were to Whites (20.1), and Hispanics (17.3). Asian and African American adolescents experienced death rates from motor vehicle injuries at a rate lower than the state average. Other race/ethnic groups had too few motor vehicle deaths to be included in the comparison.

Motor vehicle injuries are the leading cause of death in California's teen population. Alcohol use by young drivers is especially dangerous. In 2002, 24 percent of drivers ages 15 to 20 who were killed in motor vehicle crashes were intoxicated. [62] During the last decade, the California Highway Patrol has increased enforcement of DUI (drinking under the influence/drunken driving) laws and has undertaken extensive education and public awareness programs. These include: "Sober Graduation," a program targeting high school seniors; the "Designated Driver Program;" and the "EI Protector" program established in response to the high number of fatal accidents and DUI arrests involving Hispanic youth.

The Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University is a resource center on child and adolescent injury prevention. Under a contract with MCAH/OFP, CIPPP has 1) provided technical assistance to local health jurisdictions in developing, implementing and evaluating injury prevention programs, 2) organized an annual statewide childhood injury prevention conference, 3) held bi-monthly injury prevention teleconferences with injury prevention professionals from local health jurisdictions, and 4) provided local health jurisdictions with regular reviews of current injury prevention literature.

Due to Title V budget cuts in FFY 2005-06, funding for the MCAH/OFP contract with CIPPP was reduced. The reduction eliminated funding for the annual statewide conference and the bimonthly injury prevention teleconferences, as well as reducing the level of technical assistance provided to local health jurisdictions.

The MCAH/OFP Branch provides funding to 61 local health jurisdictions to promote local maternal, child and adolescent health improvement programs. Injury prevention is an important component of local programs. The primary injury reduction focus for each jurisdiction varies depending upon the hazards identified for that community. The Branch allocated funding for local childhood injury prevention in five counties in three-year cycles. Funding will be discontinued after June 2007. Counties are expected to address injury prevention issues with their general funding allotment. Counties obtained grants from several sources which augment their ability to address issues related to injury prevention.

To raise funds in support of child injury and abuse prevention programs, the State sells personalized auto license plates, called "Kid's Plates", which features a heart, hand, star, or plus sign. The proceeds fund child injury and abuse prevention programs. The Kid's Plates Program provides a wide range of technical assistance to help foster effective regional and local injury prevention efforts and fund grants for training and equipment. CIPPP is the Kid's Plate program administrator for the Epidemiology and Prevention for Injury Control Branch.

The MCAH/OFP Branch has served as a member of the UC Berkeley Center for Traffic Safety's Teen Traffic Safety Task Force, whose purpose is to put together a document summarizing both proven and promising practices to reduce teen traffic injuries. This document will be disseminated to MCAH/OFP stakeholders.

Other activities California has undertaken to reduce motor vehicle deaths among children include: increased enforcement of drinking and driving laws; passenger restraint laws; graduated driver

licensing; public education campaigns addressing the risks of drinking while driving; and vehicle safety improvements.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCAH/OFP Branch will stop funding of local childhood injury prevention programs in five counties this year since most local health agencies have successfully implemented injury prevention programs for their area.				X
2. The MCAH/OFP Branch-supported bi-monthly injury prevention teleconferences have been discontinued. Technical assistance for local health jurisdictions remains available as needed.				X
3. Funds administered by CHDS and EPIC that are raised by sales of special car license plates, called Kid's Plates, support child injury and abuse prevention programs, including motor vehicle and pedestrian safety.		X		
4. MCAH/OFP Branch collaborates with EPIC, the CDHS Childhood Lead Poisoning Prevention Branch, and other related agencies to ensure the incorporation of childhood injury prevention modalities within MCAH/OFP programs.		X		
5. The MCAH/OFP Branch participates in the Statewide Coalition on Traffic Safety, which focuses on seat belt use and prevention of speeding and driving under the influence.				X
6. The MCAH/OFP Branch aids in developing California's Statewide Strategic Highway Safety Plan spearheaded by the Dept. of Transportation to identify key safety needs and to provide a structure for data-driven decision-making.				X
7. Local health jurisdictions participate with key agencies to promote and implement traffic safety training, use of bicycle helmets, swimming pool and playground equipment safety, and use of seat belts and child restraints.		X		
8. Local health jurisdictions are using the Child Death Review data to identify trends and raise awareness about deaths due to motor vehicle injuries.				X
9. Local health jurisdictions conduct home safety evaluations when performing client home visits, and provide guidance on corrective actions when perilous situations are identified.	X			
10.				

**b. Current Activities**

CIPPP provides technical assistance to local health jurisdictions in developing, implementing and evaluating injury prevention programs. Since the 2006 reduction in the MCAH/OFP contract with CIPPP, Center staff continue to provide data updates and technical assistance to local health jurisdictions, but in a reduced capacity.

The MCAH/OFP Branch collaborates with the CDPH Epidemiology and Prevention for Injury Control (EPIC) Branch to coordinate activities to address joint areas of interest, including the Statewide Coalition on Traffic Safety, the Statewide Strategic Highway Safety Plan (SHSP), and various child passenger safety programs. The MCAH/OFP Branch works with EPIC and other agencies to promote adolescent injury prevention through MCAH/OFP programs.

Local health jurisdictions undertake various activities to promote adolescent injury prevention,

including participation in Safe Kids Coalitions, traffic safety education, bicycle helmet distribution and education, and education regarding appropriate use of automobile seat belts. The staff of local health jurisdictions conduct home safety evaluations when performing home visits to clients and provide guidance for corrective actions when perilous situations are identified. Counties are also using the Child Death Review data to identify trends and to raise awareness.

**c. Plan for the Coming Year**

Current activities of the MCAH/OFP Branch, the EPIC Branch, CIPPP and local health jurisdictions will be continued.

The MCAH/OFP Branch will continue its collaborative work with the SCOTS and SHSP coalitions. As an active partner in these efforts, the Branch assists in motor vehicle related injury control efforts by establishing common statewide goals and priorities; strengthening injury prevention and control partnerships; sharing data, knowledge and resources; avoiding redundant activities; and leveraging existing resources, including funds, people and leadership attention, toward common objectives.

The Statewide Coalition on Traffic Safety (SCOTS) is a task force containing representatives from more than 20 state and national agencies including the CDPH MCAH/OFP and EPIC Branches, the California Highway Patrol, the Office of Traffic Safety, Alcohol and Beverage Control, the Department of Education, the Department of Transportation (CALTRANS), the State Sheriff's Association, the Police Chiefs Association, the Emergency Medical Services Authority, the Department of Alcohol and Drug Programs, the Department of Motor Vehicles (DMV), Mothers Against Drunk Driving (MADD), the American Automobile Association (AAA), and the UC Berkeley Traffic Safety Center.

The SCOTS task force facilitates interagency public and private partnerships to employ interventions to reduce motor vehicle fatalities in California. The MCAH/OFP Branch's participation in SCOTS has led to an increased awareness among California's motor vehicle injury stakeholders regarding the rise of fatal motor vehicle injuries in California's adolescent and young adult populations and has lead the task force to adopt this particular indicator as a priority area.

The MCAH/OFP Branch is also participating in the development of California's Statewide Strategic Highway Safety Plan (SHSP), an effort led by the California Department of Transportation (Caltrans). In addition to identifying key safety needs and providing a structure for data-driven decision-making, the SHSP provides a framework for California safety agencies to collaborate in aligning and leveraging collective resources to work toward reductions in fatalities and injuries involving motor vehicles.

**State Performance Measure 6:** *The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective	6.5	7	7	7	5.2
Annual Indicator	7.7	7.7	5.2	6.7	6.7
Numerator	47	49	34	45	
Denominator	60937	63305	65484	67365	
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	6.4	6.2	6	5.8	5.6

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Source: State of California, Department of Health Services, 2005 California Birth Defects Monitoring Program Registry (CBDMP). Numerator: Confirmed cases of NTD in fetal deaths plus live births reported to monitored counties. Denominator: Fetal deaths plus live births among counties participating in California Birth Defects Monitoring Program Registry. The number of counties included in the registry was reduced beginning in 1998. Data since 1998 are from eight counties in the Central Valley. An analysis carried out by CBDMP of the neural tube defect incidence data from 1991-97 suggests the comparability of the 8 county sample with the larger sample used through 1997. The eight counties were deemed sufficient by CBDMP for surveillance purposes in this state.

**Notes - 2004**

Source: State of California, Department of Health Services, 2004 California Birth Defects Monitoring Program Registry (CBDMP). Numerator: Confirmed cases of NTD in fetal deaths plus live births reported to monitored counties. Denominator: Fetal deaths plus live births among counties participating in California Birth Defects Monitoring Program Registry. The number of counties included in the registry was reduced beginning in 1998. Data since 1998 are from eight counties in the Central Valley. An analysis carried out by CBDMP of the neural tube defect incidence data from 1991-97 suggests the comparability of the 8 county sample with the larger sample used through 1997. The eight counties were deemed sufficient by CBDMP for surveillance purposes in this state.

**a. Last Year's Accomplishments**

Between 2000 and 2005, the incidence of neural tube defects fluctuated between 5.2 and 7.7 per 10,000. The incidence for 2005 was 6.7. The incidence data, which is provided by the California Birth Defects Monitoring Program (CBDMP), is based on eight counties in the Central Valley.

The MCAH/OFP Branch continues its long-standing efforts to improve folic acid intake before and during pregnancy, because folic acid intake around the time of conception is associated with a number of perinatal benefits especially lower rates of neural tube defects (NTDs). The Branch continues to collaborate with, and provide technical assistance regarding folic acid use to local MCAH programs, including AFLP, BIH, CDAPP, and CPSP; other CDHS programs, including WIC, the Genetic Disease Branch (GDB) and the Nutrition Network; and outside groups such as the March of Dimes.

Local health jurisdictions have also undertaken folic acid promotion campaigns. In Contra Costa County, for example, the U.S. Department of Agriculture, the March of Dimes and the California Nutrition Network funded an 18-month campaign in English and Spanish, to raise awareness of the importance of folic acid and to encourage women of child-bearing age to take a multivitamin daily. A CD of folic-acid materials created during the campaign was distributed to MCAH Directors and Perinatal Services Coordinators throughout the state.

The Surgeon General's Select Panel on Preconception Care included a representative from the California Preconception Care Advisory Committee, which is co-led by MCAH/OFP and California MOD. The Committee provided recommendations that were included in the Recommendations to Improve Preconception Health and Health Care --- United States, published in MMWR, April 2006.

MCAH/OFP staff participated in planning for the 2006 annual National Council on Folic Acid (NCFA) meeting that was held in conjunction with the National Health Promotion Conference in Atlanta. NCFA and Folic Acid Week resources and activities were highlighted on the MCAH/OFP Branch website.

In Spring 2006 a new folic acid message was included in the GDB preconception booklet distributed with marriage licenses.

To reduce the incidence of birth defects, 400 micrograms of folic acid daily continued to be recommended for women of reproductive age. In 2005, California was far from meeting the Healthy People 2010 goal of 80 percent for women of reproductive age: only about 40 percent of all women of reproductive age, and 28 percent of Hispanic women of reproductive age, reported taking folic acid supplementation. Population groups least likely to take folic acid supplements and at the highest risk for neural tube defects included Hispanic women (especially those born outside the United States), younger women, obese women, and women with poor diet quality.

MCAH/OFP has submitted a new data point on folic acid for the WHS.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCAH/OFP Branch produces and distributes pamphlets, posters, and other educational materials, in Spanish and English, which promote folic acid use among women of reproductive age.			X	
2. The MCAH/OFP Branch collaborates with and provides technical assistance regarding folic acid use to local programs, including AFLP, BIH, and CPSP; and other programs in CDHS, such as WIC, GDB, and the Nutrition Network.				X
3. Folic acid promotion is undertaken through distribution of the CPSP "Steps to Take" guidelines, CDAPP Guidelines for Care, and AFLP's Nutrition and Physical Activity Guidelines for Adolescents.			X	
4. Information about neural tube defects and folic acid is provided on the websites of MCAH/OFP, the California Birth Defects Monitoring Program, and the Genetic Disease Branch.			X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Folic acid promotion is undertaken through distribution of the CPSP "Steps to Take" guidelines, CDAPP Guidelines for Care, and AFLP's Nutrition and Physical Activity Guidelines for Adolescents.

Information about neural tube defects and folic acid is provided on the websites of MCAH/OFP, the California Birth Defects Monitoring Program, and the Genetic Disease Branch. A folic acid document has been posted to the MCAH website providing information on folic acid needs, sources, recommendations, and resources.

The MCAH/OFP Branch participates in monthly conference calls with CDC to plan and implement strategies to fortify corn tortillas with folic acid. The goal is to increase folic acid consumption among Hispanic women, who currently have a lower rate of folic acid use and a higher rate of neural tube defects than the general population. The MCAH/OFP Branch has been encouraging CDC, MOD and others to work to expand this fortification effort to whole grains.

Information on the third National Folic Acid Week (in January 2007) has been distributed to all MCAH programs, state nutritionists, and CDPH nutrition networks. This included educational materials on the importance of taking folic acid, along with information for ordering free brochures, posters, bookmarks, etc.

**c. Plan for the Coming Year**

MCAH/OFP programs will continue their efforts to promote folic acid use among women of reproductive age.

MCAH/OFP and the California Chapter of MOD will co-host the 2007 National Preconception Conference in Oakland in October 2007. NCFA, with representation from MCAH/OFP, will hold its next annual meeting in conjunction with the National Preconception Conference, and MCAH/OFP will highlight folic acid awareness at the conference. The annual NCFA meeting will be open to all interested parties.

NCFA is also working to expand fortification efforts and develop additional training and educational materials.

The California Preconception Care Initiative has developed a provider/patient resource packet, as well as dissemination of clinical information through the Internet, regional conferences, DVD, and audio presentations. Folic acid promotion is one of the covered topics. Plans are currently in place to update the packet.

MCAH/OFP is contemplating submitting a MMWR or other publication of folic acid trends in California to be released at the National Preconception Conference in California and potentially highlighted by CDC with the media.

After a two-year hiatus, a question on folic acid use before pregnancy was re-introduced into California's Maternal and Infant Health Assessment (MIHA) survey in both 2005 and 2006. These data are being analyzed and will be reported.

Folic acid pamphlets and posters developed by the MCAH/OFP Branch will continue to be distributed across the state via local MCAH/OFP programs, as well as by the GDB, WIC, and March of Dimes.

**State Performance Measure 7:** *The percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					76
Annual Indicator				75.7	70.4
Numerator				20638	34053
Denominator				27269	48387
Is the Data Provisional or Final?				Final	Final
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	72	74	76	76	76

**Notes - 2006**

This measure is the percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.

The data are CMS Net data for 56 counties and data from LA County for FY 2005-06. Sacramento is not collecting comparable data and so it is not included in this measure.

**Notes - 2005**

This measure is the percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.

The data are CMS Net data for 55 counties and data from LA County for FY 2004-05. Sacramento and Orange Counties are not collecting comparable data and so are not included in this measure.

**a. Last Year's Accomplishments**

SPM 07 is a new California State Performance Measure in 2006.

SPM 07 is 70.4 percent for FY 2005-06. That is, 70.4 percent of new referral cases were opened within 30 days compared to 75.7 percent in 2004-05. A plan to improve this measure was not yet established for FY 2005-06. Decreasing the time interval between referral to the CCS program and receipt of CCS services was identified as one of the top ten state priorities during the five year needs assessment. Families and providers have repeatedly identified long intervals of time from referral to CCS to authorization of services as a barrier to accessing needed services and as a source of frustration. There is no single reason for delays in opening newly referred cases, but through this measure, the CCS program will be identifying areas in the process of determining program eligibility where improvements can be made so that an increasing percentage of cases are opened within 30 days of referral.

The 56 counties using CMS Net are opening 60.3 percent of their cases within 30 days; Los Angeles County, not yet on CMS Net, is opening 96.5 percent of their cases within 30 days. Sacramento County, not yet on CMS Net, is not collecting comparable data, so this county is not included in this measure. The 57 counties collectively are opening 70.4 percent of their cases within 30 days.

Last year the CCS program identified cases on CMS Net that were pending (neither determined eligible or denied eligibility) for over a year and determined if program eligibility was met or closed the case for not meeting program eligibility.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CCS program will be identifying areas in the process of determining program eligibility where improvements can be made.		X		
2. Identifying factors influencing the length of time from CCS referral to authorization and to receipt of services.		X		
3. Considering strategies to reduce the length of time from referral to receipt of services, that would include stationing CCS workers in hospitals.				X
4. Facilitating provision of medical and financial information from families and providers to expedite eligibility determinations and service authorizations.		X		
5.				
6.				
7.				
8.				
9.				

10.				
-----	--	--	--	--

**b. Current Activities**

These include finalizing the work of the CMS stakeholder group regarding strategies and actions around this performance measure so that implementation of the plan can begin, in part through the MCHB grant awarded to USC's University Center for Excellence in Developmental Disabilities (UCEDD) at CHLA for collaboration with CRISS, CMS Branch, and FVCA.

Available data from the 56 counties are being compared with LA County and the Branch has begun to analyze the variation between LA County and the 56 counties on CMS Net. LA County practices are beginning to be evaluated for "best practices" for the 56 counties on CMS Net and Sacramento County.

**c. Plan for the Coming Year**

These include implementation of the strategic plan around this measure from the CMS stakeholder group through the MCHB grant awarded to USC's UCEDD at CHLA for collaboration with CRISS, CMS Branch, and FVCA.

Continuing analysis of cases that take longer than 30 days to open will occur to identify reasons for delays and what actions, if any, could be taken to improve upon delays. A tool will be developed so that county and regional office programs can randomly audit cases opened after 30 days, categorize reasons for delays, and initiate possible interventions.

There will be further discussions with LA County and approximately six other counties that opened approximately 76 to 85 percent of their new referrals within 30 days, in order to determine their "best practices" that could be applied to the remaining counties.

**State Performance Measure 8: *The percent of births resulting from an unintended pregnancy.***

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					42.1
Annual Indicator			42.4	41.3	41.3
Numerator			228085	222148	
Denominator			538020	537394	
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	40.9	40.5	40.1	39.7	39.3

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Source: 2005 Maternal and Infant Health Assessment Survey, Maternal, Child and Adolescent Health/Office of Family Planning Branch, California Department of Health Services. Numerator: Number of women who delivered a live birth who reported that they had wanted to get pregnant later, hadn't wanted to get pregnant then or in the future, or weren't sure what they wanted. Denominator: Number of women who delivered a live birth who reported when they had wanted to get pregnant. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

## **Notes - 2004**

Source: 2004 Maternal and Infant Health Assessment Survey, Maternal, Child and Adolescent Health/Office of Family Planning Branch, California Department of Health Services. Numerator: Number of women who delivered a live birth who reported that they had wanted to get pregnant later, hadn't wanted to get pregnant then or in the future, or weren't sure what they wanted. Denominator: Number of women who delivered a live birth who reported when they had wanted to get pregnant. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year.

### **a. Last Year's Accomplishments**

According to one independent ranking of states, California leads the nation in its efforts to prevent unintended pregnancy [63] Reflecting these efforts, the proportion of births resulting from an unintended pregnancy was one of California's new state performance measures, beginning in 2006.

In 2004 it was estimated that 42 percent of all births to California women (age 15 and over) resulted from unintended pregnancies, and in 2005 this proportion decreased slightly to 41 percent. The proportion of unintended pregnancy among women giving birth in California has been steadily declining since 1999, when it was estimated at 49 percent. By comparison, in 2002, 35 percent of recent births in the United States were unintended. [64]

Data on pregnancy intentions have been collected via California's Maternal and Infant Health Assessment Survey (an annual, population-based survey modeled on PRAMS) since 1999.

There are notable disparities by race/ethnicity. The proportion of unintended pregnancy among women giving birth in California was highest for African American women (61 percent), compared to 44 percent for Hispanic women, 37 percent for White women, and 31 percent for Asian/Pacific Islander women. Data for the United States suggests that the differences between African American and other women are larger in California than in the nation as a whole. In 2002, 51 percent of recent births to African American women in the U.S. resulted from unintended pregnancy, compared to 44 percent of births to Hispanic women and 29 percent of births to White women. [65]

Unintended pregnancy rates are highest for adolescents. Adverse consequences of unintended pregnancy are more severe for teens than for adults, and may include lower educational prospects and a greater risk of living in poverty. Adverse consequences of unintended pregnancy for women of any age and their babies include: the lost opportunity to receive preconception counseling to improve the health of the fetus (such as by increasing folic acid intake or controlling diabetes prior to pregnancy); less likely to receive early or adequate prenatal care, more likely to smoke or drink during pregnancy, and more likely to have low birth weight babies. [66] Costs to society include increased health care and welfare expenditures and increased risk of child abuse and neglect. [67]

The MCAH/OFP Branch supports several programs which help women avoid unintended pregnancy by decreasing risky behavior, increasing access to and promoting the use of effective contraceptive methods, and improving the effectiveness with which all methods are used. OFP programs include Family PACT; the TSO Program; the CCG Program; the MIP; and the I&E. (See the following sub-section for a description of these programs.)

OFP contracts with the UCSF Bixby Center for Reproductive Health Research & Policy for Family PACT, TSO, CCG, MIP and I&E program monitoring and evaluation services. The Bixby Center estimated that in 2002 alone averted approximately 205,000 unintended pregnancies that would have led to 94,000 births. Each pregnancy averted saved Federal, State, and local governments an average of \$5,431 in medical, welfare, and social service costs over the next two years and \$10,508 over the next 5 years. [68]

The MCAH/OFP Branch's Epidemiology and Evaluation Section prepared a fact sheet on Unintended Pregnancy Among Women Giving Birth using 2002 MIHA data. This fact sheet has been posted on the Branch's web site. Hard copies of the brochure were distributed to MCAH programs and health officials, including County MCAH Directors, local directors and coordinators for the AFLP, BIH, CPSP, as well as to other relevant Chiefs within CDHS.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCAH/OFP Branch supports several programs that help women avoid unintended pregnancy by decreasing risky behavior and increasing access to and promoting the use of effective contraceptive methods.				X
2. The Family PACT Program provides reproductive health services, information, education, and counseling, including comprehensive clinical exams and access to contraception.		X		
3. The Teen Smart Outreach Program offers in-depth reproductive health counseling to adolescent Family PACT clients.		X		
4. CCG promotes community-based partnerships to develop effective local teen pregnancy prevention programs and to promote responsible parenting.		X		
5. MIP promotes the involvement of young men in the prevention of teen pregnancy and unintended fatherhood.		X		
6. AFLP assesses and addresses the risks and resources of adolescent clients related to pregnancy prevention, birth outcomes, child health and safety, and health care issues.		X		
7.				
8.				
9.				
10.				

**b. Current Activities**

The Family PACT Program provides family planning services, testing and treatment of sexually transmitted diseases, and education and counseling for low-income Californians. Family PACT serves 1.7 million clients a year, including about 350,000 adolescents. Family PACT undertakes ongoing efforts in the areas of client outreach; provider recruitment, training, and technical assistance; and the addition of new FDA-approved contraceptive methods to the benefits package.

CCG promotes community-based partnerships to develop effective local teen pregnancy prevention programs and to promote responsible parenting. CCG funds 117 community agencies and serves approximately 200,000 teens annually.

MIP promotes the involvement of young men in the prevention of teen pregnancy and unintended fatherhood. MIP funds 21 agencies and serves about 25,000 adolescent boys and young adult males annually.

OFP I&E projects operate in 27 community agencies and serve approximately 75,000 youth in grades 6 through 12 annually.

AFLP utilizes a case management and mentoring model to assess and address the risks and resources of adolescent clients and their children related to pregnancy prevention, birth

outcomes, and enhancing the psychosocial and economic well-being of the adolescent family. AFLP provides services to about 17,000 teens a year.

**c. Plan for the Coming Year**

In spite of the success in recent years in reducing the proportion of births that result from an unplanned pregnancy, prevention of unintended pregnancy will continue to be a major issue for California, given the current high proportion and the demographics of California's population. It is projected that Hispanics will become the largest race/ethnic group in California by the year 2011. The high birth rates for Hispanic women and the high proportion of their births that are unintended at the time of conception suggest that this demographic trend will put upward pressure on the overall proportion of births that are unintended.

The MCAH/OFP Epidemiology and Evaluation Section will produce a Teen Birth Rate Resource, which will include detailed maps and tables of teen birth rates by race/ethnicity, for targeting of teen pregnancy prevention efforts.

Family PACT, TSO, CCG, MIP, I&E, and AFLP will continue their teen pregnancy prevention efforts. CCG, I&E, TSO and MIP Programs now require clinical services linkages, i.e., they must demonstrate formal referral mechanisms and collaboration with one or more Family PACT providers. They are currently working to develop and implement teen specific strategies to increase access to Family PACT services.

Family PACT undertakes to reduce unintended pregnancy through ongoing efforts in the areas of client outreach; provider recruitment, training, and technical assistance; and the addition of new FDA-approved contraception methods to the benefits package. The Family PACT Medicaid Demonstration Project Section 1115 Waiver has been extended by the Centers for Medicare and Medicaid Services through April 2007 and may be further extended on a month-by-month basis. During this period, California is in negotiations with the Centers for Medicare and Medicaid Services for renewal of the Waiver.

**State Performance Measure 9: *The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition.***

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					32.8
Annual Indicator			32.9	33.1	33.1
Numerator			136011	147308	
Denominator			413409	445038	
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	32.9	32.7	32.5	32.3	32.1

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Source: California Department of Education. 2005 California Physical Fitness Testing: Report to the Governor and the Legislature. Sacramento, CA: California Department of Education, December 2005. <http://www.cde.ca.gov/ta/tg/pf/documents/govreport2005.pdf> . Last accessed on February 7, 2007.

Numerator: The number of 9th grade students whose body composition is not within the Healthy Fitness Zone. Denominator: The number of 9th grade students tested for body composition.

Note: The denominator and percent of 9th grade students not within the healthy fitness zone for body composition were available from the report. The numerator was calculated by multiplying the denominator by the percent.

#### **Notes - 2004**

Source: California Department of Education. 2004 California Physical Fitness Testing: Report to the Governor and the Legislature. Sacramento, CA: California Department of Education, December 2004. <http://www.cde.ca.gov/ta/tg/pf/documents/govreport2004.pdf> . Last accessed on April 25, 2006. Numerator: The number of 9th grade students whose body composition is not within the Healthy Fitness Zone. Denominator: The number of 9th grade students tested for body composition.

Note: The denominator and percent of 9th grade students not within the healthy fitness zone for body composition were available from the report. The numerator was calculated by multiplying the denominator by the percent.

#### **a. Last Year's Accomplishments**

SPM 09 was added in FY 2006-2007. For the previous five years, California reported on the percent of low-income children 0-12 years that were overweight using the body mass index (BMI) for age (former SPM 02). SPM 09 reports on the prevalence of 9th graders who are outside the healthy fitness range for body composition.

In 2005, 33.1 percent of 9th grade students were not within the Healthy Fitness Zone (HFZ) for Body Composition compared to 32.9 percent in 2004. Since 2000, this percentage has fluctuated between 32.3 and 35.3 percent. These data are from the California Department of Education's Annual Physical Fitness Test, which is administered to all 9th grade students.

There are some differences in this measure by race/ethnicity. Forty one percent of Hispanic 9th grade students were not within the HFZ for Body Composition, compared to 40 percent of Pacific Islander, 38 percent of African American, 37 percent of American Indian/Alaskan, 28 percent of Filipino, 26 percent of White and 20 percent of Asian students.

Problems associated with body composition scores below the HFZ are associated with menstrual irregularity, infertility, and osteoporosis while body composition scores above the HFZ are associated with high blood pressure, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems, and some types of cancer.

The MCAH/OFP and CMS Branches have been involved with program planning, implementation and evaluation in the CDC-funded California Obesity Prevention Initiative (COPI). In addition, the MCAH/OFP and CMS Branches have actively participated in the Physical Activity and Nutrition Coordinating Committee (PANCC), the Inter-Agency Nutrition Coordinating Council (IANCC) and the Primary Care and Family Health Nutrition Coordinating Committee.

Local MCAH health programs work with school districts to introduce healthy food choices into school cafeterias and increase opportunities for physical activities in the school curricula. Advocacy at the local level has resulted in a legislative mandate to remove soda from schools. Further accomplishments resulting from MCAH local program activities have been the development of collaborations between multiple agencies. As a result of jurisdiction-wide collaboration, local restaurants have modified menus to indicate healthier food choices. In addition to attendance increasing at farmers markets, more fruits and vegetables were made available at farmers markets, and community knowledge about the components of a healthy diet and the benefits of regular physical activity has improved.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCAH/OFP and CMS Branches participate in the CDPH Obesity Prevention Group, the Inter-Agency Nutrition Coordinating Council, and the Primary Care and Family Health Nutrition Coordinating Committee.				X
2. The MCAH/OFP and CMS Branches have been involved with program planning, implementation and evaluation in the CDC-funded California Obesity Prevention Initiative (COPI).				X
3. The AFLP and BIH Programs promote healthy food choices and physical activity by distributing nutrition and physical activity guidelines and holding discussions on how to cut fat and lower calories.		X		
4. The CMS Branch continues the collection of data from CHDP nutrition assessments by CHDP providers for infants, children, and adolescents and forwards the data to CDC for entry into PedNSS.				X
5. Local MCAH health programs have worked with school districts to introduce healthy food choices into school cafeterias and increase opportunities for physical activities in the school curricula.		X		
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

MCAH/OFP Branch actively participated in the planning of the 2007 Childhood Obesity Conference held in Anaheim, California. MCAH/OFP facilitated conference sessions, presented two posters and showcased resources at a conference booth.

The MCAH in Schools Program (formerly called School Health Connections) promotes healthy food choices and physical activity in schools through the endorsement of nutritional assessment tools, including the CDC's School Health Index.

In Humboldt County, the PHNs use growth charts for children and teen parents to help teens understand health food and exercise choices. The City of Long Beach MCAH program, in collaboration with the Long Beach Community Health Council, distributed a Physical Activity/Nutrition Resources survey and utilized the responses to develop and distribute a resource guide.

**c. Plan for the Coming Year**

The MCAH/OFP and CMS Branches will continue to actively participate in coalitions and committees promoting nutrition and activity.

The Branch will continue to provide nutrition and physical activity resources and intervention ideas to MCAH Action, which is the self-directed organization of the 61 California MCAH health jurisdiction directors.

MCAH/OFP will be assessing MCAH resources and supporting efforts in its local health jurisdictions in the areas of policy development, coordination of services and provision of enabling

services that are geared towards stemming the epidemic of obesity in children. Most MCAH local health jurisdictions are addressing the issue of adolescent obesity, in part by networking with each other and the MCAH/OFP Branch to share available resources and information. The local health jurisdictions will continue to include healthy lifestyles education within local school health clinic activities. Activities include outreach, education and guidance to children and parents related to appropriate diet and exercise. Inter and intra county coalitions have been established to plan and implement programs designed to reduce obesity within the school age population.

Local MCAH health programs will continue to work with school districts to introduce healthy food choices into school cafeterias and increase opportunities for physical activities in the school curricula. California schools will receive \$500 million in Physical Activity, Arts, and Music grants for professional development, equipment, and supplies to improve instruction in physical education and the visual and performing arts. There is no deadline on the expenditure of these funds.

Existing MCAH/OFP and CMS programs will continue to promote healthy lifestyles that include increasing physical activity, reducing television viewing, and consuming five fruits and vegetable servings per day. The Adolescent and Family Life Program (AFLP) will continue to promote healthy food choices and physical activity through distribution of nutrition and physical activity guidelines and a cookbook which is targeted to teens.

An ongoing activity for the CMS Branch is the collection of data from CHDP nutrition assessments by CHDP providers for infants, children, and adolescents. In another ongoing activity, state and local CHDP nutritionists develop and implement nutrition education, provide consultation and training to CHDP providers, and coordinate follow-up and referrals to related programs.

The CHDP program will continue to provide cholesterol and fasting blood glucose screening tests for adolescents at risk for obesity and/or cardiovascular disease. Appropriate care management and referrals to resources will be initiated for adolescents with abnormal laboratory values. The CHDP program will continue collaborating with Blue Cross of California on efforts to ensure BMI screening is being performed in provider offices.

**State Performance Measure 10:** *The percent of women, aged 18 years or older, reporting intimate partner physical, sexual or psychological abuse in the past 12 months.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Annual Performance Objective					9.6
Annual Indicator			9.7	8.5	8.5
Numerator			1026644	896672	
Denominator			10546784	10549890	
Is the Data Provisional or Final?				Final	Provisional
	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	8.4	8.3	8.2	8.1	8

**Notes - 2006**

A manual indicator is reported for 2006 based on 2005.

**Notes - 2005**

Sources: California Department of Health Services, California Women's Health Survey (CWHS), 2005. Numerator: Number of women (18 years old or older) reporting any intimate partner physical, sexual, or psychological/emotional abuse in the past 12 months Denominator: Number

of women (18 years old or older) responding either 'yes' or 'no' to any of the nine CWHS questions (in 2004) about intimate partner abuse. Numerator and denominator weighted using the California Department of Finance population data for 2000 (file name Race/Ethnic Population with Age and Sex Detail, 2000-2050).

**Notes - 2004**

Sources: California Department of Health Services, California Women's Health Survey (CWHS), 2004. Numerator: Number of women (18 years old or older) reporting any intimate partner physical, sexual, or psychological/emotional abuse in the past 12 months Denominator: Number of women (18 years old or older) responding either 'yes' or 'no' to any of the nine CWHS questions (in 2004) about intimate partner abuse. Numerator and denominator weighted using the California Department of Finance population data for 2000 (file name Race/Ethnic Population with Age and Sex Detail, 2000-2050).

**a. Last Year's Accomplishments**

SPM 10 was new in 2006, but was similar to the former SPM 08. The measure was changed last year to be more inclusive of the spectrum of intimate partner abuse. It now includes not only physical abuse, but also sexual and psychological abuse.

SPM 10 (the percent of women 18 years or older reporting intimate partner physical, sexual, or psychological abuse in the past 12 months) was 8.5 percent in 2005. At this point, this must be viewed as part of a fluctuation over the past five years between 8.6 and 9.7 percent. (These data are from the California Women's Health Survey.)

To combat the serious health threat of domestic violence (DV), the Battered Women Shelter Program (BWSP) was established in 1994 to provide comprehensive shelter-based services for women experiencing intimate partner violence in all its forms, and their children.

MCAH/OFP continues to inform the research and program communities by analyzing and presenting data on intimate partner violence from the California Women's Health Survey (CWHS) and from the Maternal and Infant Health Assessment survey. Early this year, the Office of Women's Health (OWH) published a Data Point contributed by MCAH/OFP entitled Frequent Mental Distress and Desire for Help Among California Women Experiencing Intimate Partner Violence. A similar report was presented in December, 2006 by MCAH/OFP at CDC's annual MCH-Epi conference in Atlanta, and supplied the content of a section entitled Intimate Partner Violence and Mental Health in the forthcoming report from OWH entitled California Women's Health, 2007.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCAH/OFP Branch Battered Women Shelter Program (BWSP) currently funds 94 shelter-based grantees to provide direct services to battered women and their children.		X		
2. All BWSP grantees are required to incorporate domestic violence prevention activities and outreach to unserved/underserved populations into their ongoing shelter-based services.		X		
3. Grantees are required to develop a policy statement and implementation plan to provide services to women from varying cultural and linguistic backgrounds.				X
4. Technical assistance and training is provided to all 94 BWSP domestic violence shelter agencies to help ensure competent services are provided to unserved/underserved populations.				X
5.				

6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

The MCAH/OFP Branch currently funds 94 shelter-based grantees to provide direct services to battered women and their children.

July 1, 2007 marks the start of the second year of a five-year funding cycle for 94 BWSP grantees. All grantees continue to incorporate domestic violence prevention activities and outreach to unserved/underserved populations into their ongoing shelter-based services. In a further effort to increase access to shelter services for unserved/underserved populations, the MCAH/OFP Branch incorporates Cultural/Linguistic Competency as a 14th Core Service Standard. Agencies are required to develop and submit a policy statement and implementation plan to provide services to women from varying cultural and linguistic backgrounds.

Via contracts with domestic violence expert programs, the Branch has developed a curriculum to conduct regional training and technical assistance (TAT) for BWSP shelter staff in three priority unserved/underserved (U/U) areas: Mental Health and Substance Abuse; Disabled and Developmentally Disabled; and Lesbian, Gay, Bisexual, Transgender, and Questioning populations. Training has begun in this year with technical assistance to begin during next year. The grantees also continue to provide direct services to U/U populations as part of their ongoing grants with MCAH/OFP.

**c. Plan for the Coming Year**

Throughout the coming year, the Branch will be conducting regional statewide U/U trainings for BWSP shelter staff. Trainings must be evidence-based, culturally and linguistically competent, and must address specific components such as: implementation of quality control practices; intake interviewing; outreach; case management; client counseling, etc.

The DV-experienced contractors will be providing telephone, video/teleconference, or on-site technical assistance to the 94 agencies.

In August 2007, the MCAH/OFP Branch will convene its annual statewide meeting for BWSP grantees. The meeting agenda includes a wide variety of topics geared toward state and agency identified needs including a Statewide Advisory Council update, access to state funding, grants administration, panels on best practices, and a presentation on the impact of violence on children presented from a differential response model.

The MCAH/OFP Branch will continue ongoing development and maintenance of its domestic violence website, called SafeNetwork, to facilitate the sharing of information, to promote networking among providers, and to offer resources for providers and victims of domestic violence. The webpage can be accessed at [www.safenetwork.net](http://www.safenetwork.net).

**E. Health Status Indicators**

Health Status Indicators (HSI) 01-02: Low Birth Weight (LBW)

HSI 01 and 02 are the percent of live births weighing less than 2,500 grams and 1,500 grams, respectively. HSI 01a and 02a are for all live births, and HSI 01b and 02b are for all live

\*singleton\* births. (Live births with unknown birth weight were excluded from the analysis.)

Births weighing less than 2,500 grams are classified as low birth weight (LBW). LBW births are divided into two categories: Births weighing less than 1,500 grams are classified as very low birth weight (VLBW), and births weighing between 1,500 and 2,499 grams are classified as moderately low birth weight (MLBW).

***//2008/ In 2005, the percent of live births which were LBW (HSI 01a) was 6.9 percent, up slightly from 6.7 percent in 2004. This is higher than the Healthy People 2010 goal of 5.0 percent.***

***The percent of live singleton births which were LBW (HSI 01b) remained the same as last year at 5.2 percent.***

***Among racial and ethnic groups, African American infants were twice as likely as infants of most other groups to be LBW (HSI 01 a). In 2005, 12.8 percent of African American live births were LBW. Comparatively, Asians and Pacific Islanders had approximately 7 percent LBW births. Whites, American Indians, and Hispanics had between 6.2 and 6.6 percent LBW births.***

***The percent of live births which were VLBW (HSI 02a) was 1.2 percent; there was no change from the previous year. This is slightly higher than the Healthy People 2010 goal of 0.9 percent.***

***The percent of live singleton births which were VLBW (HSI 02b) was 0.9 percent.***

***Among racial and ethnic groups, African American infants were twice as likely as infants of most other groups to be VLBW (HSI 02a). In 2005, 3.0 percent of African American live births were VLBW. Comparatively, all other racial and ethnic groups had between 1 and 1.5 percent VLBW births. //2008//***

LBW rates are important indicators of the health of California. LBW rates among populations within our society reflect not only differences in the health of the mother, access to risk appropriate care before and during her pregnancy and delivery, but also socio-economic status and lifestyle issues.

LBW is most commonly associated with prematurity and intrauterine growth restriction. These complications can lead to significantly increased risk of mortality and morbidity. Within the LBW group are two distinct populations of infants -- MLBW and VLBW. The cause, outcomes and potential strategies for improvement are different.

> Moderately Low Birthweight (MLBW)

Birth weights between 1,500 and 2,499 grams are most commonly associated with infants with intrauterine growth restriction or those delivered between 32 and 37 weeks gestation, called Late Preterm Infants /Near Term Infants (LPI/NTI). Few data are available on the intrauterine growth restriction group, as size for gestational age is not consistently available via birth certificate data.

More is known about the LPI/NTI infants. LPI/NTI may be associated with factors such as: lower order multi-fetal pregnancies (twins), mothers less than 17 years of age, perinatal factors such as pre-eclampsia, over and under weight gain in pregnancy, induction and augmentation of labor and cesarean delivery. Maternal pre-existing conditions such as over and under weight, diabetes and hypertension as well as life style issues such as tobacco, alcohol and drugs also contribute to the risk of LPI/NTI.

Outcomes of infants born at MLBW include: nearly three fold increase in neonatal and post-neonatal mortality; excess hospital costs of up to six times that of infants born between 37-40 weeks gestation, increased risk of neonatal complications including hypoglycemia, hyperbilirubinemia, Respiratory Distress Syndrome, suspected infection or sepsis and feeding difficulties. These complications lead to significantly greater medical intervention and utilization of neonatal intensive care resources.

Interventions aimed at stemming the increase in the LPI population will require public health interventions, collaboration with professional medical associations, commitment to preconception and interconception health and wellness programs. Ensuring the quality of neonatal care for LPI will require leadership in developing a greater understanding of the medical risks these infants face and facilitating health care system changes necessary to prevent complications and optimize outcomes.

***//2008/ The California Perinatal Quality Care Collaborative (CPQCC) is developing and disseminating a toolkit, "The Late Preterm Infant" in order to assist hospitals' treatment for late preterm infants (LPI) 34-36 + 6/7 weeks. LPI comprise a unique population requiring enhanced awareness and sensitivity to issues of transition, infection, nutrition, discharge readiness, and parent education that needs to begin after birth. //2008//***

Public health interventions such as tobacco cessation, perinatal substance abuse treatment and prevention of domestic violence provide key support to minimize risk. Targeted programs such as AFLP, BIH, CDAPP, and CPSP, work to improve outcomes in specific populations.

MCAH/OFP Branch encourages professional medical associations to develop and use guidelines for practice regarding labor induction and augmentation, cesarean delivery, as well as assisted reproductive therapies.

MCAH has taken a leadership role along with the March of Dimes in identifying priorities and funding for preconception care that has significant potential to reduce the risk of LBW infants.

Further efforts to understand the risks and optimize outcomes for MLBW infants are underway in collaboration with California Perinatal Quality Care Collaborative as well as the California Maternal Quality Care Collaborative, based at Stanford University. Primary data collection and evaluation, and hospital and provider based quality improvement efforts, will focus on the LPI as well as causes of maternal complications such as hemorrhage and infection. Other partners working with MCAH/OFP in these efforts include the California Children's Services, California Association of Neonatologists, Regional Perinatal Programs of California, California Perinatal Transport Systems, CDAPP and the California Pregnancy Related and Pregnancy Associated Mortality Review.

#### > Very Low Birthweight (VLBW)

Birth weights of less than 1,500 grams are almost exclusively related to prematurity with gestational ages of less than 32 weeks. While not all causes of severe prematurity are well understood, clearly women who have had previous preterm births, are carrying higher-order multi-fetal pregnancies, are African American, or are at the extremes of maternal age, have well documented risk of severe preterm delivery. Pre-existing medical conditions and life style issues as seen in the MLBW population also play a significant role in increasing risk.

VLBW infants are at significantly increased risk of infant mortality; nearly 105 times greater than infants born at normal birthweight. Morbidities associated with VLBW include Respiratory Distress Syndrome, intraventricular hemorrhage, patent ductus arteriosus, necrotizing enterocolitis and retinopathy of prematurity.

Efforts to prevent severe prematurity include those discussed above. Emphasis on improved pre-pregnancy health and wellness by providing access to preconception care are vital to these efforts. MCAH/OFP offers the optimal collaboration of state programs to address preconception care provision and funding sources.

Optimizing the outcome of VLBW infants requires improvement in risk appropriate maternal-fetal care. To evaluate variation, understand the issues and provide information on mortality rates within California, MCAH/OFP funds several data projects. The Perinatal Profiles of California (PPOC), based at the School of Public Health, University of California, Berkeley, is a risk adjusted mortality database that also reports on sentinel events such as the proportion of VLBW infants born outside of tertiary care facilities. Improved Perinatal Outcomes Data Reports (IPODR) is a web based data report allowing evaluation of perinatal outcomes at the county and zipcode levels.

#### Health Status Indicators 03-04: Child Injury Rates

Health Status Indicators 3A and 4A describe fatal unintentional injury and nonfatal (both intentional and unintentional) injury rates per 100,000 children aged 14 years and younger. Health Status Indicators 3B and 3C describe fatal motor vehicle injury rates and Health Status Indicators 4B and 4C describe nonfatal motor vehicle injury rates per 100,000 children aged 0-14 and per 100,000 young adults aged 15-24, respectively.

Injury data for these indicators are currently obtained from the California death file and the California Hospital Discharge file. Additional motor vehicle injury data are available through the Statewide Integrated Traffic Reporting System (SWITRS) collected and processed by the California Highway Patrol. SWITRS data contains detailed information regarding crash site location, collision circumstances as well as various demographic and risk factors and is used throughout the state to augment hospital discharge and death data to more specifically target motor vehicle transport (MVT) interventions.

Given the nature of overall injury data, only the most severe cases ending in death or requiring hospitalization are recorded. This results in an under representation of the true magnitude of injuries suffered by children and young adults in California.

In both children aged 0-14 and young adults aged 15-24, injury is the leading cause of death. Among fatal injuries those due to motor vehicle collisions are most frequent.

Death rates from unintentional injuries due to motor vehicle collisions in children under age 14 (HSI 3B) fell significantly from 5.4 deaths per 100,000 in 1990 to 2.9 deaths per 100,000 in 2000. Since 2000, rates have oscillated between 2.9 per 100,000 (2000) and 3.6 per 100,000 (2003) with no directional trend. Statewide data for 2004 and 2005 fall within this range at 3.1 and 3.2 deaths per 100,000 children, respectively, for each year.

Death rates from unintentional injuries due to motor vehicle collisions in adolescents and young adults aged 15-24 (HSI 3C) have been less stable. Fatal motor vehicle collision injury rates in this group increased significantly from 14.4 per 100,000 in 2000 to 21.0 per 100,000 in 2003, representing an excess of 383 deaths in 2003 for this population. The rate was slightly lower at 19.9 in 2004 and 19.6 in 2005. Although this decrease is a positive sign, overall, deaths due to motor vehicle injuries in this age group continue to be elevated and remain greater than the HP 2010 objective of 15 deaths per 100,000 for the entire population. (Denominators are based on the number of children aged 0-14 and the number of adolescents/young adults aged 15-24 rather than the number of miles driven. Projections are based on the 2000 Census.)

Statewide HSI injury indicators alone are not sufficient to describe and monitor the burden of

injury in the population as they may mask important geographic, race/ethnic, socioeconomic and age disparities. Additionally, HSI injury indicators are neither adequate to appropriately direct limited public health resources nor are they useful to develop or evaluate individual interventions.

To describe the true burden of injuries within a population and to most appropriately direct public health efforts, further investigation and sub-analyses of HSI indicators are essential. For example, prior to directing resources to combat the rise in HSI 4C (fatal injuries due to motor vehicle collisions in adolescents/young adults aged 15-24), we need to know 1) whether the increased fatalities are localized in any geographic region(s) and 2) whether any race/ethnic group(s) or sub-age group is disproportionately affected. Once the appropriate subpopulations have been identified, further investigations are needed to determine why these adolescents and young adults are crashing, and given that they crash why they are dying or being severely injured. Are the problems related to inattention and travel speed, to illegal street race competitions, to drug and alcohol intoxicated drivers, to not using restraints, or to some combination of these?

While it is important to understand the public health, rate-based impact of the various causes of injuries, including motor vehicle transport injuries, the Branch additionally considers other equally important factors when making decisions about prevention priorities and the direction of limited public health resources. These include: 1) the availability of proven interventions that reduce the risk of injury causing events among the identified target population; 2) the effectiveness of an intervention versus the maximum resources available to address the given problem; 3) the ability of the state and local health departments to reach those at greatest risk; as well as other factors.

Further, California's injury based public health efforts often involve interventions that aim to reduce environmental and/or behavioral risks. Therefore, the use of HSI rates alone even when stratified by appropriate sub-population groups may not be adequate or desirable for evaluating the impact of injury control interventions in statewide or local settings. As injuries may have several determinants acting concurrently and because different subgroups may suffer similar injury outcomes but experience disparate antecedents, directly assessing behavioral and environmental risks before and after a risk reduction intervention may in some cases be more appropriate.

The MCAH/OFP Branch recognizes the interplay of the above mentioned factors is complex. The public health approach to the reduction of fatal and non-fatal injuries and specifically motor vehicle injuries in California is therefore multifaceted and multidisciplinary, encouraging experts from scientific disciplines, organizations and communities to work together to find innovative solutions to reduce the burden of injury and death in our youth.

Despite recognized limitations, the HSI injury indicators can give the State a general indication of the success of our many diverse local and statewide interventions intended to diminish and prevent child and adolescent injury. The MCAH/OFP Branch utilizes the HSI injury measures as well as various sub-analyses of these measures to recognize disparities and provide impetus of increased action on proven interventions.

Concern regarding the spike in fatal motor vehicle injuries in California's adolescent and young adult population, for example, prompted the MCAH/OFP Branch to write and submit a grant application to the California Office of Traffic Safety. Although the grant was denied funding, MCAH/OFP has remained vigilant in collaborating with state, local and non-profit agencies and stakeholders to understand the contributing factors leading to the rapid elevation in motor vehicle fatalities as well as to develop multidisciplinary strategies to mitigate it.

Additionally, the Branch continuously participates in public and private partnerships and actively seeks involvement of key state, local and community-based stakeholders to reduce the burden of injury in our youth. The Branch's current injury control partnerships include the Center for Injury Prevention Policy and Practice, the CDHS Epidemiology and Prevention for Injury Control (EPIC) Branch, local health jurisdictions, the Statewide Coalition on Traffic Safety, and the working group

on the California Statewide Strategic Highway Safety Plan, all of which are described below.

The Center for Injury Prevention Policy and Practice (CIPPP), at San Diego State University, serves as a resource center on child and adolescent injury prevention and provides training and technical assistance in the development, implementation and evaluation of state and local injury prevention programs. CIPPP has worked with the MCAH/OFP Branch to organize the annual childhood injury prevention conference, administers the 'Kids Plates' injury prevention grant program for the EPIC Branch, and also produces Safety Literature updates with weekly references of current injury prevention articles to 1404 California subscribers.

Due to Title V budget cuts in FFY 2005-06, funding for the MCAH/OFP contract with CIPPP was reduced. The reduction eliminated funding for the annual statewide conference and the bimonthly injury prevention teleconferences, as well as reducing the level of technical assistance provided to local health jurisdictions.

The MCAH/OFP Branch collaborates with the CDHS Epidemiology and Prevention for Injury Control (EPIC) Branch to coordinate activities to address joint areas of interest, including the Statewide Coalition on Traffic Safety, the Statewide Strategic Highway Safety Plan, and various child passenger safety programs.

***//2008/ The MCAH/OFP Branch provides funding to local health jurisdictions (58 counties and three cities) in support of local efforts to promote maternal and child health; local jurisdictions may use this funding for child injury prevention, among other projects. The Branch has been allocating additional funding for local childhood injury prevention programs in five counties in three-year cycles. However, this funding, specifically for childhood injury prevention, will be discontinued after June 2007. Counties are expected to continue to address childhood injury prevention issues with their general funding allotment. Counties have also received grants from the Office of Traffic Safety, which have enabled them to expand childhood injury prevention programs. //2008//***

The MCAH/OFP Branch also supports regular injury prevention teleconferences available to all local MCAH jurisdictions and injury stakeholders enabling statewide networking, joint planning, and skill development as well as an injury prevention list serve used to give updates, alert programs of funding sources, and share information.

The Statewide Coalition on Traffic Safety (SCOTS) is a task force containing representatives from more than 20 state and national agencies including the CDHS MCAH/OFP and EPIC Branches, the California Highway Patrol (CHP), the California Office of Traffic Safety (OTS), the California Alcohol and Beverage Control (ABC), the California Department of Education (CDE), the California Department of Transportation (CALTRANS), the California State Sheriff's Association, the California Police Chiefs Association, the California Emergency Medical Services Authority (EMSA), the California Department of Alcohol and Drug Programs (ADP), the California Department of Motor Vehicles (DMV), Mothers Against Drunk Driving (MADD), the American Automobile Association (AAA), SafeKids West Coast, the UC Berkeley Traffic Safety Center, the Federal Motor Carrier Safety Administration (FMCSA), the Federal Highway Administration (FHWA), and the National Highway Traffic Safety Administration (NHTSA).

The SCOTS task force was established to unite traffic safety stakeholders throughout the state to engage interagency public and private partnerships to employ diverse evidence based interventions to reduce motor vehicle fatalities in California. The MCAH/OFP Branch's participation in SCOTS has led to an increased awareness among California's motor vehicle injury stakeholders regarding the rise of fatal MVT injuries in California's adolescent and young adult populations and has led the task force to adopt this particular indicator as a priority area.

The MCAH/OFP Branch has also participated in the development of California's Statewide Strategic Highway Safety Plan (SHSP) spearheaded by CALTRANS as a result of the August

2005 federal legislation entitled the Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU). In addition to identifying key safety needs and providing a comprehensive structure for data-driven decision-making, the SHSP will provide a framework for California safety agencies to collaborate in aligning and leveraging collective resources to achieve significant reductions in fatalities and injuries on all public roads in the State.

As active partners in both the SCOTS and SHSP coalitions, the MCAH/OFP Branch has assisted in motor vehicle related injury control efforts for children, adolescents and young adults by establishing common statewide goals and priorities; strengthening injury prevention and control partnerships; sharing data, knowledge and resources; avoiding redundant activities; and leveraging existing resources, including funds, people and leadership attention, toward common objectives.

#### Health Status Indicator 05: Chlamydia Rates

Health Status Indicators (HSI) 05a-b describe Chlamydia trachomatis (CT) rates per 1000 women aged 15-19 years and 20-44 years, respectively. For 2004, the CT rate for women aged 15-19 years was 22.3 per 1000. Among women aged 20-44, the chlamydia rate was considerably lower at 8.6 per 1000.

***//2008/ CT rates for both age groups increased between 2004 and 2005. Rates for women aged 15 through 19 increased from 22.3 in 2004 to 22.8 in 2005. Rates for women aged 20 through 44 increased from 8.6 in 2004 to 9.1 in 2005. //2008//***

Data are currently obtained from the California STD surveillance systems operated by local and state STD control programs mandated by Title 17 reporting regulations. To augment case-based surveillance and to address inconsistent patterns of STD screening and reporting, prevalence monitoring of women is conducted at sentinel sites. These sites include family planning clinics, STD clinics, managed care clinics and juvenile halls.

California is concerned about the large number of CT infections in women. With over 120,000 cases in 2004, CT is the most commonly reported communicable disease in California and nationally. Given the asymptomatic nature of the disease, these cases represent only a fraction of the true number of infections that occurred. CT is also costly due to the long term reproductive health consequences which include infertility, potentially fatal ectopic pregnancy, chronic pelvic pain, and poor perinatal/neonatal outcomes including prematurity, pneumonia and conjunctivitis.

Among females, more than 61,000 cases of chlamydia were reported among those aged 15- 24 years, representing almost 70 percent of all reported female cases. African Americans age 15-19 years have the highest CT rate at 50.1 per 1000 compared to the 22.3 per 1000 statewide. This heightened vulnerability to CT infection in females is observed in both case-based reporting data as well as in prevalence monitoring data gathered from the sentinel sites.

Trends in case-based CT rates show consistent increases over time. However, this may be due to increased screening of young women, targeted screening of older women, and the use of more sensitive screening tests. The interpretation of trends should be based on additional information, including screening coverage and access to health care. Additional data from sentinel prevalence monitoring in specific health care settings are important for comparison with case-based rates. For 15-24 year old females seen in family planning clinics, managed care organizations and STD clinics, chlamydia prevalence was relatively stable from 1999-2005.

HSI 05b (CT rates for women age 20-44 years) is not particularly useful for monitoring populations at risk for CT: More specific age groups should be used. Case-rates in women 20-24 and 25-29 are significantly higher than rates among women age 30 and older.

HSI 05a is preferable for focusing CT control strategies. With effective public and private partnerships and involvement of key community stakeholders, STD Control Branch resources, coordinated with resources from CDPH partners, focus CT control strategies in the following areas:

- 1) Community and Individual Behavior Change Interventions aim to increase both awareness and screening. In particular, it aims to increase awareness of CT screening for adolescent girls.
- 2) Medical/Clinical and Laboratory Services support these goals by increasing CT screening among sexually active women age 25 and younger in managed care, family planning, and juvenile detention settings.
- 3) Partner Services intend to increase the number of CT cases who receive timely partner referral and treatment services for CT.
- 4) Leadership and Partnership Development efforts strive to create and implement a strategic plan in partnership with public and private stakeholders. In particular, planning efforts will include developing innovative strategies to reduce disparities in CT infection rates among populations of special emphasis, specifically among adolescents and African Americans.
- 5) Surveillance and Data Management efforts aim to enhance timeliness and completeness of CT case data and prevalence monitoring test result data through electronic transmission.
- 6) Quality Improvement (QI) Initiative to enhance CT screening among women age 25 and younger: This intervention, targeting individual providers, will include the analysis of individual provider screening data, provider feedback via provider-specific letters, and possibly chart audits performed on a subset of low performers in order to validate screening estimates.

As indicated above, use of case rates alone may not be adequate for evaluating impact of CT control interventions in statewide or local settings/populations. Other health status measures to consider include: CT positivity rates, the percent having been tested for CT in the past year, repeat testing rates (to reduce repeat infections), and population-based or clinic-based behavioral surveillance to assess awareness and access to CT testing.

***//2008/ The STD Control Branch attempts to reduce chlamydia prevalence by working in the domains of behavior change, clinical and laboratory services, surveillance, quality improvement, and leadership. On the individual level, the STD community intervention program supports youth organizations educating adolescent girls about CT screening. On the clinical level, the Branch works to increase screening in private settings including managed care, Medi-Cal, family planning, and juvenile detention settings. The Branch has released guidelines for expedited partner therapy and field therapy for chlamydia, to address infections among partners. Surveillance efforts aim to enhance timeliness and completeness of chlamydia reporting. Leadership and partner development efforts include initiatives such as 1) working with outside partners to address inequities in chlamydia rates associated with race/ethnicity, and 2) partnering with medical groups to provide chlamydia screening rates to individual providers. //2008//***

Health Status Indicators 06-12: Demographics

The categorization of race/ethnicity requested by HRSA for Health Status Indicators (HSI) 06-12 is different from that commonly used in California. Because neither the race nor the ethnicity classification alone provides a complete picture of the California population, little attention has been focused on the narrative for HSI 06-12.

*/2008/*

*The population of California age 0-24 was 13.4 million in 2005. Of these, 46 percent were of Hispanic ethnicity, and 54 percent were not Hispanic. By race, 79 percent were White, 7 percent were African American, 10 percent were Asian, less than 1 percent were American Indian and 3 percent were Other. By age, about 4 percent were less than 1 year old and 16 percent were between 1-4 years old. California children were evenly distributed among the remaining age categories (about 20 percent in each).*

*The number of live births to California women in 2005 was 548,700. Of these births, the mother's ethnicity was 52 percent Hispanic, 47 percent not Hispanic, and 1 percent Unknown. The mother's race was 79 percent White, 5 percent African American, 11 percent Asian, less than 1 percent American Indian, and 4 percent Other.*

*Of the 548,700 live births, 3 percent were to women age 15-17, 6 percent to women age 18-19, 73 percent to women age 20-34, and 17 percent to women age 35 or older.*

*The number of deaths of children age 0-24 in California in 2005 was 7,948. Of these deaths, 48 percent were of Hispanic ethnicity, 52 percent not Hispanic, and less than 1 percent Other/Unknown. By race, 75 percent of the deaths were White, 13 percent were African American, 7 percent were Asian, less than 1 percent were American Indian, and 5 percent were Other.*

*The population of California age 0-19 was 10.7 million (2005). Of these, 47 percent were of Hispanic ethnicity and 53 percent were not Hispanic. By race, 79 percent were White, 7 percent African American, 10 percent Asian, less than 1 percent American Indian, and 4 percent Other.*

*Of the population age 0-19, 27 percent lived in households headed by a single parent (2005). For children of Hispanic and non-Hispanic ethnicity, 28 percent and 27 percent lived in households headed by a single parent, respectively. The proportion living in households headed by a single parent, by race, were 25 percent for Whites, 60 percent for African American, 46 percent for American Indian, and 15 percent for Asian.*

*Of the population age 0-18 receiving benefits from Temporary Assistance for Needy Families (TANF), 52 percent were of Hispanic ethnicity and 48 percent were not Hispanic (2005). By race, the children receiving benefits were 69 percent White, 19 percent African American, 8 percent Asian, 2 percent American Indian and 2 percent Other/Unknown.*

*The number of children (0-19 years) enrolled in Medi-Cal (Medicaid) in 2005 was 3.5 million, similar to that for year 2004. Of those enrolled, 62 percent were Hispanic and 34 percent were non-Hispanic, and less than 5 percent were of other racial/ethnic backgrounds. By race, the proportion of children enrolled in Medi-Cal was 78 percent White, 11 percent African American, 7 percent Asian and less than 1 percent American Indian.*

*In 2006, 778,623 children were enrolled in Health Families (SCHIP), up from 743,340 in 2005. Of those enrolled, 58 percent were Hispanic, 39 percent were non-Hispanic. By race, the proportion of children enrolled in Healthy Families was 69 percent White, 2 percent African American, 12 percent Asian/Pacific Islander, less than 1 percent American Indian, and 16 percent Other/Unknown.*

*The January 1, 2006 caseload for children living in foster home care was almost 78,000. About 41 percent of the children living in foster home care were of Hispanic ethnicity. By race, the children living in foster home care were 68 percent White, 29 percent African*

**American, 2 percent Asian/Pacific Islander, and 1 percent American Indian.**

**In 2005, 1.4 million or 13 percent of children ages 0-19 were enrolled in the Food Stamp Program. Of these children, 57 percent were of Hispanic ethnicity. By race, the children enrolled in the Food Stamp program were 74 percent White, 16 percent African American, 9 percent Asian, and less than 1 percent American Indian.**

**Of the population aged 0-19, almost 2 million were enrolled in WIC (2006). Almost 76 percent of the children enrolled in WIC were of Hispanic ethnicity. The proportion of children enrolled in WIC, by race, were 85 percent White, 7 percent African American, 5 percent Asian, and 1 percent American Indian/Alaska Native.**

**In 2005, there were 2,846 arrests per 100,000 for juvenile felony and misdemeanor offenses among those 19 years old and younger. The arrest rate (per 100,000) for non-Hispanic juveniles was slightly higher than for Hispanic juveniles (2,815 vs. 2,726). By race, the arrest rates for juvenile offenses were 6,773 for African Americans, 2,752 for Whites, 1,381 for American Indians/Alaska Natives and 935 for Asians.**

**For the 2004-2005 school year, the percentage of high school dropouts (grades 9-12) was 3 percent. Four percent of Hispanic students dropped out of high school, compared to 2.5 percent of non-Hispanic students. By race, 2 percent of White, 5 percent of African American, 1 percent of Asian, and 4 percent of American Indian students dropped out of high school.**

**Of the 10.7 million children less than 20 years old, only 2 percent lived in rural areas in 2005. The majority of children lived in metropolitan or urban areas.**

**In 2005, 6 percent of the California population were living below 50 percent of the federal poverty level (FPL). About 13 percent of the total population were living below 100 percent FPL, and 33 percent were living below 200 percent FPL.**

**In California, 7 percent of children less than twenty years old were living below 50 percent FPL. About 18 percent of children were living below 100 percent FPL, and 41 percent were living below 200 percent FPL.**

**//2008//**

## **F. Other Program Activities**

### Telephone Hotlines

Both the State and local MCAH jurisdictions have phone number/hotlines that provide information regarding maternal and child health services and programs. There are several statewide toll free telephone hotlines run by the State, including ones for MCAH and BabyCal.

BabyCal (800-BABY-999) provides information about the importance of prenatal care, practicing healthy behaviors during pregnancy, and the availability of state programs that can help pay for prenatal care services. Funding for the BabyCal media campaign and outreach publications was discontinued after June 2003, but the phone number is still in use.

In January 2004 the MCAH/OFP Branch added a hotline (866-241-0395) specific to MCAH services. It is staffed during office hours and, outside of office hours, is answered with a recorded message.

The number of calls to the BabyCal and MCAH numbers combined was nearly 20,000 in FY 2003-2004, down from 38,000 in FY 2002-03. The decline is attributed to the discontinuation of

the media and outreach campaigns for BabyCal.

***//2008/ The combined number of calls to the BabyCal and MCAH numbers was 11,580 in FY 2005-06, down from 13,780 in FY 2004-05. //2008//***

Emergency Preparedness

***//2008/***

***CDPH public health emergency preparedness efforts are consolidated in the Emergency Preparedness Office (EPO) to coordinate activities related to implementation of the CDC Public Health Emergency Preparedness (PHEP) grant, the federal Hospital Preparedness Program (HPP) grant and the state general funds for pandemic influenza preparedness and responses to natural disasters such as earthquakes, fires, and floods. EPO works with programs throughout CDPH to prepare for and respond as needed to emergencies.***

***Under the CDC PHEP Cooperative Agreement, CDPH allocates approximately 70 percent of funds to local health departments to implement local response capacity, including pandemic influenza preparedness. CDPH and local health departments share responsibility to assure that all requirements under this grant are met, including meeting the needs of special populations. This responsibility is carried out in all grant activities, including development of state and local emergency response plans, risk communication messages, and training programs for local health department staff and the medical community.***

***Under the HPP Grant, 80 percent of direct service funds support preparedness and response activities conducted by hospitals, poison control centers, emergency medical service agencies, and clinics. To date, HPP expenditures have covered procurement of personal protective equipment, increasing isolation capacity, and establishment of hospital pharmaceutical caches to assure that medical personnel are protected during a bioterrorism incident. CDPH has undertaken two projects to develop advisory materials and train medical providers in addressing the mental health issues Californians may experience during a bioterrorist event.***

***The CMS Branch has undertaken one of the mental health projects to assure that pediatric primary care providers have the necessary skills to care for the mental health needs of children. CMS is receiving \$300,000/year for this four-year project which began in October 2003. CMS is collaborating with EPO and the Department of Mental Health to develop a training curriculum and training sessions that will link pediatric primary care providers, local bioterrorism networks, experts on childhood trauma, public and mental health agencies, and medical societies. An on-line course is available to provide pediatric primary care providers with tools to address the mental health needs of children in the event of a large scale disaster or bioterrorism event; see <http://www.californiaschildren.org>.***

***The MCAH/OFP Branch has begun work on the California Perinatal Transport Systems Northern and Southern programs for the integration of perinatal populations into existing disaster preparedness plans at the hospital, local, county, and statewide emergency response system levels.***

***The MCAH/OFP Branch promotes optimal infant feeding for mother-infant dyads in emergency situations via participation on the US Breastfeeding, the Office of Women's Health Breastfeeding Group, and the Breastfeeding Promotion Advisory Group. The Branch has also provided optimal infant feeding and care resources/guidelines on their web site; see <http://www.mch.dhs.ca.gov/programs/bfp/emergency-prep.htm>.***

//2008//

#### March of Dimes

The MCAH/OFP Branch collaborates with the California March of Dimes (MOD) on perinatal health issues. In addition to supporting research and advocacy efforts to accomplish this mission, the MOD invests in community services and education, with a specific focus on decreasing the disparities in infant mortality among ethnic groups.

The MOD is currently in its third year of an eight year Prematurity Campaign. The revised goals of the campaign are to 1) raise awareness of the problems of prematurity to 60 percent for women of childbearing age and 50 percent for the general public by 2010 and 2) Reduce the rate of premature birth from 12.1 percent in 2002 to 7.6 percent in 2010, in accordance with the Healthy People 2010 objective.

To meet these goals, MOD is collaborating with the MCAH/OFP Branch at the state and county levels to 1) increase awareness of the signs and symptoms of preterm labor through CPSP and BIH-based educational classes, clinic displays, and community events; 2) educate healthcare providers about prematurity risk detection and reduction through annual Prematurity Summits and the development and dissemination of tools to identify women at increased risk for preterm delivery; and 3) provide funding to agencies that are reaching high-risk communities with education and support services.

Additionally, Comenzando bien™, a culturally and linguistically appropriate prenatal education curriculum for Latina women, has been implemented and evaluated in a number of sites across the state. In the Central Valley, Comenzando bien™ boasts an 81 percent graduation rate and significant reported changes in behavior related to prenatal care, nutrition, and exclusive breast feeding.

/2007/ Currently a Preterm Labor Assessment protocol is being promoted and implemented; an African American faith-based prematurity prevention program has been initiated; and a strategic plan for preconception care is being developed. //2007//

***/2008/ A statewide council is developing an action plan for preconception health and health care; MOD is funding three multi-year preconception/interconception demonstration projects; and a national preconception summit in collaboration with CDC is planned. //2008//***

#### Nurse Family Partnerships

Eight counties in California utilize Nurse Family Partnerships (the David Olds home visiting model) to follow high-risk, first-time pregnant women, mothers and families. Several other counties have incorporated the work of Dr. Ira Chasnoff in dealing with fetal alcohol and perinatal substance abuse issues. The Olds model is a home visitation model that utilizes public health nurses; other counties utilize a home visitation format with staff ranging from Promotoras to registered nurses.

## **G. Technical Assistance**

***/2008/***

### ***Capacity Assessment***

***The MCAH/OFPP Branch requests training and resource materials in the area of capacity assessment, including:***

***1) Clinical capacity assessment (availability of and access to clinics, maternity beds, neonatal intensive care units, etc);***

***2) Clinical workforce assessment at state and county levels (physicians, obstetrician/gynecologists, pediatricians, dentists, nurses, etc);***

***3) Public health capacity assessment (epidemiologists, program evaluators, etc); and***

***4) Integration of needs assessment, capacity assessment, and implementation planning.***

*//2008//*

*/2007/*

Annual MCAH California Conference

The MCAH/OFPP Branch requests assistance in reviving an annual (or bi-annual) MCAH California Conference. The conferences would be a collaborative effort undertaken by the MCAH/OFPP Branch, MCAH Action (the statewide organization of local MCAH Directors), and the University of California Berkeley School of Public Health.

Such conferences were held annually in California prior to discontinuation in 2002 due to budget constraints. The conferences were well attended, with approximately 700 participants each. Conference locations alternated between northern and southern California.

The conference provided opportunities for participants -- from the state, local jurisdictions, academia, and other interested groups -- to network and strategize on issues affecting the health of women, children and families in California. Each year the conference had a theme. The Branch encouraged interested parties to submit general or scientific abstracts on current and emerging MCAH issues pertinent to the theme. Programs that addressed the conference theme were recognized.

*//2007//*

Methodological training in epidemiology and program evaluation

The MCAH/OFPP Branch Epidemiology and Evaluation Section (MCAH-EES) has an excellent staff of researchers and analysts for epidemiological analyses and evaluation of Title V programs. However, MCAH-EES requests training for recent hires and junior research staff on several aspects of the methodology of epidemiological analyses of maternal, child, and adolescent health and program evaluation. The CMS Branch would also benefit from receiving training on these issues, including epidemiological methods, analyses of the cost-effectiveness or budget neutrality of programs, and the analysis of trend data. While it would be desirable to obtain this training directly through seminars and workshops offered at CDC, HRSA, and other Federal agencies, policies designed to address budget constraints in California prohibit out-of-state travel.

A workshop on epidemiology (e.g., risk ratios, sensitivity, specificity, validation, and bias) and appropriate statistical analyses commonly used in maternal, child, and adolescent health would be valuable to both the MCAH/OFPP and CMS Branches. Applied examples, including examples of analyses commonly used by comparable state and federal entities, would demonstrate

concepts and inform possible areas for enhanced analysis and program development. Many MCAH/OFP Branch programs are local; data collected at the state level may be useful for smaller areas, so an overview of small-area and geographic analysis would also enhance current and suggest future analyses.

Technical assistance on how to conduct cost-effectiveness, cost-benefit, and cost avoidance analyses for Title V programs would also be very beneficial for staff. During the current era of budget shortfalls in California, there has been greater scrutiny by decision-makers as to the cost-effectiveness and fiscal neutrality of programs run by the MCAH/OFP and CMS Branches. Technical assistance on the steps involved in analyses, parameters to consider, accepted methodologies, and effective presentation of results would supplement staff's ability to provide this critical information to program managers and administration officials.

### Maternal Morbidity and Mortality

The CDC reports that more than 40 percent of women experience some type of complication during childbirth; many of these complications are preventable. Maternal morbidity is a serious public health problem that can impact maternal, fetal, and infant health and can lead to maternal death.

The MCAH/OFP Branch is working to monitor maternal morbidity. The MCAH/OFP Branch is developing a Maternal Quality Improvement (MQI) project and has contracted with an academic research group to assess variation in maternal outcomes and an evidence-based quality improvement collaborative to analyze the data. The MCAH/OFP Branch requests assistance in the development of systems for identifying, reviewing, and analyzing maternal morbidity that will serve as a framework for improved maternal standards of care.

The maternal mortality ratio for California in 2003 was 15.2 maternal deaths per 100,000 live births. Mortality among African American women was about three times higher than among non-Hispanic White women. The MCAH/OFP Branch will be conducting a Pregnancy-Related and Pregnancy-Associated Mortality Review Project under an agreement with the University of California, San Francisco. The goal of the study is to analyze causes of and risk factors contributing to pregnancy-related and pregnancy-associated deaths so that the MCAH/OFP Branch and its stakeholders can develop a public health component to reduce such deaths.

The MCAH/OFP Branch requests technical assistance from the CDC on how to conduct such reviews, including study design, data for linkages and case selection, medical record review protocols, guidance on determination of whether cases are pregnancy-related or pregnancy-associated, development of recommendations to reduce mortality based on findings, and implementation of recommendations.

### Consumer Involvement - Youth

The MCAH/OFP Branch requests assistance in how to obtain youth input into decision-making for the Branch and its adolescent-related programs. Currently, the Branch does not have sufficient manpower to carry out this activity, but would like to include more youth input into our decision-making process.

### Consumer Involvement - Families

Based on feedback given in a previous federal block grant review, the Branch requests training on consumer/family involvement in the needs assessment and other Title V activities at both the state and local level. This is a Title V requirement and the Branch has been asked to be more

proactive in including families.

#### Evaluation of Clinical Outcomes

The CCS program has embarked on a quality initiative to assure that children receive appropriate services in an environment of dwindling financial and professional resources. The CMS Branch is requesting assistance in acquiring skills to develop and evaluate appropriate outcome and performance measures for clinical practice.

#### Strategic Planning and Facilitation

The CMS Branch has developed a collaborative relationship with the stakeholder community through the Title V Needs Assessment process, which is expected to continue with the development of strategies and activities as the next steps in the process. Additionally, there are issue-specific collaborations with families and agency partners to address and improve family-centeredness and client outcomes in the coming years. As the Branch moves into more infrastructure-building activities, it will be very helpful to have a core group of staff who are trained in strategic planning and facilitation techniques.

## V. Budget Narrative

### A. Expenditures

*//2008/ The budget and expenditures for FFY 2008 are presented in Forms 2, 3, 4, and 5. //2008//*

### B. Budget

Since the enactment of the Omnibus Budget Reconciliation Act (OBRA) 89, California has maintained the availability of Title V funds under both the maintenance of effort and the match requirements. The California Title V agency will continue to do so in the coming year.

The proposed allocation of Title V funds for California for FFY 2007 is \$44,430,440. Preventive and primary services for pregnant women, mothers, and infants are designated to receive \$12,230,634 (27.53 percent of the total), preventive and primary services for children to receive \$14,394,384 (32.40 percent), and CSHCN to receive \$15,374,114 (34.60 percent).

*//2008/ The proposed allocation of Title V funds for California for FFY 2008 is \$44,452,058. Preventive and primary services for pregnant women, mothers, and infants are designated to receive \$12,562,689 (28.26) percent of the total), preventive and primary services for children to receive \$14,523,469 (32.67 percent), and CSHCN to receive \$14,523,500 (32.67 percent). //2008//*

#### State Match/Overmatch

At the time the Title V Annual Report and Grant Application for FFY 2007 was written, California was to receive \$44,430,440 in Federal Title V Block Grant funds for FFY 2007. The required match was \$33,322,830. California's FFY 2007 expenditure plan for MCAH programs included \$964,859,736 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceeded the required 4:3 matching ratio.

*//2008/ California expects to receive \$44,452,058 in Federal Title V Block Grant funds for FFY 2008. The required match is \$33,339,044. California's FFY 2008 expenditure plan for MCAH programs includes \$753,798,124 in State funds. Consequently, the state-funded expenditures for preventive and primary health care services for the Title V populations exceed the required 4:3 matching ratio. //2008//*

#### Administrative Costs Limits

In FFY 2007 no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2006, California expended only 5.47 percent of Title V funds on administrative costs.

*//2008/ In FFY 2008 no more than 10 percent of the Federal Title V MCH Block Grant funds will be used for administrative costs related to each program component. During FFY 2008, California will expend only 6.39 percent of Title V funds on administrative costs. //2008//*

#### Definition of Administrative Costs

In this Application, administrative costs are defined as the portion of the Title V dollars used to support staff in the MCAH and CMS Branch Operations Sections. Funds supporting State

program and data staff (but not administrative staff) in the MCAH/OFP and CMS Branches are considered to be program rather than administrative costs.

Administrative costs include staff and operating costs associated with the administrative support of specific MCAH/OFP Branch and CMS Branch programs. These support functions include, but are not limited to, contract management, accounting, budgeting, personnel, audits and appeals, maintenance of central contract files, and clerical support for these functions.

#### "30-30" Minimum Funding Requirement

At least 30 percent of the MCH Title V Block Grant funds will be used for children's preventive and primary care services delivered within a system which promotes family-centered, community-based, coordinated care. At least 30 percent of the Title V Block Grant funds will be used to provide services to CSHCN delivered in a manner which promotes family-centered, community-based, coordinated care.

In some cases, the CDPH uses estimates to assess expenditures for both individuals served and the types of services provided. These estimates are based on the target population and program activities authorized in statute, excluding the State budget, and specified in the scope of work for each contractor. Requiring contractors to bill according to actual amounts spent on each type of individual served and by service provided is not possible within current administrative and fiscal policies. Changing State contractual policies would result in undue financial and administrative hardship to local governments and non-profit community-based organizations. This added burden without increased funding would result in many of them not being able to continue to provide needed services to women and children in the state.

#### Maintenance of State Effort

CDPH has an ongoing commitment to provide maternal and child health services to women and children within the State of California. This commitment includes continued support to local health jurisdictions, local programs, clinics and Medi-Cal providers for maternal and child health services.

It is the State's intent to ensure that State General Fund contributions to these local programs, which are also funded in part by the Federal Title V Block Grant, be administered by the MCAH/OFP and CMS Branches. The State's General Fund contribution for FFY 2007 was \$964,859,736 which was \$877,700,986 greater than the State's General Fund contribution of \$87,158,750 in base year FFY 1989.

***//2008/ The State's General Fund contribution for FFY 2008 is \$753,798,124 which is \$666,639,374 greater than the State's General Fund contribution of \$87,158,750 in base year FFY 1989.//2008//***

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.