

**California Grant Application and Annual Report**  
**for the**  
**Maternal and Child Health Services**  
**Title V Block Grant Program**

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**Attachment to the Abridged Document**

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**Center for Family Health**  
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## A. Health Systems Capacity Indicators (HSCI)

### Introduction

Social, demographic and economic factors have been identified to explain the disparities in health. Some argue that health disparities may reflect the variation in health system characteristics such as the adequacy of public health services and the availability and quality of health care services received.

This section covers a discussion of select health indicators, a comparison of health disparities with programs targeting the economically disadvantaged populations and public health activities that aim to close the disparity gap. Please note that in California, the Medicaid Program is called Medi-Cal; SCHIP is called HF; EPSDT is called the CHDP Program.

### >Asthma Indicator

HSCI 01 is the rate per 10,000 for asthma hospitalizations among children less than five years old. The rate of children hospitalized for asthma decreased from 22.9 per 10,000 in 2009 to 22.3 per 10,000 in 2010. The HP 2020 target for asthma hospitalizations for children less than five is 18.1 per 10,000 population; this rate was achieved for Whites. Hospitalization rates for asthma were highest among African American children (54.0 per 10,000) compared to Hispanics and Whites (21.1 per 10,000 and 18.1 per 10,000, respectively).

Efforts to address childhood asthma are guided by the California Asthma Public Health Initiative (CAPHI), which is implemented by the CCDPHP in CDPH. CAPHI seeks to reduce preventable asthma morbidity and mortality; to eliminate disparities in asthma practices and outcomes; and to implement effective programs and policies in asthma education, management, and prevention according to the National Asthma Education and Prevention Program Guidelines.

CAPHI and CDPH spearhead the Enhancing Local Capacity to Address Asthma Priorities (ELCAAP) Program. The purpose of the ELCAAP Program is to work directly with six California county health departments (Fresno, Kern, Kings, Madera, Stanislaus and Tulare) collaboratively facilitate local efforts to reduce the burden of asthma in the 5 key goal areas identified in the Strategic Plan for Asthma in California (2008-2012). These areas include: awareness and infrastructure, data/surveillance, health care, indoor environments, and outdoor environments.

Kings County local MCAH priority is to collaborate with their local asthma coalition to develop and implement one strategy to provide educational outreach about appropriate asthma management to parents and children with asthma in relation to the effect of 2<sup>nd</sup> and 3<sup>rd</sup> hand smoke.

## >Perinatal Indicators for Medicaid and non-Medicaid Population

HSCI 5a to HSCI 5d compares Medicaid and non-Medicaid perinatal indicators. Payment source data are obtained from birth certificates. Non-Medi-Cal payment sources include private insurance, self-pay, no charge, other government programs and medically indigent.

HSCI 5a compares Medicaid and non-Medicaid in the percent of low birth weight (<2,500 grams, LBW) babies. HSCI 5a remained at 6.7 percent for Medicaid clients and 6.8 percent for non-Medicaid clients in 2010. African Americans covered by Medicaid had a rate of 13.0 percent compared to 11.1 percent among those not covered by Medicaid.

HSCI-5b compares Medi-Cal and non-Medi-Cal infant death rates. The infant death rate was higher among Medi-Cal births (5.5 per 1,000) than among non-Medi-Cal births (4.2 per 1,000) in 2009. The infant death rate decreased for Medi-Cal births and non-Medi-Cal births in 2009. The non-Medi-Cal births achieved the Healthy People 2010 goal of 4.5 infant deaths per 1,000 in 2009.

The disparity by payor was most apparent for Whites, for whom the infant death rate was much higher for Medi-Cal (6.0 per 1,000) than for non-Medi-Cal (3.5 per 1,000) births in 2009. Infant death rates at 11.1 per 1000 were highest for Medi-Cal births among African Americans. Infant death rates for non-Medi-Cal African Americans were at 8.3 per 1,000.

Health Systems Capacity Indicator 05c (HSCI-05c) compares the number of Medi-Cal and non-Medi-Cal pregnant women receiving first trimester prenatal care. After a decline between 2005 and 2008, HSCI 5c has increased the past two years, reaching 83.5 percent in 2010. The percent of women entering prenatal care in the first trimester was lower for Medi-Cal births (77.5) than for non-Medi-Cal births (88.9%) in 2010. This difference was noted for all race/ethnic groups.

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). This index considers the mother's timing of initiation of prenatal care and the number of prenatal care visits recommended by ACOG. In 2010, 76.6 percent of Medi-Cal women, a slight increase from 76.4 percent in 2009, and 82.3 percent of non-Medi-Cal women had adequate prenatal care.

HSCI4 duplicates what is already reported for HSCI 5d, the percent of women ages 15 to 44 with a live birth during the year whose observed to expected prenatal visits are at least 80 percent on the Kotelchuck Index. The percent for HSCI slightly decreased to 79.6 percent in 2010. Asian and White women had the highest percent at 82.8 and 82.6 percent, respectively, followed by Hispanics (78.0%), Multi-Race (77.6%), African Americans (74.2%), and Pacific Islanders (65.8 percent). AIs had the lowest rate at 65.7 percent.

MediCal clients have lower rates of early entry into prenatal care or the number of prenatal care visits and have a higher infant mortality rate. Despite this disparity, MediCal has helped narrow the gap in access to care faced by those without insurance and promoted broader use of preventive and primary care services. As the workhorse of California's healthcare system for those left out of private health insurance, it provides coverage of the low-income population who tend to be sicker, poorer a minority, unmarried, has less than high school education and has a health condition that limits work compared to the privately insured low-income population. [1] Attempting to address the disparity in the current economic climate is even more. As MediCal rates are cut further, more providers are turning down MediCal beneficiaries or leaving the program making it even more difficult to access qualified providers. Multiple lawsuits have been filed to stop scheduled reductions in MediCal payment rates, reflecting the generally low reimbursement rates in California. For example, California ranks 47<sup>th</sup> lowest physician payment rate among the 50 Medicaid programs in 2008. [2] Although not yet approved by the federal Medicaid program, Legislature imposed MediCal copayments as part of the 2011-12 state budget agreement. Enrollees will potentially face copayments ranging from \$3 to \$100 for prescription drugs, hospitalization, and other services in 2012. Research shows that low-income individuals who are charged more for health care tend to reduce their use of essential health services. [3]

For women with a health insurance but no maternity coverage, two bills were chaptered that would require maternity coverage to be included in comprehensive health insurance policies by July 2012. SB 222 would apply to the market for individual policies, and AB 210 would apply to small group health plans. This relieves pregnant women from choosing between paying for maternity care herself, seeking help from a state program for low-income women or choosing from a small number of plans with comparatively expensive maternity coverage.

AFLP and BIH continue to assist low-income women by promoting the importance of accessing prenatal care and assist and refer clients to enter into care as early in their pregnancy as possible. Additionally, program case managers follow-up to ensure they are continuing to receive prenatal care throughout their pregnancy.

CPSP offers a comprehensive prenatal care, which includes obstetrics, nutrition, health education, and psychosocial support. CPSP providers receive a financial incentive to initiate prenatal care in the first trimester of pregnancy.

MCAH LHJs partner with prenatal care providers in their community to assist women to access early, quality prenatal care. MCAH also promotes preconception and interconception care as part of the continuum of care for women of reproductive age.

MCAH works to decrease the incidence of LBW infants by providing at-risk women with comprehensive services including prenatal care, education, and psychosocial support. African American infants are more than twice as likely as infants of other racial/ethnic groups to be born with LBW in California. BIH identifies at-risk pregnant and parenting

African American women and assists them in accessing appropriate health care and supportive services.

MCAH and CMS collaborate with CPQCC on performance improvement in perinatal outcomes. RPPC supports implementation of clinical quality improvement strategies by collaborating with providers to address evidence-based quality improvement projects and improve risk-appropriate care.

MCAH participates in PHCC, providing information and resources to communities on achieving optimal health for women prior to pregnancy. Both participate in the Premature Infant Health Coalition to reduce premature births and improve outcomes for children born prematurely. CDRTs make recommendations on ways to prevent infant deaths. SAC Branch has completed CDRT trainings to promote the recruitment of injury prevention specialists. The Safe Surrender Baby Law and remedies for unsafe sleeping environments have been emphasized by CDRTs.

MCAH, the CDPH lead in reducing infant mortality, developed an action plan to address the infant mortality disparities.

Sixteen LHJs implement the national FIMR model. In Contra Costa, preconception education is integrated into the maternal interview, an essential component of the FIMR data-gathering process. Given its size, L.A. County uses a survey tool to conduct FIMR. Survey questions focus on maternal behaviors and health system variables that can be addressed by public health interventions.

Consistent with the Life Course Perspective, which emphasizes the importance of maximizing healthy living prior to and between pregnancies in addition to the life-long consequences of risks and poor health conditions, several LHJs implement programs to improve awareness of preconception and interconception health.

Unintended pregnancies are associated with lower rates of first trimester prenatal care utilization. [4] One of the goals of PHCC is to address unintended pregnancy by encouraging RLP.

### **>Eligibility and Access to Care for Medicaid and EPSDT Population Indicators**

Eligibility requirements by MediCal and SCHIP for children and pregnant women remained stable. Health Systems Capacity Indicator 06a (HSCI-6a) compares the income eligibility requirements for Medicaid and the SCHIP for infants (ages 0 to 1). Infants were eligible for Medi-Cal if the family income was at or below 200 percent of the FPL. Infants were eligible for HF if the family income was between 200 and 250 percent of FPL.

Infants up to one year old born to women with family incomes between 200 and 300 percent of FPL and who were enrolled in AIM were eligible for 2 years in the AIM Program, provided the infant was not enrolled in no-cost Medi-Cal or employer-

sponsored health insurance.

Health Systems Capacity Indicator 06b (HSCI-06b) compares the income eligibility requirements for Medicaid (Medi-Cal) and SCHIP for children from 1 year up to age 19. Children aged 1-5 years were eligible for Medi-Cal if the family income was at or below 133 percent of FPL; for children age 6-18, the eligibility level was 100 percent of FPL. Children aged 1-5 were eligible for HF with family incomes between 133 and 250 percent of FPL, and children aged 6-18 were eligible for HF if the family income was between 100 and 250 percent of FPL.

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 with a family income at or below 200 percent of the FPL. Pregnant women with family income levels between 200 and 300 percent of the FPL are eligible for the AIM Program.

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. For 2010, it is estimated that 93.4% of Medicaid eligible children received a service paid for by the Medicaid Program.

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. For FY 09-10, the annual indicator is 50%.

One of the most important steps a state can take to provide health coverage to its children is to reach uninsured children who already qualify for Medicaid or the SCHIP. For 2010, it is estimated that 38.4% of California children were covered by MediCal or HF; among low-income children, the rate was 64.8%. [5] The number of uninsured children decreased significantly in recent years, largely because Medicaid started covering more kids who otherwise would have remained uninsured, according to a report by the Georgetown University Health Policy Institute's Center for Children and Families. California's uninsured children decreased by 11% to about 931,000, making it the third largest decline in uninsured kids over the two-year period [6] across states despite that more and more Californians lost their private coverage due to cost or they lost their jobs in the economic downturn and many more children found themselves living in poverty. This has significant impact nationally as 12.5% of the estimated 74 million children in the U.S. live in California.

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

- 1) Support of streamlined Medi-Cal eligibility processes that encourage continuous coverage.

2) Support for LHJ MCAH programs, which screen and assess children for Medi-Cal eligibility and assist them to obtain needed services. LHJ MCAH programs also identify pregnant women and refer them to appropriate programs such as CPSP, AFLP and BIH. Several LHJ MCAH programs have local initiatives that assist families with uninsured children to enroll in government funded health insurance programs or pay for health insurance costs for children who are not eligible for government funded programs. The San Diego Kids Health Assurance Network Community Collaborative assisted the local Medi-Cal program in the development of educational materials to inform Medi-Cal eligible clients about the new citizenship verification requirements for Medi-Cal enrollment. Additionally, LHJs perform a wide variety of community outreach activities in multiple venues to facilitate enrollment in Medi-Cal and educate target populations about Medi-Cal 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.

4) Facilitation of the provision of Medi-Cal paid prenatal care services to adolescents by providing financial incentives to prenatal care providers.

5) Recruit, retain, and educate providers about the CHDP program, Gateway, and preventive services for children from families at or below 200 % of FPL. The CHDP Provider Manual is available online to assist providers with programmatic issues and day-to-day activities and provide statewide standardization of CHDP provider requirements for program participation. 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 may also participate in community Advisory Boards.

The CHDP Health Assessment Guidelines for CHDP providers are under revision to include methods to provide FCC and culturally competent care. There will be continuing CHDP collaboration with schools, Head Start and providers in order to assist more low-income children to receive periodic preventive exams. Sections of the CHDP Health Assessment Guidelines include updated recommendations from AAP, Advisory Committee on Immunization Practices and CDPH.

With regard to EPSDT dental services, the CHDP Gateway covers dental services for pre-enrolled children up to 60 days after a CHDP health assessment and has increased access to dental services. CHDP Gateway offers the opportunity to apply for permanent enrollment in Medi-Cal or HF which includes dental benefits. Most Denti-Cal providers accept the pre-enrollment receipts and many children receive dental services through the Gateway.

CHDP tools such as the revised two-sided full color "PM 160 Dental Guide" will continue to improve the quality of dental screenings and more acceptable annual referrals to a dentist beginning at age one. A provider notice, under development, will encourage CHDP providers to discuss the importance of dental sealants with families of 6 and 12 year old children. Fluoride varnish applications (3/year) became a benefit of the Medi-Cal program. CHDP providers were informed of this benefit, asked to apply fluoride varnish, and be reimbursed through Medi-Cal.

Brochures entitled, "Fluoride Varnish-- Helping Smiles Stay Strong" and "Every Child Needs a Dental Home" have been released to local CHDP programs and available online in three languages. A resource guide has been developed and distributed to local programs. It includes online links for brochures including most oral health topics for children ages 0 through 5 and 6 through 20. A Power Point training is being developed for CHDP Providers and local program staff which includes resources and oral health topics specific to screening and referring children to a dentist by age one. This training is expected to be placed on the CMS website. The Growing Up Healthy brochures with age specific dental information have been completed in 4 languages and are on the CMS Branch website

The State Dental Hygienist Consultant in conjunction with the Dental Subcommittee of the CHDP Executive Committee continues dental updates to providers, local program staff, and families. The dental sections of the Health Assessment Guidelines, including anticipatory guidance, are being aligned with Bright Futures Oral Health. Changes specific to California are being added.

### >Rehabilitative Services for CSCHN Indicator

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 CSCHN Program. HSCI-8 is 30.4 percent for FY 2009-10 ; 30.1 percent for FY 2008-09 and 28.2 percent in the previous year. The numerator, 30,123 for FY 2009-10; 20,907 for FY 2008-09 and 25,534 FY 2007-08), is the number of open CCS cases under 16 years of age with aid codes of 20 and 60. The denominator, 95,788 for FY 2009-10; 93,899 for FY 2008-09 and 90,464 for FY 2007-08, is the percent of SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSCHN Program.

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 MTP services. The denominator is from the Social Security Administration Office of Policy, Children Receiving SSI for December, the midpoint of the current FY, 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.

MTU Online is a separate web-based software program for clinical documentation of MTU services. Twenty one counties are actively using MTU Online as of January 2009. This software allows for single entry of clinical data and narrative description by occupational and physical therapists and Medical Therapy Conference physicians.

Statewide clinical data is collected annually for MTP program management. The Functional Improvement Score (FISC) is used to measure the amount of functional change that a child achieves in a 6-12 month. The Neuromotor Impairment Severity Scale (NISS) measures the amount of neuromotor impairment for children with cerebral palsy or similar upper motor neuron conditions. Data analysis is limited due to budget cuts and it is projected that it will take several years to develop meaningful baselines and targets for program management.

The MTP module has moved to the web as of March 27, 2010. This web based administrative module is used to search, track, enter, modify, and report administrative data related to MTP.

Several county CCS programs utilize a new service care model that increases family responsibility in the child's therapy and its implementation. Data is currently being gathered to measure the effectiveness and outcomes of this service delivery model including FISC data.

### >Data Systems and Data Access Indicators

MCAH has access to linked birth statistical master files (BSMF) and death statistical master files (DSMF) used for surveillance and program evaluation . The Perinatal Profiles report provides annual perinatal data analyses to hospitals annually. MCAH has access to patient discharge data (PDD) that contain information on population demographics, hospital/clinic characteristics, payer source, births and other conditions, procedures, and injuries. PDD is linked to both BSMF and DSMF... MCAH has access to BSMF linked with NBS data and birth defects registry data. MCAH also has access to Medi-Cal data. MCAH has linked BSMF and WIC prenatal services data.

In collaboration with UCSF, MCAH's MIHA is an annual survey of post-partum women modeled after CDC's PRAMS. Birth outcomes are provided through linkage with birth certificate data. Local data for the 20 largest California counties are available online.

CWHS, is an annual telephone survey that collects information on health insurance status, family planning, sexually transmitted infections, pregnancy, mental health, and lifestyle issues. MCAH sit on the CWHS advisory group, contribute questions to the survey, analyze data and present findings.

The California Health Interview Survey (CHIS), conducted by UCLA in collaboration with CDPH, DHCS, and PHI, is a bi-annual telephone survey of adults, adolescents, and children that collect information on health insurance coverage, health behaviors, chronic disease, mental health, oral health, and lifestyle issues. MCAH sit on the CHIS Technical Advisory Group.,

MCAH also collects data on its various programs, including AFLP, BIH, CDAPP, CPSP, FIMR, Home Visiting and SIDS. Data elements cover client socio-demographic information and service access information.

The Office of Vital Records (OVR) and MCAH collaborate on providing trainings emphasizing the importance of hospital administration, nursing and birth clerks working together to accurately report birth data.

who report using tobacco products during the past month. California obtains data on adolescent tobacco use from multiple sources. These include the biennial California Youth Risk Behavior Survey (YRBS), the California Student Survey (CSS), the California Healthy Kids Survey (CHKS), the California Student Tobacco Survey (CSTS) and CHIS.

YRBS was implemented statewide for the first time in spring 2009 in schools using a random sample of 9th through 12th graders. The YRBS was developed to monitor priority health risk behaviors that contribute to the leading causes of mortality, morbidity and social problems among adolescents. The survey is part of a surveillance effort conducted by CDPH, CDE and the PHI in cooperation with the CDC. The biennial sample size for this survey is approximately 1,500 surveys. California is working closely with CDC to improve the YRBS response rate.

CSS utilizes data from a voluntary, representative, randomly-selected biennial sample of schools and classrooms (seventh, ninth graders, and eleventh graders). CSS collects information on adolescent alcohol and other drug use patterns, including data on tobacco use (smoking), marijuana, and inhalants, along with physical activity, nutrition and eating habits, depression, and external and internal resilience enhancing assets. CSS allows for trend data analyses, and provides data on a range of health related behaviors comparable with the CHKS, which is a school level survey that is similar to YRBS.

CHIS is a telephone survey of adults, adolescents, and children from all parts of the state. The survey is conducted every two years. CHIS is the largest state health survey and one of the largest health surveys in the United States and is able to provide statewide and local level estimates on a number of health related issues, including adolescent tobacco use. MCAH sit on several CHIS Technical Advisory Groups, helping to develop topic areas and survey questions, and analyzing the data.

CDPH's Tobacco Control Program (CTCP) coordinates statewide tobacco control efforts and funds CSTS. CSTS is a large-scale, biennial, in-school student survey administered to middle (grades 6-8) and high school (grades 9-12) students. The survey includes questions about tobacco-use behavior, such as cigarette, smokeless, and menthol,

exposure to tobacco prevention efforts, exposure to tobacco marketing, and beliefs about the health consequences of using tobacco products. The County and Statewide Archive of Tobacco Statistics web site aims to provide access to a wide variety of tobacco-control related information and statistics, including evaluation resources for local projects, publications, and local information on tobacco-related indicators, ranging from behavioral measures to local policies. Data can be viewed by type, county, or statewide level. The sources of data originate from the U.S. Census Bureau, California Tobacco Survey (CTS); CSTS; Cost of Smoking Report 1999; Database, and the California Smokers' Helpline.

The annual Youth Tobacco Purchase Survey uses random, onsite inspections at retail sites by minors 15 and 16 years old to monitor illegal sales to adolescents.

## **B. 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.*

#### **a. Last Year's Accomplishments**

In 2010, GDSP detected and confirmed almost 600 genetic and congenital abnormalities as a result of its NBS Program. California has effectively achieved universal coverage for NBS for genetic, metabolic and hematological disorders, with nearly 100 percent of newborns screened for all conditions for which screening was mandated.

All the conditions for which the NBS Program screens, including over 40 metabolic disorders, endocrine disorders, and hemoglobinopathies, are CCS-eligible. GDSP and CMS have been collaborating to ensure that infants identified with abnormal metabolic, endocrine, sickle cell, cystic fibrosis, or pilot severe combined immunodeficiency disorder (SCID) screening results from the current and expanded testing receive prompt diagnostic evaluations at one of the CCS-approved Special Care Centers (SCC) in the state. The county CCS programs expedite GDSP referrals, so that infants with suspected 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 over 40 additional metabolic disorders and congenital adrenal hyperplasia are in place.

In 2011, the California Prenatal Screening Program expanded to allow 1st trimester specimens for Integrated Screening and will consist of all 4 types of screening tests:

-Patients who submit a blood specimen in the 2nd trimester (15 to 20 weeks): Quad Marker Screening [AFP, hCG, uE3, and Inhibin]

-Patients who had CVS and submit a blood specimen in the 2<sup>nd</sup> trimester: Neural Tube Defect (NTD)/Sickle Cell Disease (SCD) Screening [Risk assessment for NTDs and SCD only]

-Patients that submit a blood specimen in the 1st trimester (10 to 13 weeks 6 days) and 2<sup>nd</sup> trimester (15 to 20 weeks): Serum Integrated Screening [Pregnancy Associated Plasma Protein and hCG in the first trimester, plus Quad Marker Screening in the second trimester] -Full Integrated Screening:

-Nuchal Translucency Ultrasound when the crown rump length is between 45-84 mm, combined with Serum Integrated Screening.

The pilot study for SCID began in August 2010 and was the first DNA-based test used by the state laboratory as a screening tool. Findings of the pilot study show that 86% of “classic” SCID cases are Hispanic. To date there are no Caucasians with classic SCID, only SCID variant. It also found 3 Chinese cases of SCID variant or non-SCID immune deficiency which was unexpected. Almost all false positives are due to DNA amplification failure which occurs almost exclusively from babies in the NICU. The results from the pilot had received national and international acclaim for its success and in increasing the knowledge base for what was thought to be an extremely rare disorder. With the success of the pilot study, AB 395 was introduced in February 2011 which requires CDPH to expand statewide screening of newborns to include screening for severe combined immunodeficiency (SCID) and, insofar as it does not require additional costs, other T-cell lymphopenias detectable as a result of screening for SCID, and would make related changes. The bill became law (Chapter 461, Statutes of 2011).

## **b. Current Activities**

CMS and GDSP programs work together to address issues as they arise and update policies and reporting forms as needed in an effort to ensure that babies who screen positive receive expedited care at a CCS approved Special Care Center. Although CCS makes a special effort to expedite these cases some slight delays may occur due to the CCS staffing cuts.

GDSP, along with several other states, conducted a pilot study during 2010 – 2011 to evaluate the feasibility of screening for Severe Combined Immunodeficiency Disorders (SCID). The Health and Human Services Secretary’s Advisory Committee for Heritable Disorders in Newborns and Children (ACHDNC) had made a national recommendation to states to add SCID to the (NBS) panel.

CCS provides services for conditions identified on NBS tests, develops standards, and approves Metabolic, Endocrine, Sickle Cell, Cystic Fibrosis, and SCID SCCs for treatment.

## **c. Plan for the Coming Year**

GDSP will continue to screen for genetic and congenital disorders, including testing, follow-up and early diagnosis, in order to prevent adverse outcomes and minimize

clinical effects. GDSP ensures the quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them. GDSP 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 (e.g., Hemoglobin Trait Carrier Follow-up Program, Maternal PKU Program, GeneHELP Resource Center and the Sickle cell Counselor Training and Certification Program).

SCID has become a regular part of the state's NBS program, with a legislated fee increase for testing and follow-up case management. Legislation has been introduced in 2012 (AB 1731 Block) for the use of pulse oximetry as a screening tool for Critical Congenital Heart Defects (CCHD). GDSP, CCS, and CBDMP are collaborating to discuss the best way to implement CCHD screening in California.

GDSP will continue to work collaboratively with state and local agencies, including CMS, CCS-approved SCCs, GDSP NBS Contract Liaisons and other NBS Program staff, local County CCS programs, and Area Service Center Project Directors and Medical Consultants 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.

GDSP will continue to administer and evaluate the 1st Trimester Prenatal Screening Program. CMS and GDSP will continue to work together to address issues as they arise and update literature as needed. Despite the decreased staff, CCS will attempt to expedite authorizations appropriate for diagnosis and treatment of babies with positive results from newborn screening NBS.

## **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*

### **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 2005-2006 survey, 46.6 percent of CSHCN age 0 to 18 have families partnering in decision making at all levels and are satisfied with the services they receive.

1) CSHCN stakeholder groups were included in the implementation of priorities selected through the Needs Assessment process.

2) FVCA was represented in the workgroups, hearings and other activities related to development of the new federal 1115 waiver, CCS redesign, and the State Title V Needs

Assessment. FVCA provided written and verbal input on the development of these programs and policies.

- 3) The CRISS-FCC Work Group met several times to share ideas and resources; plan and coordinate conferences, trainings and activities; and monitor and promote transition activities, parent liaison services, and medical home projects.
- 4) County CCS programs collaborated with agencies and families to plan conferences on family participation in the CCS program.
- 5) FVCA Council held monthly meetings to address parent and community involvement and monthly Brown Bag Lunch webinars statewide on issues affecting CYSHCN to professionals and family members.
- 6) FVCA's Youth Advisory Council met monthly via conference call and face-to-face every other month).
- 7) LAPSNC, collaborated with organizations and parent groups to plan meetings and conferences.
- 8) The CCS Workgroup, supported by LAPSNC, met bimonthly and includes representatives from public programs, hospitals, and parent organizations. Meeting agendas were framed around the 6 core measures for CSHCN. Active parent engagement and involvement was sought for all Workgroup activities.
- 9) CRISS was represented in the workgroups, hearings and other activities related to development of the new federal 1115 waiver, CCS redesign, and the State Title V Needs Assessment.

**b. Current Activities**

1. FVCA participates in the Pilot Project Evaluation Oversight Committee.
2. FVCA youth advisory council continues to meet.
- 3) In April 2012, FVCA held its ninth statewide Health Summit in Sacramento, bringing together families, advocates, state agency representatives, health policy advocates, legislative representatives, providers and insurers. The Summit focused on identifying budget issues in California that significantly affect the health care of CSHCN and developing strategies to ensure that families in California are able to access family-centered, affordable care.
- 4) FVCA tracks emerging issues and statewide trends, the numbers of families and professionals provided with education, information or training, identifies solutions, and determines training needs.

5)FVCA continues to support and promote the use of CCS Parent Health Liaisons and other partnerships between community-based organizations and the state.

### **c. Plans for the Coming Year**

- 1) Families included in stakeholder groups will continue to participate in activities to improve the delivery of care for CSHCN through the 1115 Waiver.
- 2) Family members will participate on advisory committees and in-service training of CCS staff and providers
- 3) FVCA will support and promote Parent Health Liaison (PHL) services and provide training materials to PHLs to assist families.
- 4) FVCA will continue to emerging issues and statewide trends, the number of families and professionals provided with information, education and support and the impact of family support services on families.
- 5) FVCA will continue to collaborate with CMS and respond to requests for input on materials and committees.
- 6) CMS medical director or designee will attend bimonthly FVCA webinars
- 7) FVCA's Youth Advisory Council will continue to meet bimonthly and implement their strategic plan (pending ongoing funding).
- 8) .CRISS convenes quarterly meetings of county CCS medical consultants, CRISS staff, and the CCS Chief Medical Officer in order to ensure consistent application of state CCS policy. Starting this year, the Southern California medical consultants are also meeting quarterly, and twice a year, consultants from northern California attend the southern California meeting and vice versa.

### **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)*

#### **a. Last Year's Accomplishments**

NPM 03 is from the National CSHCN Survey. Based on the 2005-2006 survey, 42.2 percent of the CSHCN in California receive coordinated, ongoing, comprehensive care within a medical home. The most recent National Survey of CSHCN (2005-2006) conducted by the Special Population Surveys Branch of the CDC- NCHS, identified approximately 750 parents of children with special needs in each state.

## **b. Current Activities**

- 1) CRISS continues to expand and improve the Alameda County Medical Home Project. The project targets clinics in Alameda with high numbers of CCS children.
- 2) CRISS is distributing medical home materials in hard copy and electronically for the 11 new rural counties, including Fresno. All these materials also will be available on the CRISS website.
- 3) CRISS continues to distribute updated medical home materials and Child Health Notebooks to CRISS counties.
- 4) CRISS continues to distribute Child Health notebooks to the CRISS counties and are available electronically.
- 5). CRISS convenes quarterly meetings of county CCS medical consultants, CRISS staff, and the CCS Chief Medical Officer in order to ensure consistent application of state CCS policy. Starting this year, the Southern California medical consultants (LAPNC) are also meeting quarterly, and twice a year, consultants from CRISS attend the southern California meeting.
- 6) FVCA will continue to provide trainings for families and professionals on Medical Home and distribute binders to help families organize healthcare information and medical records.
- 7) FVCA Agencies will provide "resource referral pads" to physicians, listing local resources for families.
- 8) The Sonoma County FQHC continues its activities to promote medical homes for children with epilepsy.

## **c. Plan for the Coming Year**

Plans for the coming year include:

1. CRISS will continue to share Alameda County Medical Home Project activities and resources with 3 other counties, San Mateo, Contra Costa, San Francisco.
2. For counties not in a Pilot Project, CCS will continue to monitor number of CCS clients with a designated Medical Home.
3. CCS 1115 Waiver Pilot Projects will incorporate Medical Home into the comprehensive health care delivery system and will be one of the major areas of performance evaluation for the project.

#### **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.*

##### **a. Last Year's Accomplishments**

NPM 04 is from the CSHCN Survey and is related to population-based services. For the 2009-2010 survey, 62.8 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 (2005-2006), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified at least 750 parents of children with special needs in each state.

##### **b. Current Activities**

- 1) CMS continues to collaborate with various stakeholders in helping to ensure that families of CSHCN continue to receive necessary services.
  
- 2) The CHDP Gateway pre-enrollment process serves as a means of assisting Medi-Cal eligible children and youth to access periodic preventive health assessments and CMS continues to support this process.

##### **c. Plans for the Coming Year**

- 1) CMS will continue collaborative efforts with various stakeholders to identify and provide necessary services for CSHCN.
  
- 2) The CHDP Gateway pre-enrollment process will continue to serve as a means of assisting Medi-Cal eligible children and youth to access periodic preventive health assessments and the CMS Branch will continue to support this process.
  
- 3) CMS will continue to review the impact that Health Care Reform may have on families of CSHCN that are currently being served by CCS, AIM, HF and Medi-Cal.
  
- 4) As resources become available, CMS will continue to review initiatives that have the goal of promoting insurance coverage for children.
  
- 5) Through the 1115 Waiver's CCS pilot projects, infants, children, and youth with special health care needs will receive comprehensive care instead of care being fragmented.

#### **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)*

**a. Last Year's Accomplishments**

NPM 05 is a National CSHCN Survey measure and is the percent of CSHCN age 0 to 18 years who can easily access community based services. For California in 2009-2010, the result was 64.8 percent.

The most recent National Survey of CSHCN \), conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics, identified approximately 750 parents of CSHCN in each state.

FVCA Council Agencies continued to work with their local CCS agency to provide trainings to CCS employees, and connect families to Family Resource Centers (FRC) for community resources, support and information.

**b. Current Activities**

Current activities include:

- 1) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric Representatives) meets quarterly to improve consistency in inter-county interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the now 25-county CRISS region. Biannually a Southern CA medical consultant comes to the CRISS meeting, and a CRISS consultant attends the Southern California meeting..
- 2) CHDP, HCPCFC, and CCS programs report on a performance measure evaluating effective care coordination.
- 3) LAPSNC works on increasing parent involvement by inviting representatives from the FRC to meetings, and joining committees.
- 4) FVCA collaborates with DHCS on an ongoing basis and its member agencies work with their local CCS agencies to provide trainings to CCS employees, and connect families to FRCs for community resources, parent-to-parent support and information.
- 5) The FCC Work Group meets bimonthly to review county FCC activities, share resources, and plan conferences, trainings, and activities.
- 6) The CCS Workgroup, supported by LAPSNC, meets bimonthly and seeks active parent engagement and involvement.
- 7) The CMS Branch and Medi-Cal continue to meet and collaborate on the Pediatric Palliative Care Pilot program.

**c. Plan for the Coming Year**

Plans for the coming year include:

- 1) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric Representatives) will continue to meet quarterly to improve consistency in inter-county interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the now 25-county CRISS region.
- 2) CHDP, HCPCFC, and CCS programs will continue to report on a performance measure evaluating effective care coordination.
- 3) LAPSNC will continue to focus on increasing parent involvement by inviting representatives from FRC to meetings, and joining committees.
- 4) FVCA will continue to collaborate with DHCS on an ongoing basis and FVCA's member agencies will work with their local CCS agencies to provide trainings to CCS employees, and connect families to FRCs for community resources, parent-to-parent support and information.
- 5) The FCC Work Group will continue to meet 4 or 5 times per year to review county FCC activities, share resources, and plan conferences, trainings, and activities. The group is planning the 2011 annual FCC conference focusing on best practices.
- 6) The CCS Workgroup, supported by LAPSNC, will meet bimonthly and seek active parent engagement and involvement.

### **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.*

#### **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. For California in 2005-2006, the result was 37.1 percent.

The most recent National Survey of CSHCN (2005-2006), conducted by the Special Population Surveys Branch of the CDC NCHS, identified approximately 750 parents of children with special needs in each state.

- 1) CCS social work consultants met quarterly and discussed transition issues.
- 2) CMS staff collaborated with KASA via conference calls on issues surrounding transition. One particular topic was a "Transition Toolkit" designed for youth with disabilities. The toolkit is entitled "*Things are About to Change*" A Young Person's Guide to Transitioning to Adulthood", and became available at [www.tknlyouth.info](http://www.tknlyouth.info) in the fall 2010.

- 3) CMS continued to collaborate with Counties, FVCA, and the KASA group on transition issues for CSHCN.
- 4) CMS staff met quarterly with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

**b. Current Activities**

- 1) CMS is collaborating with the California Health Incentives Improvement Project (CHIIP) which is funded by the Medicaid Infrastructure Grant from the Centers for Medicare and Medicaid Services.
- 2) CHIIP participated in a panel presentation at the October 2010 Children’s Regional Integrated Service System’s Conference in which they presented information on the new “Transition Toolkit”. Attendees included CCS staff and CCS families.
- 3) CMS is collaborating with CHIIP on marketing the “Transition Toolkit”.
- 4) CMS social work consultants continue to meet on transition issues.
- 5) CMS continues to collaborate with Counties, FVCA, and the KASA group on transition issues for CSHCN.
- 6) As staffing allows, the CMS staff are meeting with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

**c. Plan for the Coming Year**

- 1) CMS will continue to collaborate with CHIIP on the “Transition Toolkit” marketing effort.
- 2) CMS and CHIIP will explore piloting the Toolkit with one or two local CCS programs.
- 3) CMS and CHIIP are planning online webinar training on the toolkit for local CCS programs and to have a link on the CMS Branch website to the Transition Toolkit.
- 4) As staffing allows, CMS social work consultants will continue to meet on transition issues.
- 5) CMS will continue to collaborate with Counties, FVCA, and the KASA group on transition issues for CSHCN.
- 7) As staffing allows, the CMS staff will meet with FVCA council members and PHL to develop strategies to improve transition for CSHCN to adult health care providers.

## **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.*

### **a. Last Year's Accomplishments**

In 2010, the immunization rate for children age 19-35 months was 76.5 percent; due to methodological changes in data collection, it cannot be compared to previous years' rates. . Statewide, the number of fully vaccinated children has been falling steadily since 2004, when 92.9 % of students entering kindergarten had all required immunizations. Only 90.7% were fully vaccinated in 2010, resulting in more children vulnerable to preventable illnesses. The decline in kindergarten immunization rates has been especially marked in the northeast corner of the state with rates between 73 and 75.3% in Calaveras, Mariposa, Nevada and Tuolumne counties . Likewise, Santa Cruz, Marin, Sacramento, El Dorado, Mendocino, Humboldt, Trinity, Shasta and Siskiyou counties all had kindergarten vaccination rates below 85 percent in 2010. Some private schools in these areas, particularly those that cater to college educated, middle to upper income families, have the lowest immunization rates.

MCAH and CMS advocated 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. LHJs, including AFLP and BIH, continued to assess the immunization status of adolescent and women clients and their children on a periodic schedule, and promoted the importance of maintaining up-to-date immunizations by assisting program clients to access ongoing preventive care.

In 2010, California saw a pertussis outbreak kill ten children and affect 8,383 others — the largest epidemic in 63 years. In the same year, California passed Assembly Bill 354 to make a pertussis booster vaccination mandatory for 7th to 12th graders in the 2011 school year. The legislation had been stalled for several years amid concerns that California would have to pay hundreds of thousands of dollars for vaccinations for children on Medi-Cal. Studies show that undiagnosed family members are most likely to infect infants with whooping cough and teens that have not been immunized have been a factor in the spread of the disease. Those most vulnerable to whooping cough are infants too young to be immunized. In 2011, there were no recorded deaths attributed to pertussis.

Many local MCAH programs focused activities on immunizations and participated on Immunization Collaboratives and coalitions to increase access to immunizations through health fairs, seasonal flu clinics and public health immunization clinics.

Alameda County has an extensive immunization assistance program. In FY 2010/11 they provided training which emphasized new Medi-Cal services or changes in services or policy, to about 300 physicians, nurses and medical assistants. In addition, they collaborated with the Immunization Partnership of Alameda County (IPAC) to coordinate

services for implementation of AB 354. Alameda County MCAH Program also conducted selective reviews at kindergarten schools and feedback was given to the schools on how to improve compliance with California School Law. The Perinatal Hepatitis B program was able to enhance the capacity of providers to integrate Hepatitis B Vaccine (HBV) testing, counseling and informed consent into their prenatal care services and in labor and delivery.

## **b. Current Activities**

MCAH work with the IZB in its roll-out of the new adolescent immunizations. Many MCAH LHJs conduct outreach at health fairs and other venues to provide education and resources for childhood immunizations and health insurance. Orange County's will link to the L.A. County Immunization Registry. Programs such as CHVP, AFLP and BIH discuss and encourage clients to keep immunizations up-to-date. With the late start of the flu season (Winter 2012) and widespread geographic distribution, CDPH is recommending influenza vaccination for everyone except for those with contraindications.

Alameda County continues to screen clients for immunization assistance, increase the number of Medi-Cal provider participation in California Immunization Registry (CAIR), and provide schools with training about immunization laws; it is also coordinating community education and outreach to promote "Flu for Everyone" and "Toddler Immunization Month" campaigns. Shasta County has an education campaign targeted at worried parents by creating shastashots.com, a website that provides facts on vaccines and an "ask the nurse" email link. Ventura County, have started organizing vaccination clinics at area parks and schools, and offering a drive-through flu shot station.

CMS and IZB encouraged all California VFC providers to attend the CDC's 1<sup>st</sup> Online ('Virtual') National Immunization Conference held last March 2012.

## **b. Plan for the Coming Year**

CMS and IZ Branches, Medi-Cal, and MCMC continue to meet three times per year to discuss results of the ACIP-VFC National Meetings. CMS and IZ branches work together on adding new vaccines and modifying existing vaccine benefits in concordance with the ACIP recommendations.

MCAH partners with the IZB to provide immunization updates to the MCAH Perinatal Services coordinators, review immunization brochures on immunization during pregnancy, development of educational materials on H1N1 in pregnancy and the importance of influenza vaccination. MCAH will continue to work closely with IZB to provide information on pertussis to MCAH providers.

MCAH and CMS will continue to advocate for and assist families to enroll in low/no cost public and private health insurance entities. Local MCAH programs, including CHVP, AFLP and BIH, will continue to discuss and encourage clients to keep immunizations up-

to-date. .

LHJs will be involved in ongoing efforts to improve immunization rates by participating in local collaboratives. The Perinatal Services Coordinators (PSCs) in many LHJs disseminate information on immunizations to local providers participating in the Comprehensive Perinatal Services Program. Local MCAH programs coordinate with schools to provide outreach and education to parents and children to improve immunization rates among elementary and middle school children. Some local MCAH programs are actively planning to address childhood immunization in their communities. For example, El Dorado County is developing a vaccine safety and local resources campaign to target school districts with high Personal Belief Exemption rates.

Immunization rates have an impact on vaccine-preventable disease rates for the population. In general, in order for unvaccinated people to be protected against communicable diseases, approximately 75 to 95 percent of the population has to be vaccinated against them.

California school immunization laws grant exemptions which allow parents to opt out from providing proof that their children have received mandatory vaccinations for medical and philosophical reasons, such as personal, moral or other beliefs. To obtain a personal belief exemption; parents are only required to sign their name to a brief standard exemption statement on the back of the vaccination requirement form. In evaluating data on the rates of exemptions from CDPH, CDE and the U.S. Census, researchers found that in 2010, California had about 11,500 kindergartners with personal belief exemptions, representing a 25% increase over the previous 2 years. Assembly Bill 2109 was introduced, and is intended to strengthen California's "personal belief" law to ensure that parents have accurate information and understand that they place their child and other children at risk by failing to get their children immunized [7].

### **Performance Measure 08**

*The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

#### **Last Year's Accomplishments**

In 2010, births to teens aged 15-17 years continued to decline. The Hispanic teen birth rate decreased 13.6% to 24.7 (per 1,000 female teens aged 15-17 years) and the African American teen birth rate declined 14.8% to 16.1 (per 1,000 female teens aged 15-17 years). The teen birth rate for Whites decreased 8.7% to 4.2 (per 1,000 female teens aged 15-17 years) and the Asian/Pacific Islander teen birth rates decreased 23.3% to 3.2 (per 1,000 female teens aged 15-17 years). Rates for White and Asian/Pacific Islander teens continue to be lower than rates for Hispanic and African American teens.

OFP, Family Planning, Access Care & Treatment program (Family PACT), and I&E Program continued their teen pregnancy prevention efforts. However, budget reductions resulted in less program evaluation, education, and outreach for teen pregnancy prevention programs.

OFP developed Requests for Applications (RFAs) for I & E. I&E program design will integrate outreach strategies previously funded under Teen Smart Outreach.

MCAH continued to fund and monitor AFLP. AFLP uses a case management model to enhance, through associations with families and community resources, the health, educational potential, economic opportunity, and self-sufficiency of adolescents during pregnancy and parenthood, and to promote healthy, family relationships.

Cal-SAFE continued serving pregnant and parenting students. School districts now have full flexibility in directing Cal-SAFE funds. Some school districts have closed or decreased their Cal-SAFE programs, since flexible spending was implemented.

MCAH worked with the Internet Sexuality Information Services to develop the youth component of the First Time Motherhood grant. The text messaging campaign developed 52 weekly texts to forward to teens on areas related to preconception health. A web site has been developed to provide preconception health information and links to teen pregnancy prevention websites. In addition, an electronic photo contest addressing preconception health issues will be held.

## **b. Current Activities**

MCAH began to implement a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers award from the U.S. Department of Health and Human Services (HHS) that provides \$2 million annually for federal project periods 2010 – 2013. MCAH is developing a standardized reproductive life planning model with integrated case management for AFLP. This grant is called AFLP (PYD, and it is in 11 AFLP sites.

OFP has begun to implement the California Personal Responsibility Education Program (PREP): Replication of Evidence-based Programs program. This funding from the ACA provides \$6,553,554 annually through 2014. It has submitted an RFA to the 19 LHJs eligible to apply for the funding based on their teen pregnancy rates.

I&E continues its teen pregnancy prevention efforts. CDPH and the CFHC have launched the Condom Access Project [[http://cfhcweblog.typepad.com/for\\_the\\_press/2012/02/index.html](http://cfhcweblog.typepad.com/for_the_press/2012/02/index.html)] designed to reduce unintended pregnancy in youth and the rate of transmission of STDs by making free condoms and health brochures that discuss STDs and pregnancy prevention available year round.

Tehama County has the second highest teen birth rate among California counties. In early 2012, a special school curriculum aimed at preventing teen pregnancy was launched in area high schools in Tehama County funded by a grant from the Sierra Health Foundation.

### **c. Plan for the Coming Year**

Family PACT, and I & E will continue their teen pregnancy prevention efforts.

MCAH will continue to support LHJs and CBOs that implement the AFLP program. In addition, MCAH will pilot the AFLP PYD intervention in its 11 funded sites. A formative evaluation will be used to evaluate the newly developed intervention. To implement the AFLP PYD intervention, MCAH will continue its work with the University of California, San Francisco, Bixby Center for Global Reproductive Health and the California Adolescent Health Collaborative.

### **Performance Measure 09**

*Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

#### **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 since 2005 since no new survey has been implemented to update this rate.

The numerator for this performance measure is from the Oral Health Needs Assessment a survey of a representative sample of elementary schools in California in 2004-2005. Dental sealant information is based on a one-minute, non-invasive oral health screening of all third graders in selected schools. The California Office of Oral Health (OOH) partnered with MCAH and the Dental Health Foundation (DHF) to conduct the Oral Health Needs Assessment. In 2010, DHF changed its name to Center for Oral Health (COH) and OOH is now known as the Oral Health Unit (OHU).

To meet the demand for TA at both the state and local levels, MCAH contracts with UCSF School of Dentistry for a dental hygienist to serve as the MCAH Oral Health Policy Consultant. MCAH, CMS, Medi-Cal and OHU are members of the California Oral Health Access Council (OHAC) and the Oral Health Work Group (OHW). OHAC is a diverse panel of stakeholders that are working to improve the oral health status of the state's traditionally underserved populations. OHW assists in the coordination of state oral health activities and serves as a clearinghouse for member organizations. In addition, MCAH, OHU and Medi-Cal are liaisons to the CHDP State Dental Subcommittee whose goal is to increase access to dental care for the CHDP eligible population.

Forty LHJs report oral health activities for children; 23 LHJs report activities focused

on pregnant women. Eleven LHJs have a dental coordinator on staff. Other LHJs rely on collaboration with local oral health coalitions to bring outreach programs and preventive services to MCAH target populations. Many LHJs select WIC sites, pre-schools, and public school locations to deliver these services. MCAH case management programs, such as CPSP, BIH and AFLP, enroll women and their families into Medi-Cal and HF, and provide them with necessary dental referrals. However, dental providers are difficult to find in many locations because few will accept public insurance or agree to treat low-income pregnant women or children under the age of 3.

California law requires that 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). Schools are encouraged to collect and submit data but are not mandated to do so because of state budget cuts. California Dental Association (CDA) collects assessment data from a majority of counties. As of May 2011, 126,409 out of 462,131 eligible children submitted an assessment during the school year. Approximately 22% were found to have untreated decay, consistent with last year's results.

The Children's Dental Workforce Campaign, led by Children's Partnership, is a statewide coalition-based effort aimed at increasing access to dental care for underserved children by expanding the capacity of the dental workforce to deliver preventive and routine restorative services. This group is examining current workforce models, training programs and funding sources.

A HRSA MCHB Targeted Oral Health Services Systems grant allowed COH to develop an innovative program that provides screening, health education, fluoride varnish and dental referral resources to families in 13 WIC sites. Since the end of the grant in 2011, several thousand children have received services. COH created a guidebook to assist dental providers, WIC personnel, and public health advocates in developing additional Early Entry into Dental Care programs in their own communities.

In 2010, a partnership between OHU, COH, California Primary Care Association, and the University of the Pacific was awarded a 3-year HRSA Oral Health Workforce grant. Activities include: developing a dental prevention and treatment pilot project in schools and FQHCs using Virtual Dental Home and direct service models; conducting an assessment of the impact of the elimination of the adult Denti-Cal optional benefit on the current safety net workforce loss; identifying strategies to increase the current dental health workforce; and creating a low-cost culturally competent curriculum and training program for midlevel allied dental personnel.

#### **b. Current Activities**

MCAH promotes the California perinatal clinical oral health guidelines to assist health care professionals deliver oral health services to pregnant women and their children. MCAH also dispatches updated information, web links, grant resources and educational materials to local oral health advocates and coordinators. MCAH assists LHJs to develop oral health activities to increase community access and outreach.

The Managed Risk Medical Insurance Board received a grant to help promote dental

exams within their Healthy Family Program in 8 counties. This effort is part of the national Oral Health 2014 Initiative.

CDA commissioned a comprehensive report aimed at improving access to dental care for underserved populations. Titled *Phased Strategies for Reducing the Barriers to Dental Care in California*, it identifies ways to improve access to dental care for the nearly 30 percent of the population that experiences barriers to care. A 3-phased proposal recommends: establish state oral health director under CDPH and optimizing existing resources; focus on prevention and early intervention for children; and innovate the dental delivery system to expand capacity. To begin implementation, CDA and Children's Partnership are sponsoring a legislative bill that will enhance the state OOH with a licensed dentist to serve as dental director. The bill will also authorize a study to assess the feasibility of additional dental workforce models to provide care for the underserved populations.

### **c. Plan for the Coming Year**

State and local programs will continue to promote oral health. MCAH will encourage LHJs to strengthen strategies to increase the number of children and pregnant women receiving preventive dental services. MCAH will update and integrate oral health educational components into MCAH program guidelines and curricula.

MCAH will provide TA to LHJs, including presentations, resources, and links to grant funding. Educational materials that address early childhood dental decay prevention for mothers and young children will be distributed through MCAH programs. For example, CHDP Dental subcommittee and MCAH have collaborated on developing brochures regarding oral health care and resources for establishing a dental home by age 1 and made available through the MCAH website. CDE has chosen one of these brochures to print in English and Spanish to be offered to Early Head Start and Head Start families this year.

MCAH will continue to promote and disseminate the California perinatal clinical oral health guidelines to health care providers. Since the guidelines were released in 2010, MCAH hopes to detect an increase in the number of pregnant women receiving prenatal oral health counseling. Two multi-part questions from the 2009 MIHA survey will be added back into the 2012 MIHA survey to discern any change among respondents.

DHCS will finalize a ruling that may allow safety-net clinics, like FQHCs, to contract with private dentists within their service area to provide dental care to their patients. This can greatly expand access to dental care for their patients, usually allowing patients to secure appointments with much shorter wait times, without making a significant capital investment in facilities and equipment.

The governor has proposed to merge HF (which provides subsidized health, dental, and vision coverage to eligible children whose family incomes are below 250 percent FPL) into the current Medi-Cal program. Oral health advocates are expressing concern about the potential impact on beneficiaries and provider networks, particularly if there is a movement toward expansion of dental managed care offerings within Medi-Cal. The

mandated dental managed care system in Sacramento County is currently under review by DHCS

MCAH will monitor efforts, including legislation, to expand the dental workforce by identifying successful and sustainable models which increase access to preventive services and treatment for low-income pregnant women, children, and teens.

In 2007, schools lost nearly \$30 million in attendance-based district funding due to oral health-related missed school days and cost hospitals \$55 million in emergency room visits for preventable dental problems. SB 694 was introduced to create an office of oral health within CDPH to address the need for a strong oral health infrastructure that will provide a comprehensive, coordinated strategy to address the public dental health needs of the state.

### **Performance Measure 10**

*The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

#### **a. Last Year's Accomplishments**

CIPPP provided 52 issues of the SafetyLit Bulletin- a weekly update of research literature published in scholarly journals and added items to the searchable SafetyLit literature database. To assist with evidence-based decision-making, SafetyLit provided information about the occurrence of and risk factors for unintentional injuries, interpersonal violence, and self-harm to LHJs and non-governmental agencies. SafetyLit.org received > 60,000 unique visitors each week for an average total of 375,000 visitors. About 3% of these are from California. CIPPP worked closely with the California Coalition on Childhood Safety and Health (a group of insurance company representatives and other stakeholders) to provide guidance for forming policies and justifications for positions on safety regulations and legislation. One example was the information CIPPP provided that resulted in strong support for modifying existing CPS law to require booster seats for children up to age eight. Another example was information CIPPP provided to support zero tolerance for texting while driving under California's graduated driver licensing system. In other legislation enacted in 2011, a child who is six years of age is now allowed to sit in the front seat of a vehicle if all other seats are occupied by children under age eight (Chaptered by Secretary of State, Chapter 474, Statutes of 2011). In consideration of the declining funds available to support LHJ's independent injury prevention activities, CIPPP began assisting with their collaboration with community groups (Safe Kids chapters, parent-teacher organizations) that could serve needs of LHJ clients.

#### **b. Current Activities**

CIPPP established a calendar of online training opportunities and webinars to partially fill the gap created by declining resources and travel restrictions for in-person training opportunities. CIPPP developed age-appropriate recommendations to parents for keeping

their children safe at home, at play, and when traveling. These "Be Safe, Not Sorry" sheets are available in English, Spanish, and Vietnamese languages.

### **c. Plan for the Coming Year**

The planned activities of MCAH, CIPPP and LHJs include continuation of current activities as resources allow. CIPPP will continue to maintain and update SafetyLit and a calendar of online training opportunities and webinars on injury prevention. CIPPP will continue to provide developmental age-appropriate recommendations to parents for keeping their children safe at home, at play, and when traveling. Future "Be Safe, Not Sorry" information sheet series will be updated when appropriate--such as with the change in the booster seat law and the sheets will be made available in English, Spanish, and Vietnamese languages.

## **Performance Measure 11**

*The percent of mothers who breastfeed their infants at 6 months of age.*

### **a. Last Year's Accomplishments**

In 2010, 59.5 percent of mothers reported breastfeeding their infants at three months post-partum which is slightly lower than previous years. African American (47.4%) and Hispanic (51.2%) mothers were less likely than White (69.9%) and Asian/PI (75.0%) mothers to breastfeed their infants at three months of age.

MCAH programs promoted exclusive breastfeeding. BBC: a hospital breastfeeding quality improvement and training project was presented at the 2010 Academy of Breastfeeding Medicine and 2011 Association of Maternal and Child Health Programs annual meetings. Technical assistance to implement BBC was offered to all RPPC regions by PAC-LAC until June 2011.

MCAH shared information with its programs during World Breastfeeding Week and encouraged county and community-based organizations to participate.

MCAH coordinated with the California Obesity Grant, WIC, WIC Association, and Breastfeeding Coalition to celebrate World Breastfeeding Week with a breastfeeding walk, write testimony to IOM on preventive services and durable medical goods that promote and support breastfeeding and host the first State Hospital Breastfeeding Summit in 2011.

MCAH has representation on the U.S. Breastfeeding Committee and ASTPHND MCH Nutrition Council which address policy, programs and breastfeeding services. MCAH was on the planning committee for a joint USBC-ASTPHND symposium on breastfeeding; it was offered at the 2011 ASTPHND meeting.

MCAH was involved in the nutrition revisions of Caring for Our Children: National Health and Safety Standards: Guidelines for Out-of-Home Child Care Programs, with emphasis on breastfeeding.

MCAH led the development of a CDPH lactation accommodation policy, researched a "bring-your-baby to work policy" for the CDPH obesity program. MCAH added a webpage for CDPH employees on lactation accommodation and updated the CDPH and MCAH breastfeeding webpages.

There are several local activities that promote breastfeeding. Humboldt's Breastfeeding Task Force authored breastfeeding in the workplace and safe infant sleeping articles for the Department of Health and Human Services newsletter. A breastfeeding resource brochure was sent to obstetric and pediatric providers, community partners such as play groups and FRCs.

The Imperial County Breastfeeding Coalition hosted the World's Largest Baby Shower and shared nutrition tips for breastfeeding moms.

The Kings County Breastfeeding Coalition (KCBC) distributed a breastfeeding resource and obtained a Board of Supervisors resolution to declare August 2010 as Breastfeeding Awareness Month. Coalition members participated in the Central Valley Grow Our Own Lactation Consultant Training Program. An advocate reported about the 2011 Breastfeeding Summit at a Lunch & Learn Breastfeeding Session and spoke at the 2011 KCBC breastfeeding conference.

The Breastfeeding Task Force of Greater Los Angeles held three-hour trainings for human resources professionals on the business case for breastfeeding. The MCAH Director is advocating for a workplace breastfeeding policy at the city level.

Mono County Breastfeeding Task Force stopped the distribution of infant formula marketing bags to new mothers at a local hospitals. Breastfeeding-friendly bags were created and distributed to all new mothers.

The Breastfeeding Coalition of Nevada County provided and staffed a comfortable place for women to feed and change their babies at various venues. They provided crib cards for mothers to use to ask hospital staff to not give formula or pacifiers to their infants. The Coalition staffed a 24/7 breastfeeding warm line and educated members about safe infant sleeping. They collaborated on a Breastfeeding Peer Counseling program through WIC.

San Diego MCAH staff met with American Red Cross, WIC, Epidemiology, Bioterrorism and Emergency Medical Services staff to recommend emergency shelters that consider the needs of lactating and pregnant women in an emergency.

The Sonoma County Breastfeeding Coalition promoted workplace lactation accommodation through awards and recognition, used public libraries to raise awareness

of breastfeeding benefits, developed “Lactivists” with a Facebook page linked to public health and supported a “Positive Images of Breastfeeding” photo contest. The Sonoma Native Breastfeeding Council designed diaper bags for patients who exclusively breastfed for at least 30 days. They facilitated having a breastfeeding tent available at Gathering of Nations.

#### **b. Current Activities**

MCAH hospital initiation breastfeeding data is posted online and was used by the California WIC Association and UCD to produce a 2012 Hospital Breastfeeding Rates Report & County Fact Sheets. MCAH collaborated with CDC to show that evidence-based policies and practices measured by mPINC are associated with increased exclusive breastfeeding rates in California hospitals; results were shared at the 2012 Hospital Breastfeeding Summit.

PAC-LAC, a RPPC region and MCAH published a report outlining elements and lessons learned from BBC. MCAH offers technical assistance to implement BBC and worked with FHOP to develop a BBC/breastfeeding webinar and breastfeeding fact sheet.

Per California Health & Safety Code §123365, WIC and MCAH finalized a hospital administrators web-based breastfeeding policy curriculum. MCAH is working with Licensing and Certification on a webinar to prepare hospital evaluators for Health & Safety Code §123366: Hospital Infant Feeding Act, requiring hospitals to have a breastfeeding promotion policy by 2014 using guidance from the Baby-Friendly Hospital Initiative or CDPH Model Hospital Policy Recommendations.

MCAH is represented on the Emergency Preparedness and Marketing workgroups., MCAH participates in RPPC’s emergency preparedness efforts for birthing hospitals and posted related resources on the web.

For home visiting efforts, MCAH developed breastfeeding benchmark indicators and is researching WIC’s Peer Counselor Curriculum.

#### **c. Plan for the Coming Year**

Of the 134 birth facilities in the U.S. certified as baby-friendly as of May 2012, 54 are in California and MCAH aims to increase this number in the coming FY through breastfeeding promotion activities.

MCAH will support CDPH and DHCS in adhering to California Health & Safety Codes § 123360 and § 123365 and §123366 in creating a public health campaign to provide breastfeeding information and referrals, making available an 8-hour training course that promotes exclusive breastfeeding, and assisting hospitals in developing policies to support breastfeeding by keeping the Model Hospital Policy Recommendations Toolkit and hospital quality improvement resources updated. By 2013, Kaiser plans to have all 29 of its birthing sites either as being designated Baby-Friendly or join a program of the Joint Commission, the national nonprofit that accredits hospitals, which aims to have as many new moms as possible feeding their babies only breast milk, no formula, when they leave the hospital.

MCAH promulgates breastfeeding information and referrals. MCAH will investigate using mother-to mother support, fathers and grandmothers to support breastfeeding. MCAH will advocate for 1) breastfeeding support in childcare and emergency preparedness efforts and 2) marketing of infant formula is conducted in a way that minimizes its negative impacts on breastfeeding.

MCAH will host and support conferences and meetings such as the 2013 Hospital Breastfeeding Summit, California Breastfeeding Coalition, and Childhood Obesity Conference. MCAH will continue to meet bimonthly with state WIC breastfeeding staff to coordinate efforts.

MCAH will continue to monitor California infant feeding patterns, including breastfeeding initiation, duration and exclusivity, and maternity care policies and practices that support breastfeeding through the NBS Program-to monitor in-hospital infant feeding practices; California MIHA Survey to monitor breastfeeding initiation, duration and exclusivity, as well as hospital experiences and worksite accommodations that affect breastfeeding; and CDC mPINC Survey to monitor maternity care policies and practices that affect breastfeeding.

LHJs will promote breastfeeding. For example, Kings County will collaborate with the local breastfeeding coalition to develop a “breastfeeding friendly sites” directory. Marin Breastfeeding Coalition will create a Facebook page. Marin will assist the county to adopt a workplace breastfeeding policy and provide training for department heads on their roles and responsibilities around supporting a breastfeeding-friendly workplace. Mendocino will develop at least one protocol incorporating breastfeeding support in the MCAH Field Nursing home visiting program. Solano County is in its 7<sup>th</sup> year of implementing the “More Excellent Way,” an African American, peer counseling, church-placed infant feeding and parenting training and intervention program.

## **Performance Measure 12**

*Percentage of newborns who have been screened for hearing before hospital discharge.*

### **a. Last Year's Accomplishments**

- 1) The CMS Branch provided TA and consultation support to HCCs to ensure that all general acute care hospitals with licensed perinatal services provide hearing screening tests to all newborns in a manner consistent with NHSP standards and requirements.
- 2) The CMS Branch continued to facilitate the NHSP Quality Improvement learning collaborative.
- 3) The CMS Branch worked with the Speech Language Pathology and Audiology licensing board regarding quality of care issues and standards of audiologic practice.

- 4) The CMS Branch worked with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing, screening and audiology services.
- 5) The CMS Branch executed amendments to the interagency agreements with the CDE and the University of California Davis (UCD) Medical Center to implement the MCHB Teleaudiology Grant to improve the quality of and access to audiology services and minimize the shortage of pediatric audiology providers in Northern California.
- 6) The CMS Branch collaborated in the implementation of the parent support grant from MCHB.
- 7) The CMS Branch worked with the NHSP DMS vendor, Neometrics, to prepare the DMS for implementation in hospitals. The DMS was used by one HCC and three pilot hospitals.
- 8) The CMS Branch was awarded a 5-year Centers for Disease Control and Prevention Cooperative Agreement to continue support activities in the implementation of the DMS.

**b. Current Activities**

- 1) The remaining and all new general acute care hospitals with licensed perinatal services are being certified for participation in the NHSP.
- 2) CMS continues collaboration in the implementation of the parent support grant from MCHB.
- 3) The NHSP DMS vendor, is implementing the DMS in additional hospitals and all three HCCs.
- 4) CMS is an active participant in the NHSP QI learning collaborative.
- 5) CMS provides technical support to the HCCs.
- 6) CMS to collaborate with UC Davis Hospital to execute the activities in the teleaudiology grant. Six patients have received complete diagnostic audiological evaluations via telehealth between December 2011 and March 2012.
- 7) CMS is applying for continued funding from MCHB for the parent support and teleaudiology projects.

**c. Plan for the Coming Year**

- 1) CMS will finalize the certification of any remaining or new hospitals.

- 2) CMS will continue to collaborate in the implementation of the parent support grant from MCHB, assuming new grant is awarded.
- 3) The DMS for NHSP will be rolled out in a phased implementation process to 1/3 of the certified hospitals throughout the state.
- 4) CMS will continue participation and facilitation of the NHSP QI learning collaborative.
- 5) TA and consultation support will continue for all HCCs to ensure compliance with NHSP standards and requirements.
- 6) The Audiology Telehealth pilot project in the rural northern region of California will allow rural families to receive local services without any lengthy travel, assuming new grant is awarded.

### **Performance Measure 13**

*Percent of children without health insurance.*

#### **a. Last Year's Accomplishments**

The percent of uninsured children in California has decreased since 2000 when the percent of children without health insurance was 15.7 percent. After slight increases in 2005-06, the percent without insurance is at 11.2 percent in 2010. Despite this success, over a million children still lack coverage. Data for NPM 13 are based on the U.S. Current Population Survey.

In an effort to decrease the number of uninsured children, a comprehensive outreach and education campaign continued to increase enrollment in Medi-Cal and HF. Efforts to reduce administrative barriers include a shortened joint application for both Medi-Cal and HF, elimination of quarterly status reports under Medi-Cal, and on-line enrollment. 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 with family income at or below 200 percent FPL (and not already in the Medi-Cal Eligibility Data System (MEDS) system) is "presumed eligible" for Medi-Cal or HF and given a temporary Medi-Cal Benefits Identification Card. This provides access to no-cost, full scope fee-for-service Medi-Cal benefits for up to 60 days. From July 2003 through December 2009, 4.4 million children were pre-enrolled in the Gateway, and 79 percent requested a joint application for Medi-Cal and HF. From June 2004 through December 2009, 358,193 infants were automatically enrolled in Medi-Cal, with 73,166 infants automatically enrolled as the result of a Gateway transaction in 2009. Significant shares of the uninsured but eligible children are served by the Special Supplemental Nutrition Program

for WIC. Senate Bill (SB) 437, enacted in October 2006, created the WIC Gateway. This 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 HF and apply for enrollment to either as well.

MCAH programs, including AFLP, BIH, and CPSP, encouraged and facilitated enrollment in Medi-Cal, HF and CHI. Efforts included public awareness media campaigns and other community education and outreach efforts. For example, Humboldt County implemented local systems changes to assure that infants born to mothers on Medi-Cal are immediately enrolled in Medi-Cal and to better track children accessing health care through the CHDP Gateway.

CDPH, DHCS and MRMIB, in collaboration with stakeholders, continued to promote the WIC Gateway to streamline and expedite health insurance enrollment for children served at local WIC agencies.

Local CHDP programs informed new providers about the Gateway and directed them to CHDP Gateway resources. The CMS Branch analyzed CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.

State funding for Certified Application Assistants (CAA) was terminated as of July 2003 due to the state budget crisis. Some CAAs continued 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 navigate the complex eligibility structures of Medi-Cal and HF.

Children received coverage from four main sources of coverage: job-based insurance, privately purchased insurance, Medi-Cal and HF. According to the 2009 CHIS public coverage insured 31.8% of all children in the state, compared to 24.7% in 2007, prior to the Great Recession. The percent of children covered by job based insurance decreased from 52.2% to 49.4 percent.

Many counties have created Children's Health Initiatives (CHI) to locally fund insurance programs for children ineligible for Medi-Cal or HF coverage. CHI is a collaboration of 29 local CHI's dedicated to ensuring that all California children have access to quality health coverage. Together, the CHI's emphasize streamlined enrollment into HF, Medi-Cal and Healthy Kids insurance programs, and share a goal of creating and maintaining a sustainable health care program for all children in California.

## **b. Current Activities**

MCAH programs, including AFLP, BIH, and CPSP, encourage and facilitate enrollment in Medi-Cal, HF and CHI through outreach, education and referral programs.

DHCS and MRMIB implement and support improvements in the process of determining eligibility and enrollment in Medi-Cal and HF.

Local MCAH programs provide outreach and referrals to health insurance plans for pregnant women, infants and families and provide supportive activities to ensure continuous access to recommended health care services. These activities may include identification of high risk populations, targeted outreach, provision of case finding and care coordination for women, children and adolescents who are not linked to a source of care. Other high risk groups targeted are CSHCN, low income pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes.

Local CHDP programs inform new providers about the Gateway and direct them to CHDP Gateway resources. CMS will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.

### **c. Plan for the Coming Year**

MCAH programs, including AFLP, BIH, and CPSP, will continue to encourage and facilitate enrollment in Medi-Cal, HF and CHI through outreach, education and referral programs.

DHCS and MRMIB will continue to implement and support improvements in the process of determining eligibility and enrollment in Medi-Cal and HF. The Governor's Budget has proposed moving HF enrolled children into the Medi-Cal program. The Legislature will be evaluating this proposal. The Department of Health Services will be implementing this change if the proposal passes the Legislature and is signed by the Governor.

Local MCAH programs will continue to provide outreach and referrals to health insurance plans for pregnant women, infants and families and provide supportive activities to ensure continuous access to recommended health care services. These activities may include identification of high risk populations, targeted outreach, provision of case finding and care coordination for women, children and adolescents who are not linked to a source of care. Other high risk groups targeted are CSHCN, low income pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes.

Local CHDP programs will continue to inform new providers about the Gateway and direct them to CHDP Gateway resources. CMS will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.

### **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.*

### **A. Last Year's Accomplishments**

In 2010, California identified 33.4% had a BMI at or above the 85<sup>th</sup> percentile for children ages 2 to 5 years. To prevent this high rate, MCAH focused on modifying risk factors before pregnancy, in utero and in infancy by promoting optimal preconception weight, euglycemia and breastfeeding,

In 2010, the MCAH Nutrition and Physical Activity Coordinator was a Board member of the Association of State & Territorial Public Health Nutrition Directors (ASTPHND), which works to strengthen nutrition policies, programs and environments at state and national levels. MCAH and CMS participated on the Obesity Prevention Group (OPG), which aims to integrate obesity prevention into CDPH programs. MCAH and CMS provided expert input for planning the 2011 Childhood Obesity Conference.

MCAH helped author national guidelines released in 2011 promoting optimum nutrition, breastfeeding and physical activity in childcare centers. State and local CHDP nutritionists developed and implemented nutrition education, provided consultation/training and monitored childhood obesity. On-line train-the-trainer modules for assessing and managing overweight children were used by MCMC Health Plans and CHDP providers. CHDP trained medical staff on the use of the World Health Organization growth charts.

MCAH addressed childhood obesity locally. Alameda County hosted workshops about adolescent overweight/obesity interventions, developed childhood obesity peer education trainings for churches and a street-level nutrition and exercise project for day laborers. Berkeley had a Walk & Roll to School Day to encourage walking/biking/rolling to school. Imperial's Childhood Overweight/Obesity Prevention Alliance developed provider standards-of-care and best practices on childhood overweight/obesity. They established gardens in local preschools and promoted healthy eating and exercise through health fairs; provided support to schools, cafeterias, and local grocery stores; collaborated on a Mall Walk; and provided food demonstrations in libraries, preschools and grocery stores. Long Beach implemented a wellness forum for churches to promote healthy eating to African-American families; their Best Babies Collaborative provided education to women/teens on nutrition. Mono County held a Screen Turnoff Week campaign and focused on avoiding sugar-sweetened beverages, eating a healthy breakfast, fruits and vegetables, and being active for at least an hour every day; they implemented a 10-week program with cooking demonstrations and nutrition/physical activity for obese school children and their families. Plumas Home Visiting Coalition advocated for obesity prevention and nutrition in all home visits. San Francisco developed healthy recipes including in Chinese and Spanish. They implemented a "Re-Think Your Drink" Campaign; their Headstart Services Advisory Committee provided education on reducing "junk food" in children's diets and improving access to fresh produce. In Santa Cruz, nutrition classes were given at the kindergarten level with quality physical education, including rhythms and dance.

Efforts were undertaken to help community environments support optimal nutrition and physical activity. Contra Costa held Healthy and Active Before 5: A Community Summit

to promote organizational policy changes around breastfeeding, healthy food/beverages and highlight local success stories. L.A. assessed nutrition and physical activity practices in licensed child care centers. Merced established a community garden with classes and evaluated a walkable and safe community. Mono County worked with a school district to reinstate the salad bar and remove unhealthy foods from school menus; sport organizations to foster sport participation and facilities; and Sierra Bounty to unite farmers with their local market and increase accessibility to fresh, organic produce. To create a plan for increasing access to healthy food, Sonoma evaluated communities' access to healthy/unhealthy food, farmers markets, emergency food providers and local transit; walkability of neighborhoods and advertising of unhealthy food. Stanislaus County collaborated with Modesto City to fund safer streets/sidewalks using Safe Routes to School grants. Ventura County worked with school districts to improve the quality of food served.

### **b. Current Activities**

Two new laws support CDPH efforts to reduce obesity: one makes obtaining federal funds easier for CDPH and one establishes a "Safe Routes to School Program."

As part of a lifecourse approach to prevent obesity, a new MCAH webpage shares policy and community-based interventions that support healthy weight for reproductive-aged women. MCAH assisted in developing interconception guidelines/handouts for women with risks, e.g., gestational diabetes, in a prior pregnancy. MCAH is evaluating the Perinatal Food Group Recall for accuracy and ease of implementing by CPSP Community Health Workers; it sets a goal and identifies food group and calorie deficiencies/excesses. MyPlate for Moms was finalized and encourages pregnant/breastfeeding women to eat healthy meals, with limited sugar, solid fats and salt. It is a primary message for CPSP/ AFLP and is tailored for CDAPP Sweet Success.

MCAH finalized English and Spanish healthy cookbooks for AFLP to encourage healthy eating and physical activity. MCAH collaborated with FHOP to create a healthy weight webinar and fact sheet. MCAH is updating nutrition and physical activity guidelines for AFLP, BIH, CDAPP Sweet Success and CPSP. MCAH researched nutrition, physical activity and breastfeeding benchmarks for home visiting and disseminated WIC child nutrition and baby behavior educational materials to local MCAH.

### **c. Plan for the Coming Year**

MCAH will continue to collaborate with state programs, advocates, experts and local MCAH Directors to prevent overweight and obesity in children. Messages and products will be shared with MCAH partners via the MCAH website, email and other mechanisms.

MCAH and CMS will work with OPG to integrate obesity prevention into CDPH programs and develop an action plan and funding proposals. MCAH and CMS are on the Planning Committee for the 2013 Childhood Obesity Conference. MCAH will continue to work on nutrition policy development with ASTPHND and serve on the MCH Nutrition Council Steering Committee.

MCAH will collaborate with experts and LHJ MCAH Directors to address MCAH's role in utilizing strategies and tools to advocate for environmental changes to support optimum nutrition, physical activity and breastfeeding. Materials will be found on the MCAH webpage and shared by webinar.

MCAH will explore ways to promote optimal nutrition, physical activity and breastfeeding in home visiting.

In collaboration with the University of California Los Angeles (LA), a CPSP Food Group Recall will be evaluated by comparing it with the 24-hour Recall and Food Frequency questionnaires in collecting diet intake of perinatal women; community health workers focus group results about usability will also be reported.

Train the trainer modules for assessing and managing overweight children located on the CHDP website will be utilized by MCMC Health Plans and CHDP providers. CHDP will be offering provider office staff training on the use of the WHO growth charts (based on CDC PedNSS WHO growth chart training curriculum).

PedNSS has been discontinued by CDC. CMS is working with UC Berkeley Center for Weight and Health to transfer to them the California data collection and analysis, dependent on funding which is currently being pursued.

Examples of local MCAH plans include Alameda's nurses' training on how to promote healthy eating habits and increased physical activity in their female clients of childbearing age. Alpine will determine the BMI of 7- 8th grade students and provide type 2 diabetes information. LA will recruit child care centers to participate in a study to improve the nutrition and physical activity practices in licensed child care centers. Modoc will present on Harvest of the Month to preschools and kindergartens. Monterey will partner with the Nutrition Network and local schools to increase physical activity and healthy nutrition and provide cooking demonstrations to migrant families. Riverside will update a Child and Adolescent Obesity Provider toolkit. San Benito will provide nutrition and physical activity education to 5th grade students using the Power Play Curriculum. San Francisco will develop guidelines to improve physical activity and nutrition in child care centers and after school programs. Stanislaus will develop a built environment that is supportive of physical activity.

## **Performance Measure 15**

*Percentage of women who smoke in the last three months of pregnancy.*

### **a. Last Year's Accomplishments**

In 2010, 3.0 percent of women aged 15 years and older who had a recent live birth reported smoking in the last trimester of pregnancy. Though the prevalence of smoking during the last trimester of pregnancy increased slightly between 2009 and 2010, the

prevalence has shown substantial decline since 1999, when the prevalence was 5.7 percent among all women in California.

In 2010, African American and White women had the highest rates of smoking in the last trimester of pregnancy (7.7 and 6.2 percent, respectively) compared to Hispanic (1.0 percent) and Asian/Pacific Islander (0.7 percent) women. Reported smoking declined in each of these groups since 2008, with the exception of Hispanic women, whose rate did not change.

The state's adult smoking rate has hit a record low of 11.9 percent in 2010, making California one of only two states to reach the HP 2020 target of reducing the adult smoking prevalence rate to 12 percent.

One of California's biggest examples of its influence on public health law is tobacco regulation. In 1988, California was the first state to tax cigarettes to fund a tobacco control program. Ten years later, California banned smoking in public places such as trains, planes, buses, workplaces and restaurants. Now, about half of the states have similar policies about smoking in public places. California became a guide for developing anti-smoking policies.

In 2011, two new tobacco-related bills were signed into law. AB 795 provides authority to the governing bodies of the California State University and each community college district to enforce smoking policies by citation and fine. SB 332 was signed into law and would authorize a landlord of a residential dwelling unit to prohibit the smoking of tobacco products on the property premises or in a dwelling unit.

Efforts to reduce and prevent smoking continue to be prominent features of MCAH programs that serve pregnant women and teens. AFLP provided smoking exposure assessment and cessation assistance to pregnant teens. BIH provided health education and health promotion related to smoking cessation in groups and case management for African-American pregnant and parenting women. CPSP included smoking cessation as one goal for improving pregnancy outcomes. CPSP guidelines, "Steps to Take," assisted providers and practitioners with health education, nutrition, and psychosocial interventions. Handouts, in English and Spanish, were available for CPSP to educate women about smoking cessation.

Smoking cessation is a key part of preconception care. The Preconception Health Council of California (PHCC) provided information, tools and resources focusing on the importance of achieving optimal health before pregnancy, including refraining from tobacco use. Low-literacy fact sheets on the PHCC's website, [www.everywomancalifornia.org](http://www.everywomancalifornia.org), encourage women and their partners not to smoke in the event that they may have a baby in the future. In 2010, PHCC consumer handouts, including those on smoking and alcohol, were available in Spanish via the PHCC's website and [www.cadamujercadadia.org](http://www.cadamujercadadia.org).

MCAH was awarded a First Time Motherhood grant to develop and test preconception health messages, including smoking prevention and cessation.

CTCP supported statewide and local smoking cessation projects to create effective and innovative tobacco control interventions throughout California. One project, Protecting the Hood Against Tobacco Scum- Los Angeles (PHATS-LA), was a smoking cessation intervention in L.A. in which most participants were low income and African American. LA's MCAH provided data early on and connected CTCP with BIH. Data from follow-up surveys were collected and are being used to assess the impact of the PHATS-LA project. CTCP released "Creating Tobacco Turbulence: A Tobacco Quit Plan for California," to guide tobacco cessation efforts.

The California Smokers' Helpline provided intensive tobacco cessation counseling, which includes tailored counseling services for pregnant women, teens, and adults in multiple languages. California Medi-Cal made changes to its Contract Drugs List and now includes up to 14 weeks of Nicoderm CQ; Zyban patches or behavior modification support and this new policy was communicated to MCAH partners and programs.

### **b. Current Activities**

AFLP, BIH, and CPSP continue smoking assessment, education, and cessation support activities for pregnant and parenting women. AFLP clients are assessed and counseled at entry and annually for past, current, and second hand smoke exposure. The new PYD intervention will facilitate client-driven life goal development in areas including tobacco use. BIH provides smoking cessation health education and promotion in the new group intervention which was pilot tested this year. Clients who use tobacco products are identified and referred. Biannual trainings for CPSP providers include smoking cessation health education.

The MCAH First Time Motherhood grant campaigns formally ended, but materials continue to be used to address preconception health behaviors in Black, Latina, and young women.

CTCP continues to fund the Smokers' Helpline and projects that facilitate community norm change and support local tobacco control efforts.

To shift toward a more pragmatic harm reduction strategy, the PHCC revised its EVERYDAY mnemonic recommendation to "Avoid tobacco, alcohol and drugs. Or, use birth control until you can." This message was coupled with cessation resources for smokers and the development of clinical preconception care guidelines.

MCAH monitored Senate Bill 575 which has been held in committee without recommendation since July 6, 2011. This bill would expand the workplace smoking ban to cover employee common spaces, tobacco shops, and private residences used for business.

### **c. Plan for the Coming Year**

LHJs will continue their smoking cessation activities, including outreach, education, referrals, data collection, and data analysis.

AFLP, BIH, and CPSP will continue activities to promote smoking cessation and as necessary, update health education and training materials. With the full implementation of the piloted BIH group intervention, there will be opportunities to educate pregnant and parenting African-American women on the benefits of quitting smoking for mom's health as well as the health of the baby. CPSP updates training materials periodically; this would include updating health education handouts and information about smoking cessation.

As part of Reproductive Life Planning, MCAH programs encourage pregnant and parenting teens to set personal goals that support smoke free lives for them, their children, and unborn babies.

The PHCC will continue to provide information, tools and resources to local communities focusing on the importance of achieving optimal health before pregnancy, including refraining from tobacco use.

The California Smokers' Helpline will continue to provide intensive tobacco cessation counseling via the telephone and access to materials through its website. CTCP will continue to provide technical assistance, resources, and/or services to the California tobacco control community. The California Diabetes Program, in collaboration with CTCP and diabetes educators, will continue to participate in the "Do You cAARd?" (Ask, Advise, Refer) campaign to help patients reduce their risk of complications and improve their health. The campaign includes a gold "TAKE CHARGE" card to be handed out to encourage use of the California Smokers Helpline.

MCAH will continue efforts to prevent and reduce tobacco use by pregnant women and women of reproductive age. Coordination with existing programs and initiatives, such as those developed statewide and locally via CTCP can be explored. Additionally, the expansion of covered preventive services via provisions of the ACA, including those for smoking cessation by pregnant women, represents an opportunity to reduce tobacco use and the burden of related health outcomes for MCAH population. The PHCC has developed preconception health screening guidelines to help providers take advantage of this clinical opportunity.

At the policy level MCAH will collaborate with CTCP to monitor their new local policy database. MCAH will explore opportunities to examine smoking trends in relationship to local policies and policy changes in multiunit housing prohibition, tobacco retail license fees, sampling ordinances, and second-hand smoke policies. Meanwhile, all University of California campuses are banning cigarettes over the next 2 years, to both protect nonsmokers from secondhand smoke and prevent young people from smoking.. If young people can stop smoking, or never start smoking, before they reach their late 20s, they will be unlikely to ever develop the habit as older adults.

### **Performance Measure 16**

*The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

### **a. Last Year's Accomplishments**

The DMH, Office of Suicide Prevention (OSP) provides suicide hotline referrals in Spanish and English, a link to the California Strategic Plan on Suicide Prevention, and general information and fact sheets on suicide. CDE publishes an extensive list of youth suicide prevention resources on its Web site. CIPPP provides regional data (hospital discharges, fatalities, and now ED visits) on youth self-harming behavior to LHJs. Local school districts and parent teacher organizations have distributed summaries of research on suicide and self-harm selected from journals of several fields (e.g., anthropology, behavioral sciences, civil engineering, criminology, medicine, nursing, social work, sociology.)). CIPPP continues to work with AAP-CA, the California Academy of Family Physicians, and members of the American Academy of Child and Adolescent Psychiatrists to provide summaries of recent research on the occurrence and prevention of child and adolescent self-harming behaviors. Improving mental health among adolescents and decreasing substance use in the MCAH population is one of the priorities that California identified in its 2010 Needs Assessment Local MCAH Programs work with local collaboratives to address adolescent health issues including youth development, drug abuse prevention and intervention, and mental health issues including suicide prevention. Many of the LHJs have implemented the 4 P's Plus Program by training local providers to screen and provide brief interventions for clients at risk for tobacco, alcohol and other drug use. CPSP and AFLP programs in the LHJs assess and refer teens at risk for evaluation and treatment when appropriate. Under a contract with MCAH, the California Adolescent Health Collaborative (CAHC) reviewed adolescent health indicators, including suicide rates, and developed a statewide profile that identified "hot spots" (jurisdictions with poor health indicators) and "cold spots" (jurisdictions with good health indicators and effective adolescent health programs). CAHC developed a tool for LHJs to use in assessing local community support for positive youth outcomes.

### **b. Current Activities**

DMH will no longer have direct oversight of local MHSA, as a result of 2011 legislation (AB 100, Statutes of 2011) that moves oversight to counties, but it continues to further the California Strategic Plan on Suicide Prevention. OSP will continue to serve as a statewide resource on suicide prevention. MCAH continues to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer youth at risk for suicide to appropriate assessment and treatment. MCAH collaborates to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery. MCAH promotes provider screening, education, and referral to treatment and services for adolescence at risk of substance youth, domestic violence, depression, and stress and encourage LHJs to incorporate mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of adolescents. CIPPP provides regional summaries of data on the occurrence of self-harming behavior among youth, through data reports and the SafetyLit Weekly Update.

Humboldt County, with a 2010 suicide rate of 24.8 per 100,000 is working to end stigma and help individuals learn to cope with suicidal people by providing trainings on how to

connect someone at risk with mental health services and to prevent suicide deaths by teaching people about the warning signs of suicide.

### **c. Plan for the Coming Year**

As requested by LHJs, DMH OSP will continue to assist counties in implementing the MHSAs, as well as ensuring the appropriate implementation of the four strategic directions listed on the California Plan on Suicide Prevention. MCAH will continue to work with CAHC and others to promote best practices in mental health and to investigate best practices in suicide prevention, domestic violence, depression, and stress and encourage LHJs to incorporate 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, such as develop additional strategies for evaluating suicide prevention interventions; establish mechanisms for state- and local-interagency collaboration to improve monitoring systems for suicide and suicidal behaviors. MCAH will continue to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer adolescents at risk for suicide to appropriate assessment and treatment. MCAH will work to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery. MCAH 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.

## **Performance Measure 17**

*Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

### **a. Last Year's Accomplishments**

NPM 17, the percent of Very Low Birth Weight < 1500 grams (VLBW) infants delivered at facilities for high-risk deliveries and neonates, was 75.9 percent in 2009. This was an improvement from the 73.8 percent in 2008, but 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 and neonates. In 2009, Native American/ Alaska Native had the lowest percentages of these VLBW deliveries at NICU facilities at 73.1 percent. Pacific Islanders had the highest percent (79.4), followed by Asians (76.9), African Americans (74.8), and Whites (74.5).

The California figures are based on data from hospitals designated by the CCS program as Regional, Community or Intermediate NICUs. For 2010, there were 128 CCS-approved NICUs in California; however, not all facilities providing care for VLBW infants seek certification by CCS. Fourteen RPPCs provide planning and coordination to ensure that all high-risk patients are matched with the appropriate level of care. The RPPCs develop communication networks on many perinatal topics, disseminate education materials including toolkits, assist hospitals with data collection for quality improvement, and provide hospital linkages to CPeTS.

MCAH has two data projects which monitor perinatal outcomes: IPODR (<http://www.cdph.ca.gov/data/indicators/Pages/InfantPerinatalOutcomesDataReport.aspx>) 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.

Efforts continue to improve data collected from birth certificates. Since 2004, OVR has collaborated with MCAH working with RPPC leaders to plan and present a statewide series of birth data quality trainings. The interactive presentations include discussions of difficulties in data collection, and explanations of medical terminology including illnesses, complications and procedures of labor and delivery. Twelve recently developed fact sheets from the Birth Defects Monitoring Program have been included in the training packets. Awards for excellence and improvement in data collection have been presented to hospitals.

MOD collaborated with RPPC and LHJs to implement the Preterm Labor Assessment Toolkit in 30 California hospitals, triaging women with suspected preterm labor. The importance of perinatal emergency preparedness continues to be an active topic and RPPC Region 4 selected this as its annual quality improvement topic.

CMS continues to collaborate with CPQCC to develop a plan to monitor outcomes of infants/children, 0-3 years of age in the recently restructured HRIF Program. This monitoring capability, coupled with perinatal/neonatal CPQCC data elements, will allow the assessment of infant outcomes in association with perinatal/neonatal care.

MCAH, in collaboration with CPQCC and CPeTS, continues to implement an electronic data system to allow tracking of neonatal transports and monitoring of outcomes. This web-based perinatal transport data collection system helps to identify data elements to guide perinatal transport quality improvement.

CPeTS held two regional trainings in 2010 and plans to develop an on-line training system.

## **b. Current Activities**

RPPC and CPeTS continue matching high-risk patients with the appropriate level of care. RPPCs review birth outcomes data, Perinatal Profiles, and transport agreements with hospitals during site visits.

All CCS approved NICUs are required to submit data annually, and CPQCC continues to retrieve and analyze NICU data. There were 129 CPQCC member hospitals in 2011. The 2010 CPQCC dataset included 12,000 “Big Babies” (>1500 grams), 7,000 “Small Babies” (<1500 gram), and approximately 7,000 acute transports. The CPQCC

databases have expanded and include: 1) Vermont Oxford Network Small Baby <1500 grams; 2) CPQCC High-Acuity, Big Baby 3) All-California Neonatal Transport Database; 4) All-California, Rapid-Cycle Maternal/Infant Database, including Census, Birth Certificate and OSHPD Hospital Discharge data linked to CPQCC outcomes, and 5) HRIF dataset which follows eligible infants 0-3 years of age.

RPPC, with OVR, is providing eight trainings beginning in March 2011, emphasizing the importance of hospital administration, nurses, and birth clerks working collaboratively to accurately report birth data. MCAH is working with OVR to capture more complete information on complications/procedures of pregnancy and complications/procedures of labor and delivery on the birth certificate.

### **c. Plan for the Coming Year**

RPPC and CPeTS continue their work in 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 surrounding patient transfer.

CMS and CPQCC will continue to respond to member questions, analyze data for CCS-approved NICUs, and address outliers and concerns about quality of care. RPPC, with OVR, will continue to present 8 Birth Data Trainings emphasizing administration, nurses, and birth clerks collaborating to obtain and accurately report birth data in 2012. RPPC regional leaders continue to explore opportunities for nursing staff to work with birth clerks for enhanced birth data reporting in continuing efforts to improve data quality.

### **Performance Measure 18**

*Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

#### **a. Last Year's Accomplishments**

Between 2005 and 2008, NPM 18 had steadily decreased from 86.6 percent to 82.4 percent. In 2009, NPM 18 increased slightly to 82.9 percent. In 2010, the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester increased again to 83.5 percent. Asians and Whites met the statewide annual objective for 2010 at 88.0 percent and 87.6 percent, respectively. Asians were more likely to receive prenatal care in the first trimester than women who were White, Hispanic (81.0 percent), African American (78.2 percent), AI (69.6 Percent) or Pacific Islander (68.1 percent).

CPSP, AFLP, BIH, WIC, American Indian Infant Health Initiative (AIIHI) and local MCAH continued to 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 approximately 1500 providers receive a higher reimbursement rate for offering additional health education, nutrition, and psychosocial

support services. CPSP providers receive a bonus for providing prenatal care in the first trimester.

PHCC's EveryWomanCalifornia website provides information to consumers about the importance of being healthy before pregnancy. It also focuses on the importance of planning for pregnancy and emphasizes early entry to prenatal care. PHCC continued to develop the MOD/ACOG postpartum project which will help clinicians to provide information and counseling to clients about healthy behaviors between pregnancies, including optimal pregnancy spacing and the importance of early access to prenatal care, especially for women with chronic medical conditions.

MCAH provided ethnically diverse staff for recruiting clients into care, and LHJs employed a variety of methods to target diverse populations. MCAH provided a local toll free line for residents to obtain referrals to low cost health insurance and prenatal care. In addition, each jurisdiction delivered outreach in a way appropriate to their population's needs.

About 40 percent of all births in California are unintended. [8] Family PACT provided no-cost family planning services to all California residents with incomes at or below 200 percent FPL, and, insofar as these services help to reduce the rate of unintended pregnancy, they also contribute indirectly to more timely prenatal care, since women with planned pregnancies seek care earlier.

The AIM Program administered by MRMIB provided low-cost coverage for over 7000 pregnant women with incomes from 201-300% FPL.

In spite of efforts to increase first trimester prenatal care, the following obstacles remain: delays due to lack of awareness of Medi-Cal Presumptive Eligibility Program, delays due to the Medi-Cal enrollment process, economic downturn leading to more uninsured reproductive age women and high rates of unintended pregnancy.

#### **b. Current Activities**

CPSP provides comprehensive services, including routine obstetric care, nutrition, health education, and psychosocial services. Providers receive a bonus for each woman receiving an initial combined assessment and the initial office visit within 4 weeks of entry into care. MCAH works collaboratively with MCMC to ensure that CPSP is offered to enrolled pregnant women as required by law.

Family PACT provides no-cost family planning services to all California residents with incomes at or below 200 percent of the FPL. AIM provides low-cost health coverage to pregnant women with inadequate coverage and whose incomes are too high for Medi-Cal.

PHCC released the MOD/ACOG Interconception Care Project of California Guidelines in October 2011 to help clinicians provide client counseling about healthy behaviors between pregnancies, including optimal pregnancy spacing and the importance of early access to prenatal care, especially for high risk women with chronic medical conditions.

AFLP provides case management services to at-risk pregnant and parenting teens. AFLP is researching evidence-based strategies and expanding case management services by promoting the concept of Positive Youth Development (PYD), which includes reproductive life planning. BIH, which targets at-risk African American pregnant and parenting women, is implementing the new group intervention model.

LHJs continue outreach to pregnant women and assist with referrals and enrollment in Medi-Cal and other health plans.

### **c. Plan for the Coming Year**

MCAH will continue to work with LHJs to improve outreach to women of childbearing age and pregnant women and provide linkages to early prenatal care.

CPSP, AFLP, WIC, BIH, and AIIHI will continue to provide case management services and linkages to medical care for their target populations.

CPSP plans include expanding provider trainings to include a web-based provider overview training and providing local data on CPSP billing patterns to evaluate local CPSP programs. Local CPSP coordinators will continue provider recruitment.

Coordinators will strengthen utilization of the CPSP scope of benefits by training providers in documentation, program services, development of materials and evaluative reports on the efficacy of services. MCAH and LHJs undertake these activities 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. MCAH is working to consolidate data on beneficiaries, paid claims, birth outcomes, and hospital discharge to develop baseline data on the efficacy of CPSP services. MCAH will continue to work closely with MCMC to facilitate all pregnant women receive CPSP services.

AFLP will continue to implement the Positive Youth Development component into existing services.

LHJs with BIH will continue to implement the new group intervention, as well as the case management component, in order to improve the health and social conditions for African-American women and their families

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Between 2005 and 2008, NPM 18 had steadily decreased from 86.6 percent to 82.4 percent. In 2009, NPM 18 increased slightly to 82.9 percent. In 2010, the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester increased again to 83.5 percent. Asians and Whites met the statewide annual objective for 2010 at 88.0 percent and 87.6 percent, respectively. Asians were more likely to receive

prenatal care in the first trimester than women who were White, Hispanic (81.0 percent), African American (78.2 percent), AI (69.6 Percent) or Pacific Islander (68.1 percent).

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In spite of efforts to increase first trimester prenatal care, the following obstacles remain: delays due to lack of awareness of Medi-Cal Presumptive Eligibility Program, delays due to the Medi-Cal enrollment process, economic downturn leading to more uninsured reproductive age women and high rates of unintended pregnancy.

#### **b. Current Activities**

CPSP continues to provide comprehensive perinatal services, including routine obstetric care, nutrition, health education, and psychosocial services, to its clients. Providers receive a bonus for each woman receiving an initial combined assessment and the initial pregnancy office visit within 4 weeks of entry into care. MCAH is working collaboratively with MCMC to ensure that CPSP is offered to enrolled pregnant women.

Family PACT continues to provide no-cost family planning services to all California residents with incomes at or below 200 percent of the FPL. The AIM program continues to provide low-cost health coverage to pregnant women with inadequate coverage and whose incomes are too high for Medi-Cal.

PHCC released the **MOD/ACOG** Interconception Care Project of California Guidelines in October 2011 which help clinicians to provide information and counseling to clients about healthy behaviors between pregnancies, including optimal pregnancy spacing and the importance of early access to prenatal care, especially for high risk women with chronic medical conditions.

AFLP is increasing capacity of current services by promoting Positive Youth Development (PYD) through reproductive life planning.

BIH, which targets at-risk African American pregnant and parenting women, is implementing the new group intervention model.

LHJs continue outreach to pregnant women and assist with referrals and enrollment in Medi-Cal and other health plans.

### **c. Plan for the Coming Year**

MCAH will continue to work with LHJs to improve outreach to women of childbearing age and pregnant women and provide linkages to early prenatal care.

CPSP, AFLP, WIC, BIH, and AIIHI will continue to provide case management services and linkages to medical care for their target populations.

CPSP plans include expanding provider trainings to include a web-based provider overview training and providing local data on CPSP billing patterns to evaluate local CPSP programs. Local CPSP coordinators will continue provider recruitment. Coordinators will strengthen utilization of the CPSP scope of benefits by training providers in documentation, program services, development of materials and evaluative reports on the efficacy of services. MCAH and LHJs undertake these activities 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. MCAH is working to consolidate data on beneficiaries, paid claims, birth outcomes, and hospital discharge to develop baseline data on the efficacy of CPSP services. MCAH will continue to work closely with MCMC to facilitate enrollment of Medi-Cal-eligible pregnant women into CPSP.

AFLP will continue to implement the Positive Youth Development component into existing services.

Local MCAH with BIH will continue to implement the new group intervention, as well as complementary case management, in order to improve the health and social conditions for African-American women and their families

## C. State Performance Measures

### State Performance Measure 1

*The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system.*

#### a. Last Year's Accomplishments

Bridge to Reform waiver planning continued. Five demonstration project sites were selected with 4 different models of care through which CCS children will have all their care needs met through a single coordinated health system. The models are 1. Utilization of MCMC Plans, Specialty Health Care Plan (SHCP), Enhanced Primary Care Case Management (EPCCM), Provider-based Accountable Care Organization (ACO). These innovate models have projected phase in start dates anticipated for late 2012 through 2013.

#### b. Current Activities

The 1115 Evaluation Oversight Committee is a multidisciplinary team of key internal CCS leaders and Medical Consultants, plus representation from various stakeholders groups representing facilities, providers and family advocacy groups. The actual evaluation program is being developed by UCLA Center of Health Policy Research and will include a “dashboard” for rapid determination of any areas which require more attention, and extensive family/providers satisfaction to access, integration of care, and identify barriers to reform.

#### c. Plan for the coming year

- 1) These innovate models have projected phase in start dates anticipated for late 2012 through 2013 Goal to enroll children January 1, 2012
- 2) The 1115 Evaluation Oversight Committee is a multidisciplinary team of key internal CCS leaders and Medical Consultants, plus representation from various stakeholders groups representing facilities, providers and family advocacy groups.
- 3) Pilot Project Data analysis by UCLA Center for Health Policy Research and UCSF Philip R Lee Institute for Health Policy Studies.
- 4) Rate analysis by Mercer (Actuary)
- 5) Existing coordinated systems in CA include Kaiser and UC. With Kaiser, CCS has recently approved 2 tertiary care centers within the Kaiser system, but there is no data at this time on the CCS population served. Within the University of California system, there are varying levels of integration of care. CCS will be developing systems to collect this data within the next year.

## **State Performance Measure 2 (inactive starting 2011)**

*The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home.*

## **State Performance Measure 3**

*The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey.*

### **a. Last Year's Accomplishments**

SPM 03 is the percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey. The Pilot evaluation group has been meeting bimonthly to discuss development of an appropriate survey for the CCS Pilots.

### **b. Current Activities**

Developing a plan to utilize 1115 Waiver's CCS Pilot Projects' Evaluation Oversight Group and their work on a family survey to administer to CCS families enrolled and not enrolled in the Pilot Projects. Some of the clients not enrolled will be selected to be part of the control population. This method will result in not duplicating work already planned for the coming years.

### **c. Plan for the Coming Year**

- 1) Expand potential base of surveys (from 1115 Waiver's CCS Pilot Projects) including with evaluations to assess satisfaction of families enrolled and not enrolled
- 2) Utilize translation services to translate surveys into most frequently used languages for the region
- 3) Work with Regional Office Staff and local programs to administer the surveys.

## **State Performance Measure 4**

*Percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.*

### **a. Last Year's Accomplishments**

SPM 04 is the percent of women with a recent live birth that reported binge drinking during the three months prior to pregnancy. In 2010, 15 percent of mothers with a recent live birth reported binge drinking during the three months prior to pregnancy, an increase from 13.4% in 2009. This rate differed by racial and ethnic group. White women (20.5%) were most likely to binge drink during the three months prior to pregnancy, followed by Hispanic (12.6%), Asian/Pacific Islander (12.0%) and African American women (10.7%). An estimated 4,460 to 6,050 babies with FASD are born each year in California. [65, 66]

FASD describes the range of effects in individuals whose mothers used alcohol during pregnancy, including physical, cognitive, behavioral and learning difficulties with lifelong implications. MCAH works to improve birth outcomes for women at risk for alcohol abuse through screening and referral for treatment services. Community-based prevention programs such as AFLP, BIH and CPSP identify at-risk mothers and refer them for treatment services.

MCAH promotes preconception health, of which alcohol use prevention in women of reproductive age is a key feature. MCAH participates in PHCC, providing information, tools and resources for communities on the importance of optimal health for women before pregnancy. PHCC developed educational materials informing women of the risk of unintended pregnancy associated with alcohol use. The PHCC website has valuable information on perinatal substance use prevention..

MCAH participates in the FASD Task Force comprised of state/local agency representatives. An FASD Task Force website has been developed to complement its work on increasing legislators' awareness of FASD. The FASD Task Force continues to work on bringing more prominence to the annual celebration of FASD Awareness Day on Sept. 9, 2010. It partnered with DSS to produce an educational brochure on alcohol use prevention targeted to youth.

ADP reconvened the SIT Alcohol and Other Drug Workgroup, with members from DMH, DSS, DDS, CDCR, Administrative Office of the Courts, ADP and MCAH in April 2009 to address FASD prevention. It completed two projects in April 2010: a matrix of members' programs impacting FASD and FASD fact sheets tailored for each agency's specific use. MCAH participated in the SIT ADP Workgroup. The MCAH-specific FASD fact sheet was released on the MCAH website on September 7, 2010

#### **b. Current Activities**

LHJs continue to develop and strengthen coalitions with public/private agencies and providers to assess women at risk and develop appropriate referrals to resources. Many are working to develop coordinated and integrated systems of care to address issues of perinatal substance use based on evidence-based models and focusing on alcohol use during pregnancy in their presentations to providers and other interest groups.

Alameda County continues to implement their Pediatric System of Care Strategic Plan to improve care of substance-exposed children at risk for social/emotional, developmental, behavioral, psychological, and physical problems.

PHCC continues to monitor its website which connects people working in preconception health and features links to tools and resources related to alcohol use prevention among women. MCAH programs and initiatives all feature components to stress importance of abstaining from alcohol if you are or may become pregnant and provide resources to help. In evaluating the messaging, focus group testing suggested that the idea of abstaining from alcohol during your reproductive years because of the risk of prenatal alcohol exposure was viewed as too conservative by many women. As such, the PHCC

revised its EVERYDAY mnemonic recommendation from “Avoid tobacco, drugs and risky drinking” to “Avoid tobacco, alcohol and drugs. Or, use birth control until you can.” This message was consistent with our harm reduction philosophy of behavioral intervention.

### **c. Plan for the Coming Year**

LHJs will continue to work on developing and strengthening coalitions with public/private agencies and healthcare providers to determine how best to identify women at risk and how to develop appropriate referral sources. LHJs will continue to develop and implement coordinated and integrated systems of care to address perinatal substance use prevention. MCAH will continue to participate in the FASD Task Force and will continue its efforts on preconception health education and promotion, including augmenting and monitoring its preconception health website. Preconception Peer Educators at California Community Colleges and Universities will partner with LHJs and local organizations to conduct campus and community outreach to promote harm reduction strategies to reduce preconception alcohol exposure and prenatal alcohol exposure. MCAH will publish a MCAH bulletin highlighting the recent developments in preconception alcohol research and data trends.

## **State Performance Measure 5**

*Percent of cesarean births among low risk women giving birth for the first time.*

### **1) Last Year's Accomplishments**

Over the decades, cesarean rates have increased dramatically in California. In 2010, C-section births among low risk women giving birth for the first time were at 26.1%. The causes for the rise in cesarean section are not clear, but may be associated with rising rates of pre-existing maternal morbidities such as obesity, as well as rising rates of labor induction and augmentation. Some have suggested that obstetricians might be giving up on vaginal deliveries and switching to C-sections earlier in labor than they used to, or that more women are requesting C-sections so they can have greater control over when their babies are born. To explore the multifaceted contributors to cesarean delivery, MCAH funded the Maternal Quality Indicators Collaborative with UCLA to assess current levels of maternal morbidity in California and develop valid indicators to measure trends in maternal outcomes and funded the CMQCC to improve California maternity care through data driven quality improvement efforts. MQI completed a trend analysis of cesarean deliveries in California with the UCLA Maternal Quality Care Collaborative and found a significant rise in cesarean deliveries between 1999 and 2005. Of note, this rise in cesarean deliveries also corresponded to a rise in maternal morbidity due to infection and a rise in maternal mortality overall. CMQCC conducted a geographic analysis of cesarean deliveries in California and found wide variation in the cesarean rates between counties in the north and counties in the south, suggesting differences in obstetrical practices by region.

As a result of the previous work, CMQCC developed and disseminated a toolkit to reduce non-medically indicated labor induction and cesarean section prior to 39 weeks gestational age. MCAH has also collaborated with MOD to publish and disseminate the

toolkit throughout the state. The toolkit provides guidelines to hospitals and materials for patient education.

MCAH also funded a Local Assistance for Maternal Health project in San Bernardino to help the county health department provide leadership to local hospitals to implement quality improvement activities to reduce elective inductions of labor. Fourteen hospitals in San Bernardino County participated and implemented new policies and procedures to reduce elective inductions. Process and health outcomes measures are being tracked and while induction rates are decreasing, augmentation rates are rising. The concern is that definitions of labor may be confounding data collection.

MQI and CMQCC provided expertise and support for development of new obstetrical measures for the National Quality Forum which were then incorporated by the Joint Commission.

## **2) Current Activities**

L.A. County is conducting a county-wide campaign to reduce cesarean deliveries. CMQCC is working with UCSF to study racial disparities in cesarean deliveries in the state and provided technical assistance to two local health departments who are addressing maternity care issues and to the Regional Perinatal Programs of California. CMQCC published a “white paper” on cesarean deliveries that outlined marked regional variation in surgical deliveries.

San Bernardino County LAMH worked to reduce non-medically indicated induction of labor by educating the community about labor induction and promoting best practices among clinicians and providers. Their efforts included labor induction guidelines and recommendations for local area hospitals to follow when scheduling labor inductions; patient consent document to inform patients of options; and, an Advisory Council comprised of public and private organizations. Fourteen hospitals in San Bernardino participate in the project and are regularly involved in webinars and data sharing. Outcome data will be analyzed by the local health department before the project ends in June 2012.

MQI trended and composed a manuscript describing the level of medical indication associated with induction and preterm delivery; this knowledge is central to standardizing medical interventions that may reduce cesarean delivery.

The PHCC and MCAH Preconception Health and Nutrition and Physical Activity Initiatives conducted activities to address many of the preconception and prenatal morbidities that increase the risk of cesarean delivery. (See Major State Initiatives).

## **3) Plan for the Coming Year**

MQI will undertake a research project to increase our understanding of the relationship between rising prevalence of cesarean delivery and maternal morbidity. This will involve estimating the contribution of preconception, pregnancy-related, and obstetric maternal

morbidity to Nulliparous, Term, Singleton, and Vortex (NTSV) cesarean deliveries and to also estimate the contribution of NTSV cesarean delivery to postpartum maternal morbidities and repeat cesarean delivery. MQI will also continue to monitor maternal morbidity trends in California and begin exploring their associated costs.

LAMH will report on program and health outcomes regarding reduction of elective early term deliveries and share implementation guidelines for both projects and share with local MCAH directors. The LAMH project funding ends in June 2012, however if funding becomes available, other topics of interest to address are improving quality of care measures to address increasing maternal morbidity and a rising trend in rates of cesarean birth.

CMQCC will continue to provide technical assistance to local and regional maternal health efforts related to cesarean delivery.

### **State Performance Measure 6**

*Percent of women of reproductive age who are obese.*

#### **Last Year's Accomplishments**

There has been an upward trend in obesity among women of reproductive age over the past ten years. In 2000, 16.5% of women of reproductive age were obese (BMI  $\geq$  30 kg/m<sup>2</sup>), compared to 20.9% in 2010. African American (39.0%) and Hispanic (27.7%) women were more likely to be obese than White (18.2%) women.

MCAH promoted obesity reduction and healthy strategies to achieve optimal preconception weight, prenatal weight gain, and breastfeeding.

MCAH and CMS participated on the Obesity Prevention Group (OPG), which aims to integrate obesity prevention into CDPH programs. MCAH and CMS collaborate with the California Obesity Prevention Program (COPP) and the Champions for Change to promote healthy lifestyles to reduce the prevalence of obesity.

MCAH was involved in planning the California Childhood Obesity Conference which emphasized the life course perspective, focusing on the role of childhood weight gain in adult obesity.

MCAH worked on CDAPP, AFLP and CPSP program nutrition and physical activity guidelines.

MCAH was involved in developing the Health in All Policies Task Force report which has specific nutrition and physical activity recommended policies, programs, and strategies that can be implemented in the State.

PHCC Interconception Care Project of California in coordination with ACOG District IX

and MOD began work on the provider guidelines for the post-partum visit, which include weight management for women with gestational diabetes.

The PHCC's web-based fact sheets on topics related to preconception health, such as healthy weight, healthy food choices and physical activity were made available in Spanish via [www.cadamujercadadia.org](http://www.cadamujercadadia.org).

MCAH developed a preconception health social marketing campaign using First Time Motherhood grant funds. The Latina component consisted of radio messages on preconception folic acid consumption and directed listeners to [www.cadamujercadadia.org](http://www.cadamujercadadia.org). The African American and youth components featured nutrition, physical activity and weight as part of overall health.

MCAH monitored pre-pregnant weight status and pregnancy weight gain utilizing birth certificate and MIHA Survey data, and considers obesity in risk factor analysis for the Pregnancy-Associated Mortality Review.

MCAH LHJs supported state efforts. Alameda provided information on the problem of obesity in women of child-bearing age to health care providers and public health staff including strategies for patient education and behavior change. Exercise and nutrition classes were provided to promote nutrition, exercise and wellness. Technical support was given to CPSP nutritionists, regarding CPSP and Steps to Take nutrition resources, prenatal weight gain grids, dietary assessment tools, identification of high risk prenatal clients and gestational diabetes testing and referral. A nutritionist provided information on the problem of obesity in women of child-bearing age to health care providers and public health staff including strategies for patient education and behavior change. A Healthy Weight Workgroup was convened with community partners to address the goal of decreasing overweight and obesity in women of child-bearing age.

Contra Costa conducted a Healthy Living, Healthy Eating Fair to educate attendees about proper nutrition to prevent diabetes, high blood pressure, cholesterol, and weight gain. Fresno providers were given new nutrition assessment forms and instructions on how to calculate BMI for pregnant and postpartum mothers Kern collects BMI data, emphasizes the importance of nutrition assessments and reassessments to identify weight issues and to use CPSP material to educate clients on controlling weight gain during pregnancy. Long Beach a wellness forum established for African American churches to promote healthy food choices.

A curriculum and materials that were developed by Sonoma as part of the Healthy Weight in Women Action Learning Collaborative was shared with community organizations developing teen cooking classes.

#### **b. Current Activities**

MCAH collaborated with other state programs and agencies, advocates, experts and local MCAH directors to prevent overweight among women of childbearing age.

MCAH continued to integrate obesity prevention into CDPH programs through OPG, developed a web page entitled “Healthy Weight Among Women of Reproductive Age” and collaborated with FHOP to develop and present a Webinar and Fact Sheet on Healthy Weight.

The MCAH adolescent cookbook in English and Spanish was published. Recipes were coordinated with ingredients available through the new WIC food package. The cookbook includes seasonal food variation and physical activity recommendations.

MCAH researched and identified potential nutrition, physical activity and breastfeeding benchmarks for the California Home Visiting Program (CHVP).

The PHCC Interconception Care Project of California provider guidelines and patient handouts were finalized and publicized. The guidelines include postpartum obesity management.

MCAH finalized new information on model nutrition, physical activity, and breastfeeding to publish the MyPlate for Moms/My Nutrition Plan for Moms, Adolescent Nutrition and Physical Activity Guidelines for AFLP, CDAPP Guidelines for Care, and the CPSP Steps to Take Guidelines. The 24-hour dietary recall form was updated to mirror the new MyPlate materials. BIH and local MCAH LHJs used the new resources to prioritize optimal nutrition and physical activity.

### **c. Plan for the Coming Year**

MCAH will continue to collaborate with other state programs and agencies to dialogue with advocates, experts and local MCAH directors to prevent overweight among women of childbearing age. MCAH will continue to participate and collaborate on OPG, which aims to integrate obesity prevention into CDPH programs and develop an action plan and obesity-related proposals for funding opportunities.

MCAH is updating CDAPP, CPSP, BIH, and AFLP nutrition and physical activity guidelines and will finish the revision of an adolescent cookbook. in English and Spanish. MCAH will finalize the Adolescent Nutrition and Physical Activity Guidelines for AFLP and post on the web with various access points, including preconception, AFLP and the nutrition/physical activity web pages. Revised CDAPP Guidelines for Care and the CPSP Steps to Take Guidelines will be finalized to include new information on model nutrition, physical activity, breastfeeding resources and interventions. BIH and local MCAH LHJs continue to prioritize optimal nutrition and physical activity as important interventions to reduce obesity in women of childbearing age.

Options for substituting seasonal fruits and vegetables and recommendations for physical activity will be included. Recipes will be coordinated with ingredients available through the new WIC food package.

MCAH will investigate leveraging existing campaigns to include preconception messaging, such as the 50 million pound challenge (sponsored by State Farm) and the President's Council on Physical Fitness. Also, MCAH will investigate building linkages with existing nutrition resources, such as community garden programs, farmer's markets and diet support programs. Feasibility of new campaigns, such as a "Biggest Loser" spin-off geared toward women of reproductive age with incentives and rewards coming from community and corporate partners with a vested interest in promoting weight loss will be considered. MCAH will also consider expanding partnerships with organizations such as UC Davis.

Per recommendations by the IOM's Committee to Reexamine IOM Pregnancy Weight Guidelines (2009), MCAH will continue to conduct routine surveillance of pre-pregnancy BMI, weight gain during pregnancy and postpartum weight retention and report the results by age, racial/ethnic group, and socioeconomic status to inform local initiatives to promote healthy weight.

MCAH will continue to inform women of the importance of conceiving at a normal BMI as part of our preconception initiative, encourage a higher proportion of women to limit their weight gain during pregnancy based on the revised IOM guidelines and post those on the MCAH website.

MCAH programs will offer counseling, such as guidance on dietary intake and physical activity, which is tailored to client circumstances.

### **State Performance Measure 7**

*The percent of women whose live birth occurred less than 24 months after a prior birth.*

#### **a. Last Year's Accomplishments**

Between 2008 and 2010, NPM 7 steadily decreased from 13.2 percent to 12.3 percent. Among the largest race/ethnic groups, African American women were most likely to have a live birth less than 24 months after a prior birth (13.8 percent), followed by Hispanics (12.5 percent), Whites (12.2 percent) and Asians (10.4 percent).

Preconception and interconception care is a priority for the MCAH Program. The Preconception Health (PHI) aims to improve the health of women prior to pregnancy to improve birth outcomes and reduce disparities in maternal and infant morbidity and mortality. A critical part of this initiative is adequate spacing between births. To reduce unintended pregnancy and appropriate birth spacing, MCAH and the Office of Family Planning (OFP) supported programs that help women and teens understand the importance of pregnancy timing, decrease risky health behaviors, increase access to and promote the use of effective contraceptive methods, and improve the effectiveness with which all methods are used. OFP programs include Family PACT, which provided no-cost family planning services to low-income men, women and teens, the Community Challenge Grant (CCG) and the I&E Program.

MCAH activities included active participation on the Preconception Health Council of California (PHCC), which plays a pivotal role in relaying the message of the importance of reproductive life planning (RLP), intended pregnancies, birth spacing and preconception care through stakeholders to local communities statewide. The PHCC preconception health website, [www.everywomancalifornia.org](http://www.everywomancalifornia.org), has resources for consumers and providers. In 2010, the PHCC website was expanded to include consumer handouts in Spanish. The project to develop clinical guidelines for the postpartum visit began in 2010. The guidelines included content to help providers address pregnancy spacing, care for chronic conditions between pregnancies and timely prenatal care for future pregnancies.

MCAH also participated in ASHWG, which promotes an integrated system of reproductive health resources for youth to ensure access to family planning services in order to reduce the rate of unintended pregnancy. MCAH also coordinated AFLP which services pregnant and parenting teens with a goal reduce repeat births to teens and encourage the completion of secondary education.

MCAH programs including BIHCPS, CDAPP, and the PHI worked to integrate pregnancy timing and spacing messages into their content.

The BIH program model was revised to include 20 group sessions (ten prenatal and ten postpartum), addressing birth spacing and the importance of planning for a subsequent pregnancy to improve maternal and infant outcomes. In the final session, participants create a Life Plan that includes plans for future children and decisions about birth control methods.

CPSP guidelines assisted providers and practitioners with health education, nutrition, and psychosocial interventions and include information on family planning and adequate birth spacing. The health educator is also tasked with helping the patient develop a plan to achieve future reproductive goals.

MCAH began revising the toolkit for CDAPP providers to include family planning and contraception options for women with diabetes.

PHI implemented a social marketing campaign targeting African-American and Latina women and youth and features messages encouraging them to improve their health and plan for pregnancy to optimize outcomes for themselves and any children they may have.

#### **b. Current Activities**

MCAH promoted appropriate pregnancy timing and birth spacing in programs and initiatives.

Family PACT, CCG, I&E, and AFLP continued their teen pregnancy prevention efforts. AFLP began the Positive Youth Development intervention centered on RLP to empower clients with goal setting and promote optimal birth spacing among teens.

The revised BIH model was piloted and revised in preparation for full program implementation.

The CDAPP program was restructured to emphasize the online resource center. The CDAPP toolkit, with an emphasis on preconception health and optimal birth spacing for women with diabetes, was published. CDAPP resources are also linked on the PHCC website.

The PHCC website was revised to include more interactive features and link to pages designed by PHI for targeted populations, such as Spanish-speaking women and African-American women. The clinical guidelines for the postpartum visit were finalized and disseminated online at [www.everywomancalifornia.org/postpartumvisit](http://www.everywomancalifornia.org/postpartumvisit). CPSP Services Coordinators were trained to use the Interconception Care Project postpartum visit guidelines with clients.

CFHC, a PHCC member, expanded the recently completed preconception health and reproductive life planning demonstration project to more Title X clinics and helped MCAH conduct focus groups with women about the concept of RLP..

### **c. Plan for the Coming Year**

The MCAH Program will continue to strengthen and expand its interconception and reproductive life planning initiatives toward the aim of ensuring adequate birth spacing.

AFLP PYD sites will finish case-manager training and begin pilot testing the revised RLP client-centered intervention tool. Preliminary steps to align the programmatic goals of the Teen Pregnancy Prevention Program with the PHI RLP strategies will begin.

The PHCC will work with California universities and community colleges as well as LHJs to promote reproductive life planning and appropriate birth spacing through the Office of Minority Health Peer Preconception Educators Program (PPE). This program will train post-secondary students to create and support community outreach initiatives to address preconception and interconception health.

The PHCC preconception care guidelines will be released and published on the [everywomancalifornia.org](http://everywomancalifornia.org) website to provide clinical guidance on the preconception well woman visit recommended by the IOM that will be included as a health exchange benefit by the HHS preventive services for women. The PHCC will also continue to disseminate and conduct trainings on the Interconception Care Project of California for health care providers and public health professionals.

The California Federal Home Visiting Program will promote appropriate pregnancy spacing with contraceptive education, counseling, and clinical services beginning in the final trimester of pregnancy and extending throughout the postpartum period.

The CFHC will continue its efforts to expand its reproductive life planning demonstration project to all clients of Title X-funded clinics by 2015.

## State Performance Measure 8

*The percent of 9<sup>th</sup> grade students reporting a high level of school connectedness.*

### **a. Last Year's Accomplishments**

MCAH reviewed the professional literature to develop health policy and programs that support school retention. Health is intimately connected with education in multiple ways across the life course. Education influences health through its impact on employment and associated determinants of health such as living conditions, access to healthy foods, safe communities and quality health services. Increased education also allows for the opportunity for better paying jobs. Furthermore, increased educational achievement improves MCAH outcomes through its impact on health knowledge and behaviors, as well as sense of control, social standing, and social support.

Longitudinal research supports a broad school-connectedness measure: school connectedness was found to be the strongest protector against substance use, school absenteeism, early sexual initiation, violence, and risk of unintentional injury (such as drinking and driving or not wearing seat belts). Research highlights the protective effect that connectedness i.e. the emotional attachment and commitment a child makes to social relationships in the family, peer group, school, community, and culture has on adolescent sexual and reproductive health.

MCAH supports Positive Youth Development programs (PYD) as an effective public health response. These programs support the capacity and strength of youth. MCAH's AFLP is one health program that provides an opportunity to incorporate principles of positive youth development that build on strengthening protective factors that support education. By assisting adolescents in identifying important linkages to schools, MCAH AFLP can build on the education-health connection that leads to positive health outcomes.

### **b. Current Activities**

MCAH continues to work on developing a framework to integrate positive youth development in three ways: 1) the Adolescent Family Life Program; 2) CAHC, a statewide coalition of individuals and organizations, both public and private, whose main goal is to support adolescent health in California through trainings, data analysis, education, and TA to MCAH and to local MCAH programs; and, 3) ASHWG, comprised of program managers from the CDPH, including Office of AIDS, STD Control Branch, Office of Family Planning, and Maternal, Child and Adolescent Health), CDE, and key CBOs, including CAHC and the State Title X Administrator for California, the CFHC.

MCAH applied for and was awarded a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers funding opportunity from the U.S. Department of Health and Human Services (HHS), Office of Adolescent Health. CDPH/MCAH received \$2 million for federal project period 2010 – 2013. Under this grant, using a positive youth development framework, MCAH seeks to improve and increase capacity of the pregnant and parenting services currently offered to eligible youth served through its AFLP and the Cal-SAFE.

### **c. Plan for the Coming Year**

MCAH will continue to collaborate with local AFLP and Cal-SAFE programs in each awarded LHJ to implement the AFLP PYD Program. AFLP PYD case management intervention services will be provided by the selected AFLP programs in partnership with Cal-SAFE sites that no longer have case management support services, but do continue to offer child and developmental services for the teens' children. AFLP PYD interventions will be strength-based and will be formed in client goals that support a life planning approach.

AFLP will implement this intervention at 11 AFLP sites that were identified a competitive process.

MCAH will utilize the expertise within CAHC to develop and refine the intervention, as well as train providers. MCAH will also continue its work with CAHC to support local MCAH programs as they implement adolescent health measures.

## **State Performance Measure 9**

*Infant mortality rate among low-income women*

### **a. Last Year's Accomplishments**

California uses the linked birth and death cohort files to report the infant mortality rate among low income women. The low income infant mortality rate was constant at 5.7 infants per 1000 from 2006 to 2008 and decreased to 5.5 in 2009.

Sixteen LHJs implement FIMR programs. In Contra Costa, preconception/interconception education has been integrated into the maternal interview, which is an essential component in the spectrum of case management and family support services offered to clients following a fetal or infant death. Given its size and large number of birthing hospitals, L.A. County uses a survey tool (L.A. Health Overview of a Pregnancy Event) to conduct FIMR. The survey questions are designed to focus on maternal behaviors and health system variables that can be addressed by public health interventions.

All MCAH LHJs conduct outreach to encourage pregnant women to seek early prenatal care through programs such as Prenatal Care Guidance. Many LHJs integrate preconception and interconception messaging into their services as a strategy to prevent poor birth outcomes such as infant mortality.

Various MCAH programs and initiatives, including CPSP, AFLP, BIH, RPPC and PHHI, work on improving infant health and birth outcomes and enroll mostly low-income women. CPSP aims to decrease the incidence of low birthweight (LBW<2500 grams) infants by providing at-risk women with comprehensive services including prenatal care,

education, and psychosocial support. Over 1,500 Medi-Cal obstetrical practitioners provide CPSP services, serving approximately 165,000 women annually. A primary goal of AFLP is to improve birth outcomes for babies born to adolescent clients, many of whom receive Medi-Cal services. AFLP assists pregnant adolescents to access prenatal and other necessary health care early in pregnancy, provides nutrition counseling, and works with teens to eliminate behaviors contributing to poor birth outcomes. African American infants are more than twice as likely as infants of other racial/ethnic groups to be born LBW in California. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and assists them in accessing and maintaining appropriate healthcare and support services.

MCAH and CMS collaborate with CPQCC on performance improvement in perinatal and neonatal outcomes. CPQCC has 129 member hospitals, accounting for over 90 percent of newborns requiring critical care. RPPC provides consultation to delivery hospitals, using current outcomes data from Perinatal Profiles, and supports implementation of clinical quality improvement strategies by collaborating with maternal and neonatal providers to address evidence-based quality improvement projects and improve risk-appropriate care.

MCAH participates in PHCC, providing information, tools and resources to local communities on achieving optimal health for women prior to pregnancy. A social marketing campaign was conducted to foster folic acid use, reproductive life planning and self-respect. MCAH and CMS collaborated with MOD on its Prematurity Campaign , which aims to invest in research, education and community programs to identify causes of prematurity and develop strategies to improve birth outcomes. A statewide effort to reduce elective deliveries of less than 39 weeks gestational age is ongoing throughout the state through efforts with multiple stakeholders: MOD, ACOG, the California Hospital Association, and CMQCC with encouragement from RPPC.

L.A. County participated in the Partnership to Eliminate Disparities in Infant Mortality, an 18-month collaborative project (September 2008-February 2010) sponsored by the Association of Maternal Child Health Programs, CityMatCH and National Healthy Start Association, which provided tools to address infant mortality disparities. L.A. County created an Action Learning Collaborative (LAC ALC) website to provide information on resources and best practices relating to infant mortality and undoing racism. A health disparities brief addressing disparities in infant mortality and birth outcomes in L.A. County and an Infant Mortality, Preterm Births and Low Birthweight Fact Sheet have been released. The first ALC-sponsored health disparities training workshop in April 2010 was a success with over 100 providers in attendance.

#### **b. Current Activities**

Various MCAH programs and initiatives, including CPSP, AFLP, BIH, RPPC and PHHI, continue their work on improving infant health and birth outcomes.

L.A. maintains the LAC ALC website to provide information on resources and best practices relating to infant mortality and undoing racism. With its multidisciplinary local partners, LAC ALC continues with its mission of increasing capacity at the local and state levels to address the impact of racism on birth outcomes and infant health. In December 2011, the ALC held a successful Racial Justice Leadership Institute training on undoing racism for collaborative members' staff, with a total of 42 participants. MCAH and CMS continue to collaborate with MOD on its Prematurity Campaign, which aims to invest in research, education and community programs to identify causes of prematurity and develop strategies to improve birth outcomes. The Association of State and Territorial Officers (ASTHO) is partnering with MOD to further promote its Prematurity Campaign. The Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age Toolkit has been developed as a collaborative project with CMQCC, MOD and MCAH. It is being used at the local level to facilitate improvements and transform maternity practice care. MCAH has licensed the toolkit to MOD, which is disseminating it nationally as part of its Prematurity Campaign.

### **c. Plan for the Coming Year**

LHJs will continue to perform outreach, client education and case-finding functions, including a toll-free telephone information service and targeted activities designed to assist women in receiving early and continuous prenatal care. Programs also provide critical social support services, case management and client follow-up.

CPSP providers offer comprehensive prenatal care, including obstetrics, nutrition, health education, and psychosocial support. Local AFLP programs use outreach, home visitation, and follow-up with pregnant women to educate clients and stakeholders on the importance of prenatal care. Regional AFLP representatives meet to discuss strategies for improving prenatal care utilization. BIH provides community outreach and health education, to increase community awareness of the importance of prenatal care. The newly revised BIH intervention provides a 20-session group intervention (10 prenatal and 10 postpartum) with complementary case management that provides support to empower clients to make healthier choices for their babies. Case management ensures linkage to prenatal services.

FIMR is working on a Home Interview data collection tool for use by local FIMR programs. In addition to streamlining the data-gathering process, the use of this standardized tool will assist MCAH in multi-year analysis of FIMR data.

L.A. County continues with its ALC work. The ALC plans to hold more health disparities training workshops for healthcare providers as part of its mission to increase local capacity to address the impact of racism on birth outcomes and infant health. MCAH and CMS continue to collaborate with MOD and ASTHO on the Prematurity Campaign.

CMQCC and RPPC continue to provide technical assistance to other hospitals and LHJs who wish to reduce elective deliveries for pregnancies less than 39 weeks gestation.

### **State Performance Measure 10**

*The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home.*

#### **a. Last Year's Accomplishments**

This is a new performance measure. In 2008, the current set of Performance measures for California Children's Services were developed, which included that counties should indicate whether each CCS client has an identified medical home.

#### **B. Current Activities**

1. Obtain detailed reports from counties on number/percent of CCS children with 'medical home' by individual vs. Clinic, and primary care doctor vs. specialist
2. Meet with county CCS administrators to review Medical Home definition, discuss how to consistently apply Medical Home definition in the CMS performance measure reporting of medical home provider.
3. Implement the 1115 Demonstration Waiver Project of which The Medical Home is a core component. The project will be evaluating innovative health care delivery models for children with CCS conditions. As outlined in the 1115 RFP, the Medical Home is the foundation of each of the 4 models of an integrated and coordinated health care delivery system.

#### **C. Plan for the Coming Year**

- 1) Develop and issue policy letter to request that County CCS offices identify only physicians, not clinics, as designated Medical Homes.
- 2) As staffing permits, work with local program staff and stakeholder groups to promote medical homes for children enrolled in CCS
- 3) Continue implantation of 1115 and analysis of initial and interval data. The California Children's Services Waiver Evaluation Plan for the 1115 Pilots is in the final stages of development and includes several measures of Medical Home function including being family centered, satisfaction of patient, family and providers, and appropriate healthcare access.

### **D. Health Status Indicators (HSI)**

#### **>Introduction**

California utilizes various data sources to complete the indicator data for the various HSIs. These include the Birth Statistical Master file (HSI 1, 2 and 7), the Death Statistical Master file ( HSI 3 and 8) the Patient Discharge Data from OSHPD ( HSI 4), the STD Surveillance report ( HSI 5), the Race/Ethnic Population Projection with Age and Sex Detail from the Department of Finance( HSI 6 ) and the Annual Social and Economic Supplement, Current Population Survey from the U.S. Census Bureau

(HSI 11 and 12).

A composite of data gathered from the (1) Race/Ethnic Population Projection with Age and Sex Detail from the Department of Finance, (2) the Annual Social and Economic Supplement, Current Population Survey from the U.S. Census Bureau, (3) the Federal Data Reporting and Analysis Bureau of DSS, (4) MediCal Care statistics from DHCS, (5) the HF Program Monthly Enrollment Reports from MRMIB, (6) WIC data from the WIC, (7) Juvenile Arrests reported by the Criminal Justice Center of the Department of Justice, and (8) Number of Dropouts from California Public Schools from CDE are used to complete the indicators for HSI 9.

### >Low Birth Weight (LBW) and Very Low Birth Weight (VLBW) Indicators

In 2010, the percent of live births weighing less than 2,500 grams remained at 6.8 percent. Among the largest race/ethnic groups, African Americans (12.2 percent) and Asians (7.9 percent) had the highest percent of LBW births. In 2010, Hispanics and Whites had the lowest LBW births at 6.2 percent and 6.1 percent, respectively. The percent of live singleton births which were LBW in 2010 was 5.3, a slight increase from 5.2 in 2008. For 2010, it was highest among African American infants at 9.9 percent compared to infants who were Asian (6.3 percent), Hispanic (5.1 percent) or White (4.1 percent).

Births less than 1500 grams are classified as VLBW. In 2010, the percent of live births which were VLBW was 1.1 percent, remaining relatively stable since 2000. In 2010, 2.6 percent of African American live births were VLBW. All other racial and ethnic groups were generally between 1.0 and 1.3 percent VLBW in 2010. In 2010, the percent of live singleton births that were VLBW was 0.9 percent, remaining constant since 2000. Among racial and ethnic groups, African Americans were twice as likely to give birth to singleton VLBW infants. In 2010, 2.0 percent of African American live singleton births were VLBW. Comparatively, 0.9 percent of Hispanic singleton births were VLBW, while Asians had 0.8 percent and Whites had 0.7 percent.

VLBW is almost exclusively related to prematurity with gestational age of less than 32 weeks. While not all causes of severe prematurity are well understood, women who have had previous preterm births, are carrying multi-fetal pregnancies, are African American, or are at the extremes of maternal age, have a well-documented risk of preterm delivery. Pre-existing medical conditions and lifestyle issues affecting women's health 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 birth weight. Morbidities associated with VLBW include Respiratory Distress Syndrome, intraventricular hemorrhage, patent ductus arteriosus, necrotizing enterocolitis and retinopathy of prematurity. Optimizing the outcome of VLBW infants requires improvement of risk-appropriate maternal-fetal care.

California seeks to improve its infant mortality rate. Amenable to policy interventions that contribute to infant mortality are disorders related to low birth weight. To evaluate variation, understand related issues and provide information on infant morbidity and mortality rates, MCAH funds several data projects. Perinatal Profiles of California, based at the School of Public Health, University of California, Berkeley, is a risk-adjusted mortality database that reports on sentinel events such as the proportion of VLBW infants born outside of tertiary care facilities. RPPC leaders review this data with hospitals during site visits. IPODR is a web-based database allowing evaluation of perinatal outcomes at the county and zip code levels. Data are used to identify groups of women and infants at high risk for health problems, monitor changes in health status, and measure progress toward goals to improve the health of mothers and infants.

BIH addresses disparities in birth outcomes. The program provides African American women, their families and communities with support services addressing factors that negatively impact birth outcomes. Strategies to prevent prematurity and reduce LBW/VLBW include culturally competent approaches to increasing timely and adequate use of prenatal care, educating women to modify behaviors that may promote preterm labor, and educating women on recognition of the signs of preterm labor.

L.A. County participated in the Partnership to Eliminate Disparities in Infant Mortality, an 18-month collaborative project (September 2008-February 2010) sponsored by the Association of Maternal Child Health Programs, CityMatCH and National Healthy Start Association which provided tools to address infant mortality disparities. L.A. County created an Action Learning Collaborative (LAC ALC) website to provide information on resources/best practices on infant mortality and undoing racism. The ALC continues its mission of increasing capacity at the local and state levels to address the impact of racism on birth outcomes and infant health.

MCAH engages in numerous efforts to understand the risks and optimize outcomes for LBW/VLBW infants. Several MCAH programs target specific populations at risk for adverse pregnancy outcomes. BIH serves pregnant and parenting African American women through a group intervention and complementary case management to improve the health and social conditions for these women and their families. The group intervention empowers African American women by providing information and skills in a culturally relevant and affirming manner. Research has shown that promoting capacity for social support influences birth outcomes by buffering the adverse effects of chronic stress. BIH is located in 15 LHJs where over 75% of California's African American live births occur. Direct services for at-risk populations are also provided through AFLP CDAPP and CPSP, which promote not only perinatal health but women's health, thus influencing infant outcomes of subsequent births.

MCAH implements quality improvement (QI) strategies to ensure a high level of care for neonatal and maternity care practices through CPQCC and CMQCC. QI toolkits on varied clinical topics are available on these collaboratives' websites and have been used by institutions across the state and the nation. RPPCs promote access to risk-appropriate perinatal care for pregnant women and their infants through regional QI activities,

including assisting hospitals with data collection protocols, developing quality assurance policies and procedures, and providing resource directories, referral services, hospital linkages and technical assistance. BBC utilizes QI methods to implement evidence-based policies and practices that support breastfeeding within the maternity care setting.

Healthy eating, physical activity, and breastfeeding promotion are integrated within MCAH to promote healthy lifestyles and improve birth outcomes. PHHI promotes preconception health messages to women of reproductive age, integrates preconception care into public health practice, monitors indicators, and evaluates preconception health programs and interventions to guide policy strategies. LHJs conduct educational programs for women of reproductive age and providers, addressing health behaviors causing poor pregnancy outcomes. Resources and best practices for professionals and information for the general public are available through the initiative's website.

Examining data from mortality case reviews, birth defects surveillance, and the Maternal Infant Health Assessment survey guides MCAH in program planning and priority goal setting. Data are used to identify groups of women and infants at high risk for health problems, monitor changes in health status, and measure progress toward goals to improve the health of mothers and infants. Data sources such as the CA Women's Health Survey are used to examine the evidence for public health practice.

Optimizing collaboration with strategic partners, using data to understand and inform efforts, and implementing public health strategies to eliminate disparities and promote health equity are essential in MCAH's continuing efforts to address LBW/ VLBW outcomes.

### >Injury Indicators

Unintentional injury is the leading cause of death in children under aged 1 through 14. In 2010, the death rate due to unintentional injuries among children aged 0-14 was 3.3 per 100,000, way below the HP 2020 target of 36 per 100,000 for the general population. The death rate from fatal accidental/unintentional injuries to children aged 0-14 declined since 2007 when the rate was 5.3 per 100,000. In 2010, the rate was highest among African Americans (5.1), followed by Whites (3.5), Hispanics (3.2), and Asians (2.1). Rates among multiple race groups, Pacific Islanders and AIs were not calculated because of small cell sizes.

Among fatal injuries, those due to motor vehicle collisions are most frequent. The death rate from unintentional injuries due to motor vehicle accidents dropped from 1.8 per 100,000 children aged 0-14 years in 2009 to 1.0 per 100,000 in 2010. The rate for Hispanics (1.2 per 100,000) was slightly higher than the rate among Whites (0.9 per 100,000). The rate among other race/ethnicities could not be calculated due to small cell sizes. As the 2007 and 2008 rate reflects a change in methodology used to calculate this indicator, data in the table cannot be directly compared to rates reported in prior years.

The death rate from unintentional injuries due to motor vehicle traffic collisions fell from 11.5 per 100,000 children ages 15 through 24 years in 2009 to 9.0 per 100,000 in 2010.

The recent decrease is a positive sign overall, as the Healthy People (HP) 2020 objective was 12.4 deaths per 100,000 for the general population. Injury is the leading cause of death among adolescents and among young adults aged 15-24 years. In 2010, the death rate from unintentional injuries due to motor vehicle traffic collisions was highest among Blacks (11.1 per 100,000 youth ages 15 through 24), followed by Hispanics (10.4), Whites (8.5), and multiple races (7.9). The rate was lowest among Asians (3.6). The rate among AIs and Pacific Islanders was not calculated due to small sizes.

The nonfatal injury rate for 2010 is highest for African American children aged 0-14, at 266.8 per 100,000 followed by White children at 203.1 per 100,000. Rates are lower among Hispanic (176.9 per 100,000), Asian/Pacific Islander (96.6 per 100,000) and AI (111.9 per 100,000) children aged 0-14 years of age.

The rate for nonfatal injuries due to motor vehicle crashes is below the HP 2020 target of 694.4 per 100,000 for the general population. The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger continues to decline, from 18.6 in 2009 to 16.8 in 2010. In 2010, the rate was highest among Blacks (28.1 per 100,000 population), followed by Hispanics (18.2), Whites (14.9), and Asian/PI (5.6). The rate was not calculated among AIs due to small cell sizes.

The hospitalization rate for all nonfatal injuries among children aged 0-14 years has decreased since 2000, when it was 284.9 per 100,000. By 2003 it had dropped to 257.3 per 100,000, and the trend has continued falling to 186.8 per 100,000 in 2010. This is below the HP 2020 target of 555.8 per 100,000 for the general population.

Motor vehicle traffic crashes are the leading cause of hospitalized nonfatal injuries among youth aged 15-24 in California. While hospitalization rates in this population increased from 147.7 per 100,000 in 2000 to 164.5 per 100,000 in 2004; this rate has decreased markedly since then. In 2007, there were 110.8 per 100,000 nonfatal injuries due to motor vehicle traffic crashes in youth aged 15 through 24 years. In 2010, the rate continued to decrease to 88.9 per 100,000 (numerators are based on principal diagnoses codes in hospital discharge data). In 2010, the rate was highest among Blacks (113.4), followed by Whites (103.2), AIs (83.2), and Hispanics (82.6). The rate was lowest among Asian/Pacific Islanders (38.7 per 100,000).

This injury-related HSIs enable California to identify trends, focus its prevention efforts and determine the success of these efforts. SAC has statewide data systems that track injuries, and makes grants to LHJs using funds from the Kids Plates program to increase the capacity of local organizations statewide to prevent injuries (e.g., traumatic brain injury, drowning, and burns). MCAH funds the Childhood Injury Prevention Program within San Diego State University's Center for Injury Prevention Policy and Practice (CIPPP) to provide technical support to LHJs' injury prevention activities. This support involves priority-setting, program selection, and evaluation. The Vehicle Occupant Safety Program coordinates CPS efforts across California by creating essential CPS partnerships that link state and local policy, enforcement, and educational efforts. California has a mandatory seat belt requirement and child safety and booster seat laws

which are being promoted by a “click it or ticket” campaign. California's booster seat law was expanded to cover children to age 8. CIPPP revised and posted updated Safety Sheets on their website to reflect the changes and are available in English, Spanish, and Vietnamese. CIPPP distributed an updated notice concerning the new CPS law and distributed it to LHJs and to the Calif. Dept. of Ed., for redistribution to elementary schools and the California PTA.

The greatest risk to toddlers in California is drowning in back yard pools. MCAH provides funding CIPPP which works with LHJs and local building inspectors to improve code compliance with the "multiple barriers of protection" concept for existing homes and with fence law for new construction. CIPPP Safety Sheets are available to LHJs and widely promoted to private pediatricians through the AAP-CA. Safety Sheets are also widely used by local social welfare agencies.

### >Chlamydia (CT) Indicators

Chlamydia trachomatis (CT) infection is the most common reportable communicable disease in California. In 2010, over 74,000 cases were reported in females aged 15-24 years, accounting for 70% of female CT cases. The CT rate per 1,000 women aged 15 through 19 years was 22.5 in 2010 reflecting ongoing increases. Female African Americans aged 15-19 continue to have the highest CT rate at 69.7 per 1000 in 2010 compared with Latinas (14.2 per 1000), Whites (8.1 per 1000), and Asian/Pacific Islanders (5.8 per 1000).

For 15-24 year old females, CT prevalence has been fairly stable since 2000 and differed by health care setting. In 2010, CT positivity in females aged 15 to 24 years in family planning sites was 4.9 percent compared with 4.7 percent in managed care settings and 16.8 percent in STD clinics. All estimates exceed the HP 2010 objective of 3 percent for females age 15-24 in STD and family planning clinics. The HP 2020 target is 6.7% among 15-24 year old females attending family planning clinics.

In 2009, 9.9 per 1,000 women aged 20 through 44 years had a reported case of CT.; with more than 70,000 cases reported in 2010, the CT rates increased to 10.6 per 1000 . The combined 20-44 years age group is not particularly useful for monitoring populations at risk for CT, as case rates in women 20-24 and 25-29 are significantly higher than rates among women age 30 and older. In 2010, CT rates were highest for the 20-24 age group at 29.5 per 1000. While the chlamydia rate among women aged 20-44 is considerably lower than for women aged 15-19, this figure had similarly been rising over the past five years.

The increases seen in case-based CT rates may be due to screening practices, including targeted screening of older women and the use of more sensitive screening tests . Use of age-specific case-based 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.

As California has high screening levels for young women compared to national estimates, data from sentinel prevalence monitoring in specific health care settings are important for comparison with case-based rates. Nationally, young men and women aged 15 to 24 years have 4 times the reported rates for gonorrhea and chlamydia compared with the total population, according to the CDC [<http://www.cdc.gov/std/health-disparities/age.htm>].

The STD Control Branch multifaceted strategy to reduce CT prevalence includes working in the domains of behavior change, clinical and laboratory services, surveillance, quality improvement, and leadership. In addition, STD Control Branch has released guidelines for expedited partner therapy and field therapy for CT to address infections among partners. The STD Control Branch multifaceted strategy to reduce CT prevalence includes working in the domains of behavior change, clinical and laboratory services, surveillance, quality improvement, and leadership.

Surveillance efforts aim to enhance timeliness and completeness of CT case data and prevalence monitoring test result data through electronic transmission. Leadership and partner development efforts include initiatives such as 1) working with outside partners to address inequities in CT rates associated with race/ethnicity, and 2) partnering with medical groups to provide CT screening rates to individual providers.

Policywise, AB 499 which will allow a minor who is 12 years of age or older to consent to medical care related to the prevention of a sexually transmitted disease became law (Chapter 652, Statutes of 2011)

### >Infant and Child Population Demographic Indicators

In 2010, the projected child population was 14,169,093.//2013// By race, 11,287,125(80%) were White; 1,430,075(10.1%) were Asian; 856,368(6.0%) were African American; 467,026(3.3%) were multi-racial; 74,518(0.5%) were AI/AN, and 53,981(0.4%) were Native Hawaiian or Other Pacific Islander (NH/PI). Of the 2008 population aged 0-24 years, a total of 6,504,093 (47%) were of Hispanic ethnicity. The projected 2010 Hispanic population aged 0-24 years was 6,749,658. Across the U.S., California has the largest population of Hispanic residents and the largest percentage of Hispanics of Mexican origin.

Non-Hispanic white children, ages 0- 18 are now less than half of all children with 73% comprising minority populations with the growth driven by an increase in Hispanic children. The Hispanic child population in California increased by over 700,000 between 2000 and 2010 census, at the same time that the non-Hispanic white child population fell by almost the same amount over the same period [9]

Comparing the 2000 and 2010 census data , California had the largest increase in the numbers of non-Hispanic Asians compared to all other states and the third largest number increase of non-Hispanic, Two or more races in their child population.

California also had the biggest decrease in the number of non-Hispanic AI/AN and non-Hispanic white children ages 0-18 among all states. [A]

Trends in the population of children and young adults help project potential needs for health care and public health services. The increasing racial and ethnic diversity poses challenges to health care delivery and the public health system. More than ever, MCAH is continually addressing cultural competence and cultural differences in to ensure access to services and address disparities.

Having an understanding of California's ethnic population characteristics and trends is important for understanding the conditions and policy challenges facing California's health care delivery and public health systems. Cultural factors such as behavior and lifestyle influence health outcomes. More than ever, MCAH is continually addressing cultural competence and cultural differences in to ensure access to services and address disparities.

### >Indicators related to Child Enrollment in Various State Programs

The 2010 population of California age 0-19 was 11,253,589. By race, 80% were White; 10% Asian; 5.8% African American; 3.5% Multiracial; 0.5% AI/AN; and 0.4% NH/PI.

Among children ages 0-19, 28.7% lived in a household headed by a single parent in 2011, a slight increase from 26.8 in 2010. The proportion living in households headed by a single parent has been consistently highest for African American children (59.4% in 2011); figures are also high for AI/AN (45.6%) and Multiracial ( 32.5%) children.

In 2011, 10% of children 0-19 years of age received Temporary Assistance for Needy Families (TANF) or CalWorks. By race, 28.9% of African American, and 16.1% of NHPI children received TANF, compared to 9.5% of White, 15.9% of AI/AN; 4% of Asian, and 5.9% of multiracial children. While 12% of the U.S. population resides in California, it serves 33% of the nation's TANF overall recipients. Effective July 2011, TANF months of assistance limit was reduced from 60 to 40 months; eligibility was reduced by counting more work income for qualifying purposes; and, child care and employment services were cut. Monthly cash grants were reduced by 8% dropping the monthly maximum to \$638 for a family of three, lower than the \$663 that California offered the same family in 1988. There is a plan to split CalWorks into three new programs; the first would function similar to the traditional program but would only have access for two years, a second would provide two more years of services but only if the parent meets federal requirements which means 30 hours a week in a job not financed by public subsidies and a third program for "safety net" cases, i.e., families without a qualified working parent into a new Child Maintenance program where paperwork requirements are loosened and require an annual child health exam. The third program is for those who cannot work, unwilling, sanctioned or undocumented and receive a lower grant.

The number of children enrolled in Medi-Cal (Medicaid) in 2008 was 3,497,465. This was up 106,000 from the previous year.

Enrollment in HF continue to shrink. In 2008, 895,440 children were enrolled in HF; by 2011, 870,784 were enrolled. The 2011 enrollment includes 495,393 White children (56.9%; including Hispanic), 81,577 (9.4%) Asian; 15,681 (1.8%) African American; and 927 (0.1%) AI/AN. Race was Other/ Unknown for 274,781 (31.6%) children enrolled in HF in 2011.

The foster care caseload was 59,248 at the end of 2010. This figure has been steadily decreasing. In contrast, there were 89,913 foster care cases in 2003.

In 2010, 2,115,610 children were enrolled in the Food Stamp Program, including: 1,705,057 (80.6%) White; 42,240 (2.0%) Multiracial; 220,344 (10.4%) African American; 136,775 (6.5%) Asian; 7144 (0.3%) AI/AN; and 4051 (0.2%) Other/Unknown children. As part of a push to boost enrollment closer to the 75 percent participation average for states, Gov. Jerry Brown signed legislation eliminating some barriers to access. One hurdle, a fingerprinting requirement for those 18 and older, ended. Another barrier, a requirement that CalFresh recipients file quarterly reports, will end next year. Instead, California will switch to simplified semi-annual reporting, beginning in 2013.

Of those aged 0-19 years, 2,063,125 were enrolled in WIC in 2011. This includes 577,993 (28%) White (including Hispanic); 134,340 (6.5%) African American; 90,181 (4.4%) Asian; 42,240 (2.0%) Multiracial; 7,144 (0.3%) AI/AN; 12,232 (0.6%) NHPI; and 303,976 (14.7%) Other/Unknown.

There were 2634 arrests per 100,000 for juvenile felony and misdemeanor offenses among those under 19 years in 2010. This rate continue to decrease annually since 2007.. Arrest rates continue to be highest for African American (7352 per 100,000 children) and NHPI (3148 per 100,000) juveniles. The 2011-12 state budget established a framework to shift primary responsibility for a number of public safety and related services including the juvenile justice crime prevention programs and child welfare services from the state to the local counties effective October 2011.

The cohort dropout rate for the class of 2010 was 17.5 percent. For the first time, these data are based on four years of longitudinal student data used to calculate a cohort rate. As such, these data serve as a baseline and should not be compared to rates from previous years. By race, 29.2 percent of African-American, 22.8 percent of AI/AN, 20.4 percent of NHPI, 11.1 percent of White, and 7.7 percent of Asian students dropped out.

The 2009 passage of Senate Bill 651 mandated a reform in how high school dropout rates are to be reported. With the newfound awareness of dropouts, it puts into perspective the realization that California is now spending more on prisons than on the University of California and the California State Universities combined, with 85% of those inmates dropouts [10]

Overall increasing trend were observed in the number of children ages 0 to 19, the percent of households headed by a single parent, WIC enrollment and the percent of the population enrolled in CalWorks (TANF). A decreasing trend in HF, CalWorks and Cal-Fresh enrollment; those living in foster home care and the rate of juvenile arrests were observed. Enrollment trends in various juvenile justice, health and social service programs help in planning for future service needs. California's MCAH does not fund these programs although Title V funding is used to support the maternal and child health needs of populations that utilize these programs.

### >Population by Geographic Living Area

In 2010, an estimated 255,300 children resided in rural areas and 10,998,200 lived in an urban setting. Over the years, the proportion of California's child population living in rural areas has slowly decreased and conversely, slowly increased in urban areas. In 1980, 2.4% of the population lived in rural areas and by 2010, decreased to 2.27%.

Public health needs of rural and urban populations vary. Rural-urban health disparities exist with respect to shortages of some types of PCPs (obstetricians and pediatricians), shortages of specialized mental health providers and oral health providers, prevalence of tobacco use and drinking-and-driving, and delays in screening and diagnosis of cancer. In addition, particular geographic, demographic, and cultural conditions in rural areas present obstacles to both rural residents seeking services and providers who would deliver them. [11]

Disparities in chronic disease prevalence and related health behaviors, issues of diversity and shifting population demographics, and access and coverage for the underinsured & uninsured all become more complicated in rural areas. MCAH LHJs in rural areas, in addressing these issues, face challenges regarding workforce recruitment, retention and training, epidemiologic investigation, information technology, and telecommunications. Many social determinants of health unique to rural areas impact health status. Some examples include lower wages, disproportionately high housing costs (relative to wages), psychological impacts associated with increased isolation, fewer jobs, high numbers of underinsured or uninsured, increased risk of poverty, and lack of educational opportunities. Rural communities have a dearth of healthy food outlets and access to transportation due to low population density thus limiting access to healthy food and health care sites. Other barriers in the rural community to being physically active include lack of sidewalks, street lights and exercise facilities. Taken together, these factors contribute to increased inequities in the health status of rural residents.

Similarly, the built environment in urban areas creates opportunities and challenges. Higher concentrations of people make it easier to offer basic infrastructure and public health services. However, urbanization tends to create health hazards making it more environmentally as well as socially unsustainable. Health hazards resulting from urbanization are mainly connected to air pollution, as well as crime, traffic and lifestyle. A health hazard common in, but not exclusive to, the cities in California is connected to lifestyle and consumption patterns, including dietary changes and obesity.

There is interest and recognition within MCAH to address health inequities in the rural and urban population. To address health disparities, MCAH will take into account differences in rural and urban settings, with strategies that focus on environmental changes involving all sectors, through local programs, and policies to create social norm changes.

### >Poverty Indicators

The percent of the Californians at various levels of the FPL has been steadily increasing. Those below 50% FPL increased from 5.5 in 2007 to 7.5% in 2010; those between 50% and 100% FPL increased from 12.2 in 2007 to 16.3% in 2010; and, those between 100% and 200% FPL increased from 34.3 in 2007 to 36.7% in 2010.

The latest data show that the recession had a profound impact on California, particularly families with children. There has been a significant increase in poverty among children across all FPLs. The percent of children below 50% FPL increased from 7.1 in 2007 to 10.6 % in 2010; those between 50% and 100% FPL increased from 7.8 in 2007 to 23.5% in 2010; and, those between 100% and 200% FPL increased from 41.3% in 2007 to 47% in 2010.

Statewide, 11 percent of kids grow up in communities where 30 percent or more of the residents live in poverty which mirrors the national average, but not all counties experience the impact equally. Among California's counties, Marin has the smallest number of kids living in communities where at least 30 percent of residents are poor, at 1 percent. In contrast, Fresno has the highest proportion at more than 38 percent. And among the largest U.S. cities, Fresno ranks fifth with kids raised in communities surrounded by impoverished conditions.[12] Children in poverty frequently live in stressful environments, without the necessities most children have, including adequate nutrition to enable physical and cognitive development. Children from low-income families are more likely to go hungry; reside in overcrowded or unstable housing; live in unsafe neighborhoods; and receive a poorer education. They also tend to have less access to health care, child care, and other community resources, such as quality after-school programs, sports, and extracurricular opportunities.

From a life course perspective, poverty is a barrier to opportunity, with poor children more likely to have diminished access to health care translating to poorer health outcomes or do poorly in school translating into lower lifetime earnings. Although family violence, youth substance abuse, and juvenile crime are found across the socioeconomic spectrum, child poverty is correlated with these risk factors as well.

There are numerous possible approaches to improving the health of poor populations. The most essential task that CDPH is striving for is to ensure the satisfaction of basic human needs such as clean air, safe drinking water, and adequate nutrition. Other approaches adopted by the CDPH programs include reducing barriers to the adoption of healthier modes of living and improving access to appropriate and effective health and social services.

A growing body of research confirms the existence of a powerful connection between socioeconomic status and health. MCAH understands poverty and its effects on health and together with its stakeholders, endeavors to influence local and state policymakers to reduce the burden.

In November 2011, the U.S. Census Bureau released information about a revised method for calculating poverty.[13] . The revised method account for the varying cost of living threshold in various geographic areas. The supplemental poverty measure, which uses the revised methodology will be used for research purposes to provide an alternative lens to understand poverty and measure the effects of anti-poverty policies. However, the traditional poverty measure will continue to be used for budgeting purposes, since increasing the number counted as poor with the revised methodology increases the number that may qualify for public assistance programs.

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