Maternal and Child Health Services Title V Block Grant

California

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I. General Requirements

I.A. Letter of Transmittal

State of California—Health and Human Services Agency

California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Health Officer

EDMUND G. BROWN JR.
Governor

July 10, 2015

Michelle Lawler, Director
Division of State and Community Health
Maternal and Child Health Bureau, HRSA
5600 Fisher Lane, Room 18-31
Rockville, MD 20857

Dear Ms. Lawler:

The California Department of Public Health, Maternal, Child and Adolescent Health (CDPH/MCAH) Division is pleased to submit the FFY 2016 Title V Block Grant Application / 2014 Annual Report. We appreciate having this opportunity to showcase the many projects and programs we have underway in California to improve the health of mothers, adolescents and children, including children with special health care needs. We are grateful to you for your leadership in supporting our State Title V program.

If you have any questions or need additional information, please contact me at (916) 650-0300.

Sincerely,

Addie Aguirre
MCAH Title V Director

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I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix C of the 2015 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

I.E. Application/Annual Report Executive Summary

Title V is committed to mothers and children. It is a vitally important public health program to our nation and to California. As defined in legislation enacted 80 years ago, the purpose of the Maternal and Child Health (MCH) Services Block Grant is to provide and assure: mothers and children access to quality maternal child health services; reduce infant mortality and the incidence of preventable disease; provide rehabilitation services; and promote family-centered, community-based coordinated care for children with special health care needs. The services provided by California's Title V program reflect the California Department of Public Health (CDPH) Maternal, Child and Adolescent Health (MCAH) Division's commitment to improving the health and well-being of mothers, children, adolescents and their families.

MCH transformation and revision of the block grant provided the perfect platform to highlight the contributions made by California's MCAH programs in all six of the MCH population health domains. Specific priorities were developed for each domain with the ability to measure evidence-based or evidence-informed program activities that impact each domain and track accountability. Additionally, California's MCAH program provided leadership and guidance to all 61 Local Health Jurisdictions (LHJs) throughout the needs assessment process. California's MCAH program had the foresight to implement the statewide needs assessment beginning March 2013. This was a tremendous undertaking as all 61 LHJs conducted a local needs assessment. Collectively, the LHJ needs assessment, six population domains and corresponding priorities tell the unique and comprehensive story of California's Title V program.

Needs Assessment

California's Title V harnessed the power of local data to provide a shared understanding of the various strengths and needs at the local level. To further support local assessments, MCAH provided a set of priority problems to focus on in six domains; developed sample logic models, problem analyses and action plans; conducted training webinars; and hosted regular listening sessions to provide technical assistance. Surveys were developed to identify efforts and opportunities at the local level with regard to the status of implementing the Affordable Care Act (ACA) provisions, and better understanding of local health delivery to children with special health care needs (CSHCN), as well as the American Indian population. Collaboration was encouraged among local MCAH Directors, county leaders, local organizations, tribal communities and residents to identify and prioritize needs and develop a local action plan. For the CSHCN population, identification of problem needs was augmented by more in-depth needs assessment of CSHCN enrolled in the California Children's Services (CCS) Program.

For CCS, the System of Care Division (SCD) worked with the Family Health Outcomes Project (FHOP) at UC San Francisco to facilitate the process, which included key informant interviews; family, provider and administrator focus

groups; family, provider and administrator surveys; and gathering of pertinent data from CMS Net, the CCS case management system.

Accomplishments and Priority Needs by Population Domain

A summary of accomplishments in 2014 by population domain is presented below. California's priority needs from 2016 to 2020 are a continuance of priority needs identified for the 2011-2015 reporting period. For 2016- 2020, the California Title V program selected eight priority needs. Listed below are the priority needs by population domain.

Domain: Women/ Maternal Health

MCAH continued efforts to prevent and reduce tobacco use among women, with emphasis on preventing smoking relapse. LHJs, the Black Infant Health Program (BIH), the Adolescent Family Life Program (AFLP) and other teen programs, and the Preconception Health Council of California (PHCC) promoted smoking cessation.

Additionally, BIH and AFLP focus clients on life planning, self-esteem and empowerment as intermediate goals of the program.

California Maternal Quality Care Collaborative (CMQCC) provides assistance to hospitals in implementing maternal quality improvement toolkits including the Elimination on Non-Medically Indicated Deliveries < 39 Weeks Gestation Toolkit. MCAH continues to work closely with the Medi-Cal Managed Care Division (MMCD) to improve the timeliness and quality of obstetric services for Medi-Cal-eligible pregnant women.

Maternal mortality rate continue to decline. In 2013, there were 7.3 deaths per 100,000 live births, a reduction of 57% from the 2006 rate of 16.9 deaths per 100,000 live births. While California's maternal mortality rate has been rapidly descending, the U.S. maternal mortality rate has been rising dramatically to a rate of 22.0 deaths per 100,000 live births in 2013; three times California's rate.

MCAH expanded its interconception and reproductive life planning initiatives and updated its messages about birth spacing and overall preconception/interconception health. MCAH publicized its Interconception Care Project of California (ICPC) guidelines and continued to share national resources, including the preconception campaign materials developed by the Centers for Disease Control (CDC) and Preconception Peer Educators materials provided by the Federal Office of Minority Health. LHJs and the Fetal Alcohol Spectrum Disorder (FASD) Task Force continued efforts on preconception health education and promotion. MCAH continued quality improvement and education efforts to learn about emerging best practices for reducing binge drinking.

The 2016-2020 priority for the maternal/ women's health domain is:

Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.

Domain: Perinatal/ Infant Health

LHJs monitor access to early prenatal care, conduct outreach to women, provide linkages and streamline processes to increase access to early prenatal care. These are complemented by AFLP and BIH by providing case management services and linkages to prenatal or medical care to their clients. The Regional Perinatal Programs of California (RPPC) and the California Perinatal Transport System (CPeTS) continue their work with hospitals in regional health planning, care coordination and providing birth data quality improvement trainings. The Systems of Care Division (SCD) and CPQCC continue to analyze data and address outliers and concerns about quality of care.

California received an "A" grade in the March of Dimes (MOD) 2013 Prematurity Birth Report Card and garnered the 2014 Franklin Delano Roosevelt Prematurity Campaign Leadership Award. California also received MOD's 2015 Virginia Apgar Prematurity Campaign Leadership Award.

The 2016-2020 priority for the perinatal/ infant health domain is:

Priority 2: Reduce infant morbidity and mortality.

Domain: Child Health

MCAH promotes injury prevention through education in collaboration with LHJs to reduce unintentional childhood injuries and abuse. Many MCAH LHJs implement case management, home visiting programs, and parenting classes to assist overburdened families who are at risk for adverse childhood experiences. These programs and services aim to strengthen family functioning and cultivate community support.

MCAH conducted a survey of all LHJs to identify current activities and gaps in services for children with special health care needs (CSHCN). As a result of this survey, MCAH has increased efforts to provide technical assistance, training and resources to better serve this population. Examples include partnering with California Children's Services (CCS) to improve care coordination for CSHCN, especially non-CCS eligible children or children enrolled in CCS in need of services not covered by CCS, professional development, and statewide collaborative activities.

LHJs work with partners to develop resource referral networks and systems to refer and link families to appropriate care in their communities.

The 2016-2020 priority for the child health domain is:

Priority 3: Improve the cognitive, physical, and emotional development of all children.

Domain: Children with Special Healthcare Needs

Efforts to improve the systems of care for children in CCS include a high level review of current systems and options through the CCS Redesign process. SCD, with stakeholders, completed the Medical Eligibility Guideline to increase consistency in medical eligibility determinations across county programs. SCD continues to work with county programs to increase consistency and improve efforts in the area of transition, care coordination, and medical home for CCS clients. CCS and MCAH are increasing their efforts to collaborate and provide seamless care to better serve this population.

The 2016-2020 priorities for the CSHCN health domain are:

Priority 4: Provide a whole-child approach to services to children with special healthcare needs.

Priority 5: Improve access: ensuring the right patient to the Right Place.

Domain: Adolescent Health

California's adolescent birth rate has decreased substantially in recent years. Despite this positive trend, MCAH will continue to fund efforts to support adolescent sexual health programs. An example is AFLP. Funded in 30 LHJs with the highest teen births, AFLP has completed an evaluation and revised its standardized intervention based on Positive Youth Development (PYD) principles integrated with life planning.

MCAH participates in the Adolescent Sexual Health Work Group. Some of the group's activities include policy recommendation, workforce development and active engagement of youth in their sexual health rights.

The 2016-2020 priority for the adolescent health domain is:

Priority 6: Increase conditions in adolescents that lead to improved adolescent health.

Domain: Cross-cutting/Life Course

MCAH promotes obesity and substance abuse prevention, and the promotion of breastfeeding, oral health and mental health activities. These health issues are addressed through statewide collaborations and activities conducted by LHJs. MCAH promoted the California perinatal clinical oral health guidelines and assisted LHJs in developing oral health activities to increase community access and outreach. California conducted outreach and education to encourage and facilitate enrollment in Covered California, Medi-Cal and other health insurance to

increase access to care. Nutrition and breastfeeding efforts include promoting workplace accommodations for breastfeeding mothers and promoting healthy weight among women of childbearing age. The Comprehensive Perinatal Services Program (CPSP) offers enhanced nutrition, psychosocial and health education services to Medi-Cal eligible pregnant and parenting women.

The 2016-2020 priorities for the cross-cutting/ life course domain are:
Priority 7: Increase access and utilization of health and social services

Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.

II. Components of the Application/Annual Report

II.A. Overview of the State

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

- Population
  Based on the 2010 Census, California's population was at 37.3 million people, a population greater than the total population of 13 other western states combined [2]. In 2013, California's population was estimated at 38 million people. California's population will cross the 40 million mark in 2019 and grow to nearly 52.7 million by 2060. By 2020, California will have 10 counties (Alameda, Contra Costa, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego and Santa Clara) with a population of more than one million each.[3]

  The 2010 California population's median age is 35 and will rise to 37.2 by 2020, yet will remain as one of the younger states in the Union for the next 20 years.[4] This may be partially due to California's role as the primary gateway state for immigration. The White population is older and is not replenished by high levels of immigrants or birth rates. The Asian population structure is older than the Hispanic population and has a lower fertility rate. However, due to higher rates of immigration from Asia than from European or other countries with a predominantly White population, it is anticipated that the Asian population will grow in numbers but its proportion to the total population will not change.

  California is diverse. Its diversity is shaped by the multitude of racial and ethnic sub-groups across the state. For example, California's Asian population, the largest in the nation, demonstrates substantial diversity. The largest Asian sub-groups in California are Chinese, Filipino and Vietnamese. Within each Asian group is variation in language and culture. While the largest numbers of Asians reside in the large population centers of Southern California in Los Angeles (LA), Orange, and San Diego counties, counties with the largest percentage of Asian residents are in the Bay Area counties of San Francisco, Santa Clara, Alameda and San Mateo. [5] Hispanic groups in California are predominantly Mexican, followed by other Hispanic or Latino groups from Central and South America. Due to shifts in immigration patterns, an increasing number of indigenous Mexicans have settled in California. [6] While Southern California has the largest numbers of Hispanic residents, Imperial County, at 81%, had by far the largest proportion of Hispanics in 2014. In addition, more than 50% of the population in the agricultural counties of Central California is Hispanic. [5]

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

  California is a majority-minority state, i.e., over 50% of the population is minority. In 2014, White and Hispanic

groups each comprised 39% of the population, 13% Asian, 6% Black, 3% multiple race, 0.4% American Indian/Alaska Native, and 0.4% Native Hawaiian/Pacific Islander. California ranks first in the U.S. in terms of its population size for Hispanics, Whites, and Asian/Pacific Islanders. The population size of African-Americans and American Indians/Native Americans ranks fourth and fifth, respectively. In fact, one-third of all Asian/Pacific Islanders in the U.S. live in California, and the number of Hispanics is more than the entire population in 46 states. [2]

- Economy
  California, with 12% of the U.S. population, accounts for 13% of the nation's output. If it were a country, it would be the 9th ninth largest economy in the world. [7]

- Age Distribution
  The child population is growing more slowly than the overall state population. The population of children 0-17 years of age has increased by less than one percent between the 2000 and 2010 Census, and is projected to increase by 5% between 2010 and 2025. In 2014, the population of children who are Hispanic is 52%, compared to 27% White, 11% Asian, and 5% Black. The proportion of population identified as multiple race increased from 4% in 2005 to 5% in 2014. The proportion of children that are Hispanic will continue to increase while the proportion of White children will decrease. Children of other racial/ethnic groups will remain relatively stable.

  Children 0-5 years of age are in a particularly sensitive developmental period, and experiences during this time have great influence over subsequent life course health trajectories. The population of children 0-5 years of age has increased, and is projected to reach 3.8 million by 2020. As with the overall population, proportion of Hispanic children ages 0-5 is expected to continue to increase through 2020, while the proportion that is White is expected to continue to decline. Other racial/ethnic groups are projected to remain fairly stable through 2020. [5]In 2013, there were 7.6 million women of reproductive age (ages 15-44) in California. The largest group was Hispanic women (44%), followed by White (33%), Asian (14%) and African American (6%). The percentage of Hispanic women is expected to continue to increase among this age group through 2020 to 46%, and the percentage of White women are expected to decline to 31%. Other groups are expected to remain somewhat stable. Of particular interest are the youngest women of reproductive age, who demonstrate increased risks and poorer birth outcomes compared to their older counterparts. [8], [9]

- Immigration
  In 2013, California was home to 10.3 million immigrants or nearly 27% of its population, the largest number and percentage of foreign born residents in the U.S. International immigration has accounted for 40% of California's population growth since 2000. Further, since 39.7% of California births are to women born outside the U.S., [10] the well-being of this population has a strong influence on overall MCAH status in California. The leading countries of origin for immigrants are Mexico, the Philippines and China.[10] Immigration status is related to poverty among children in California, which in turn is a strong predictor of health outcomes. Overall, 48% of California's children have immigrant parents; 34% have at least one legal immigrant parent and an estimated 14% have at least one undocumented immigrant parent. Among these children, 24% of children with legal immigrant parents are poor and 38% of children with undocumented immigrant parents are poor.[11] California has the largest number and proportion of undocumented immigrants of any state. Many undocumented immigrants in California experience difficulty in meeting basic needs and accessing services, while facing additional health risks related to low wage jobs that lack protections and benefits. In 2008, approximately 2.7 million undocumented immigrants lived in California, an increase from 1.5 million in 1990. [12] In 2004, approximately 41% of California's undocumented immigrants resided in L.A. County.[11]

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

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

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

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

- Poverty
  According to the 2011-2013 American Community Survey, over six million Californians - 16.8% of the population - had incomes below 100% of the federal poverty level (FPL). The 100% FPL in 2013 was $23,550 for a family of four.

  Only examining the official federal poverty level, which has been determined using the same general framework since the mid-1960's, obscures the struggles faced by many families in California because of the high cost of living in this state. The supplemental poverty measure, which produces state level poverty rates, differ considerably from the official poverty measures. In California, the supplemental poverty rate was 23.4%, the highest in the nation. [15] The major financial stressors for households with children are housing and child care; many of these families struggle to meet the most basic needs, cannot afford quality child care, and have limited financial resources to address crises. [16] It is also worthwhile to note that rates of poverty and low income are higher during pregnancy than when measured among children. This means that many more infants are born into financial hardship than statistics on children indicate.[17]

  Research suggests that poverty in the first few years of life may undermine brain development, adversely affect overall health status and lead to both diminished success in early elementary school grades and lower chance

of ever completing high school. Among children under age 18, the official poverty rate is higher: 23.3% of the population is in poverty, or approximately 2.1 million children. The California poverty measure - more California-relevant than the Supplemental Poverty measure - estimates child poverty in the state at 24.3%. Latino (31.2%) and African-American children (33.4%) have higher poverty rates than other groups. Poverty rates are higher for children living with single mothers (45.7%) than married-couple families (15.5%) or with a single father (30%). California child poverty varies tremendously by region. It is lower in the Bay Area counties and higher in the Central Valley counties. Nearly 30% of poor children in California live in Los Angeles County [18].

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

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

  Inability to access affordable housing leads to homelessness for some families. More than 527,000 California children were homeless in 2012-13. California is ranked 48th in the percent of child homelessness in the United States, with only New York and Kentucky having higher rates among children. [18] Homelessness in children has been linked to behavioral health problems and negatively impacts educational progress. [22]

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

  The major health coverage provisions of the Patient Protection and Affordable Care Act (ACA) went into effect in 2013, providing new options for people who did not have insurance and sweeping new protections for those who buy health plans on their own. California was the first state to pass legislation to create a health benefit exchange called Covered California, a quasi-governmental body that follows the "active purchaser" model of benefits exchanges. [24] It also allowed California to expand its Medi-Cal program to people up to 138% of the federal poverty level. Starting October 2013, Covered California qualified low-income individuals and families for free health insurance through Medi-Cal and moderate-income families to premium subsidies to make private health coverage affordable. It provides consumer protections set forth by the ACA including the ten Essential Health Benefits. Several provisions of ACA strengthen coordination and integration of care among health care providers by establishing Accountable Care Organizations, adoption of the Patient-centered Medical Home model of care and community-based collaborative demonstration projects.

  A case study of five local health jurisdictions (LHJs) suggests that great strides were made at the county level

toward creating integrated delivery systems for the medically underserved. These counties have the partnerships and shared commitment to create seamless systems of care. The presence of safety net collaboratives and/or Medi-Cal managed care organizations and clinic consortia afford counties the ability to secure resources and implement integration initiatives individual stakeholders might not otherwise undertake. The analysis of the 30 safety net integration "best practices" points to several common factors for success, including leadership support at the top, shared leadership among organizations, perseverance of effort, open communications, and buy-in at all levels. [25]

Medi-Cal and Covered California created an online "one-stop shop" for health coverage. By March 2014, Covered California had nearly 1.4 million enrollees and with Medi-Cal expansion, an additional 1.5million new Medi-Cal enrollees. Counties with the largest proportion of enrollees in Covered California include Los Angeles (28.7%), Orange (9.4%) and San Diego (8.7%). By imputed race/ ethnicity, the total enrollment in Covered California health insurance plans is comprised of 40% White, 29% Latino, 21% Asian, 4 % Black, 3% multiracial and 2% other race. [26]

The State Health Access Data Assistance Center developed a framework to evaluate the impact of the ACA in California. Measures on health insurance coverage, affordability and comprehensiveness of coverage, and access to care will be used to track progress on three of the major aims of ACA. [27]

The uninsured rate dropped to 11 percent for the quarter that ended in June, down from 22 percent from the quarter that ended in September 2013, according to a survey by the Commonwealth Fund.[28]

- Health and Human Services
  California's Executive Branch of government is organized into many departments, most of which are grouped into Cabinet-level agencies. Of the seven Cabinet-level agencies in California, major health programs are administered at the state level by the California Health and Human Services Agency. Most health programs are administered by one of the following five departments: (1) Department of Healthcare Services (DHCS), (2) California Department of Public Health (CDPH), (3) Managed Risk Medical Insurance Board (MRMIB), (4) Department of Developmental Services (DDS) and (5) Department of State Hospitals (DSH). The 2012 Budget Act, AB 1464 (Chapter 21, Statutes of 2012), the Budget Act Trailer Bill AB 1494 (Chapter 28, Statutes of 2012), and the MRMIB/Healthy Families Clean-Up Trailer Bill AB 1468 (Ch.438, Statutes of 2012) eliminated MRMIB/Healthy Families as of January 1, 2013, and provided for the transition of existing MRMIB/Healthy Families subscribers to the Medi-Cal program where they receive full scope, no share of cost Medi-Cal benefits.
  Some departments administer more than one health program. For example, DHCS administers Medi-Cal (California's version of the federal Medicaid Program) as well as CCS and other programs. CCS applies for and receives Federal Financial Participation (FFP) for the administrative case management of the program for direct and enabling services rendered to State General Fund and Medi-Cal CCS-eligible children. CDPH performs various public health functions. The actual delivery of many health services often takes place at the local level and are carried out by LHJs, and by private entities, such as commercial health plans. Exceptions to the local health delivery model includes DSH (operating five state hospitals for the mentally ill) and DDS (operating four Developmental Centers (DCs) that provide developmentally disabled individuals with 24-hour care). Both the state hospitals and the DCs are staffed with state employees who directly provide services to the residents of these state institutions. [29]

  On May 3, 2012, the Governor established the Let's Get Healthy California Task Force to develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for

individual health, and advancing health equity. A public-private partnership brought together 23 California leaders in health and health care, supported by 19 expert advisors. To develop a statewide culture of health, a report was developed to provide a framework for assessing Californians' health across the lifespan with a focus on healthy beginnings, living well and end-of-life. Health equity and reduction of health disparities was an underlying principle guiding the establishment of 10-year health targets.[30]

- Public Health System
  Working with local health departments and other state agencies such as the Environmental Protection Agency and the Consumer Services Agency, CDPH is the lead state entity in California providing core public health functions and essential services. All of these operate in conjunction with federal efforts to keep communities healthy by educating them about physical and mental health and operating diverse programs that include enforcement of safety and sanitary codes and mandating reporting of certain diseases to prevent disease, injury and disability. CDPH delegates most of this authority to local health departments. [31] CDPH is organized around categorically funded programs which provide detection, treatment, prevention and surveillance of public health and environmental issues and its role include providing funding, oversight an overall strategic leadership for improving public health.

  MCAH, the lead entity that administers the Title V Block Grant and the California Home Visiting Program (CHVP), is housed under the Center for Family Health (CFH). CFH also oversees provision of supplemental food to women, infants and children, prenatal and newborn screening genetic disease detection, and programs directed at addressing teen pregnancy, maternal and child health. The other Centers within CDPH include the Center for Chronic Disease Prevention and Health Promotion, providing surveillance, early detection and prevention education related to cancer, cardiovascular diseases, diabetes, tobacco cessation, injury and obesity; the Center for Environmental Health, identifying and preventing foodborne illnesses and regulating the generation, handling and disposal of medical waste; the Center for Health Care Quality, licensing and inspecting healthcare facilities to ensure quality of care, inspecting laboratory facilities and licensing personnel; and the Center for Infectious Diseases, providing surveillance, health education, prevention and control of communicable diseases.

- MCAH Local Health Jurisdictions and local CCS Counties
  Legal authority for local public health agencies is established in the California Health and Safety Code, Chapter 2, Sections 101100 – 101115, and the California Code of Regulations, Title 17, Section 1253. Local health departments are on the front line in promoting public health and responding to health emergencies. While CDPH is responsible for most policy-making and regulatory activities, the day-to- day job of protecting the public rests with the local health agencies. [32] .

  California is divided into counties which are legal subdivisions of the state. (Constitution of California, Article 11, Section 1). There are 482 cities in 58 counties. California has 61 LHJs representing 58 counties and three incorporated cities. While there is widespread variation in providing core public health functions, all 61 LHJs provide MCH services [33] More than half of California counties have populations of 200,000 or less, presenting unique challenges in implementing a local MCAH program. Smaller LHJs generally face staffing challenges within their MCAH program and representation in the broader community. A single staff might implement several categorical programs whereas a highly populated county assigns the responsibility for a particular program to an entire unit within its health department. Smaller counties are also challenged to maintain an adequate corps of well-trained MCAH professionals. Some LHJs have dealt with these by pooling their resources regionally. In addition to providing the basic framework to protect the health of the community through prevention programs, LHJs provide health care for the uninsured, which may include mental health and

substance abuse treatment services. Given the diversity of these LHJs in size, demographics, income and culture, tremendous diversity also exists in how LHJs organize, fund and administer health programs.

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

The MCAH SOW, which includes Title V and state- required activities, reflects the priorities of the MCAH Division and incorporates locally identified objectives. LHJs must complete activities and develop at a minimum of four health objectives for their SOW. These include access and utilization of care; improving preconception health; and two objectives related to reducing infant morbidities and mortalities; with one specific to improving safe sleep practices or reducing Sudden Unexplained Infant Deaths. LHJs have the option to include additional objectives in their scope of work related to increasing the proportion of the MCAH population who maintain a healthy weight; improving the cognitive, physical, and emotional development of children; and increasing conditions in adolescents that lead to improved health. MCAH provides ongoing technical assistance such as professional development, regular statewide meetings and conference calls with LHJs as they implement their SOW. MCAH describes LHJs accomplishments in the Title V Annual Report and uses the data to drive state program and initiative development, and identify barriers and opportunities for improvement.

LHJs must also operate a toll-free telephone number and conduct other outreach activities to link the MCAH population to needed care and services with emphasis on children and mothers eligible for Medi-Cal. Other LHJ activities include assessment of health status indicators for the MCAH population, and community health education and promotion programs. Specific MCAH categorical programs administered by LHJs include AFLP, BIH, CPSP, the Sudden Infant Death Syndrome (SIDS) education and support services, and Fetal and Infant Mortality Review. Recent cuts in state funding for MCAH programs and the decrease in Title V Block Grant funding to the State forced some LHJs to dismantle some of their MCH public health infrastructure further, compounding the challenge for local MCH programs with little requisite capacity and resources. It is the persistent resolve of local MCAH leadership and a supportive local board of supervisors that local MCAH programs are being revitalized.

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

CCS is administered as a partnership between 58 county health departments and DHCS. All 58 county CCS departments are funded to provide oversight and coordination of enabling services for CSHCN with CCS-eligible conditions. In counties with populations greater than 200,000, county staff perform all case management activities for eligible children residing within their county. This includes determining all phases of program eligibility, evaluating needs for specific services, determining the appropriate provider(s), and authorizing for medically necessary care. For counties with populations under 2,000 (dependent counties), SCD provides medical case management and

eligibility and benefits determination. Dependent counties interact directly with families and make decisions on financial and residential eligibility.

- Local Healthcare and Hospital Districts
  The California Legislature enacted the Local Hospital District Law [34] in 1945 to give rural, low-income areas without ready access to hospital facilities a source of tax dollars that can be used to construct and operate community hospitals and healthcare institutions, and to recruit and retain physicians and support their practices in these areas. These districts are independent from city and county governments and support a wide range of community-based health and wellness facilities and activities. Seventy-three health care districts with 43 operating hospitals in 40 counties [35] have been formed and operate 52 public hospitals or health facilities that provide a significant portion of medical care to minority populations and the uninsured in medically underserved communities. A few districts provide health-related services such as providing grants to healthcare organizations that serve specific needs of the community. The services place great emphasis on community health and wellness programs designed to prevent or postpone acute hospital care. [36]

II.B. Five Year Needs Assessment Summary

II.B.1. Process

The MCAH assessment was guided by several frameworks including the life course perspective, social determinants of health, the socio-ecological model and Bay Area Regional Health Inequities Initiative (BARHII), a public health framework to address health inequities; and national and state health initiatives that include the National Prevention Strategy, ACA, MCH Transformation 3.0, a *Health in All Policies* approach, *Let's Get Healthy California*, and the *California Wellness Plan*.

The 2016-2020 MCAH needs assessment drew upon the expertise of over 2,700 stakeholders and partners statewide. LHJs comprise the largest body of partners and provided MCAH with qualitative and quantitative data via two approaches. First, LHJs responded to a survey designed to inform MCAH efforts with regards to the American Indian and CSHCN populations, and implementation of the ACA. Next, all 61 LHJ's completed a comprehensive local needs assessment. Each LHJ needs assessment included a review of local data, stakeholder engagement, a health status assessment process, capacity assessment, and identification of local priority needs and preliminary strategies to address identified needs. Bi-weekly technical assistance was provided to the LHJs by the MCAH Program to assure that questions and concerns were quickly addressed throughout the process. LHJs are now developing 5-Year Action Plans to address locally identified priority areas.

The State priority selection process included external and internal data collection efforts. The local needs assessment process generated a comprehensive set of health topics relevant for women of reproductive age, pregnant women, infants, children, CSHCN, and adolescents. A review of academic literature, including national and statewide surveys supported the topic's level of importance to the MCAH population. The Field Poll, for example, funded by the California Endowment, has monitored health risks for California's children for over 10 years[37]; these data were examined to support the local findings.

The data were then used to build a matrix with 26 topics and 17 health drivers (LHJ need, capacity, NPM, state law, etc.). Each health driver was then weighted based upon recommendations from topical experts at MCAH. For example, *local need* was weighted higher than *capacity*, as LHJs are implementers and are closely connected with the MCAH population. Once ranked, MCAH staff reviewed the top rankings in relationship to the qualitative needs assessment data provided by LHJs. The qualitative data assisted in adding detail to the topics to assure that data were captured accurately. Once the priorities were identified, individuals representing MCAH local programs were invited to provide feedback to finalize the priorities.

The 2016-2020 CCS-focused CSHCN needs assessment included key informant interviews, focus groups, and three surveys: a survey completed by 130 CCS physicians, a survey completed by 82 local CCS administrators and medical consultants and a survey of CCS families completed by 4065 respondents. Stakeholders were gathered and subcommittees were convened. Participants selected to complete the 16 key informant interview represented county CCS programs, Medical Therapy Programs (MTPs), Regional Centers, specialty care physicians, primary care physicians, children's hospitals, university-based researchers, managed care organizations, professional organizations and family advocates. Stakeholders contributed to the development off all 3 surveys conducted for the CCS needs assessment by providing suggestions on topic and questions for inclusion and helping with the distributions of the surveys and recruitment of respondents. Topics covered in the online surveys included: access to medical care and durable medical equipment (DME); barriers to physician and DME providers participating in CCS; strategies to address the barriers, case management and the coordination of services; county variations in CCS services; conditions covered by CCS; transitioning of youth who age out of CCS; tele-health and palliative services; and, access to and overall satisfaction with the CCS program. A final qualitative data source was drawn from focus

groups. The development and refinement of the focus group discussion guides created for each group category was informed by findings from the key informant interviews and with input from the stakeholder subcommittees. SCD also gathered both primary and secondary data from the National Survey of Children with Special Healthcare Needs (NSCHCN), and CMS Net, the case management data system and provider tracking system of CCS.

II.B.2. Findings

The statewide needs assessment resulted in the development of eight priorities and a comprehensive 5-Year Action Plan. The Action Plan is based on an analysis of data and feedback from our stakeholders and partners (including all 61 LHJs) where they assisted in identifiying emerging issues and our current and future capacity to address priority health topics and implement activities to improve the health and well-being of women, infants, children and youth, including Children with Special Health Care Needs (CSHCN), and their families. SCD completed a CSHCN assessment of children enrolled in CCS using feedback from families, stakeholders, administrators, as well as data specific to the operations of the CCS program, to assess needs and capacity of the CCS program.

The following goals guided the 2016-2020 Title V Needs Assessment Process and provided the basis and selection of eight NPMs.

Goal 1: Improve, expand, and strengthen new and existing stakeholder and community partnerships at the state and local level to improve the collective impact of both DHCS/SCD and CDPH/MCAH Programs across the state.

Goal 2: Facilitate data-driven planning to inform development of 5-Year Action Plans that will address a specific list of priority health problems using standardized objectives while also allowing for local flexibility.

Goal 3: Enhance data surveillance and program evaluation activities.

II.B.2.a. MCH Population Needs

Prevention wellness visits and access to care are the first steps in addressing the health needs of the MCAH population. To ensure that Californians are aware of health insurance options, MCAH and LHJs collaborate with their respective partners to support eligible residents in accessing healthcare made available through ACA. Data reflecting the still-nascent ACA may not reflect health outcomes for the newly insured populations.

Life course theory addresses the importance of early life experiences, including social and physical experiences that affect health and influence health disparities. The life course perspective is found within the six population health domains in the three levels of MCAH: direct services, enabling services, and public health services and systems. Despite MCAH's significant existing infrastructure for life course investments in health, there are areas in need of great improvement in California. Many of these areas are beyond the immediate influence of MCAH, but form the foundation upon which our programs and initiatives are anchored. With this understanding, we form partnerships and collaborations to address the social determinants of health from a life course approach to address the needs of California's MCAH population. Below is an overview of each population health domain with data describing California's successes, challenges, and gaps. This report outlines how successful MCAH programmatic approaches can align with areas in need of intervention and support.

1. **Women's/Maternal Health**

MCAH efforts are supported by data that is of particular concern because of the disparities in key health indicators

among women based upon race/ethnicity, geography, socioeconomic status, and other characteristics. Glaring examples exist in the areas of chronic conditions, pre-term births, and other morbidities that may impact mothers and their babies. MCAH and LHJs participate in collaboratives and partnerships to optimize preconception health to support all women particularly those affected by health disparities. One significant programmatic approach is the funding of CMQCC which seeks to prevent maternal death and injury by developing resources and techniques for maternal care providers.

To respond to its needs assessment findings that indicates the state's limitations when addressing disparities within Women's and Maternal Health, MCAH developed *Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age*. Studies indicate that whether women have had a well-woman visit in the past year gives some indication of their attention to pre-pregnancy or inter-pregnancy health status. [37] MCAH is poised to address NPM 1: *the percent of women with a past year preventive medical visit,* as most LHJs have established a process to refer people to health care. According to the Title V Needs Assessment Strategic Question Survey administered to all LHJs in September/ October 2013, 27 LHJs were involved with activities to increase public awareness of the increased coverage for women's preventive services, including outreach and education to clients, providers, community partners, and internal staff. Overall, in California, over three quarters of women ages 15-44 were insured, 23%-24% each year from 2008 to 2012 (FIGURE 1).

However, having a health care plan did not directly correlate with having a routine checkup.
By race/ethnicity, reproductive-aged Black women were far more likely to report having a routine checkup in the past year (74.6%) compared to Hispanics (61.1%) and Whites (58.9%) in 2013 (FIGURE 2).

In 2013, 68.7 percent of non-pregnant women aged 18-44 reported having one or more persons they think of as their personal doctor or health care provider. This represents a slight improvement from the (66.1%) that had a usual source of care in 2012. In 2013, the percent of non-pregnant women aged 18-44 reporting a usual source of care increased as the reported income increased. While only 54.8% of women below 100% FPL had a health care plan, 59.1% reported having a routine checkup, whereas for women with incomes over 200% of FPL, 84.8% had a health care plan, but only 65.3% had a routine visit. Women with income more than 200% above poverty level were the most likely to report a usual source of care (84.8%). The least likely were women with income at below poverty level (54.8%). (FIGURE 3) African Americans had the greatest disparity. The prevalence of mistimed or unwanted pregnancy also differed widely by income level.

In 2012, almost all women had prenatal health insurance (98.3%) and almost all infants had health insurance (97.6%) (FIGURE 4). There were few disparities by race/ethnicity and income (FIGURE 5). In 2012, 75.3% of women had insurance before pregnancy and 83.3% had health insurance after pregnancy. Hispanic women had a lower prevalence of health insurance before (68.2%) and after (75.0%) pregnancy compared with all other race/ethnic groups (FIGURE 6).

Addressing the burden of chronic conditions is a goal of preconception health efforts. In 2000, 5.6% of women had an ICD9-CM code for hypertension at the time of labor and delivery. Since then, the number of women with hypertension has steadily increased to (7.6%) in 2012. Gestational or pre-existing diabetes at delivery has doubled, from (5.0%) in 2000 to (10.0%) in 2012. Additionally, in 2000 1.0% of women had a diagnosis code for asthma at the time of labor and delivery. Since then, asthma has steadily increased to 3.2% in 2012 (FIGURE 7).
Asthma and hypertension were most common among Black women (7.9% and 12.6%) followed by White women (4.2% and 7.7%), compared with lower rates among Hispanic women (2.4% and 7.4%) and Asian/ Pacific Islander (PI) women (2.2% and 5.8%). In contrast, diabetes was more common among Asian/PI women (14.7%) and Hispanic women (10.6%), as compared with Black women (7.6%) and White (7.5%) women.

Maternal Morbidity: In 2000, the rate of severe maternal morbidity was 97.8 per 10,000 delivery hospitalizations but by 2012, had increased to 175.5, a nearly 80 percent increase. The number of deliveries with severe maternal morbidity increased across all racial/ethnic sub-groups from 5,026 in 2000 to 8,508 in 2012. In 2012, Black women were more likely than all other race/ethnic groups to have at least one severe maternal complication (281.3 per 10,000). Hispanic women were the next most likely to have a severe morbidity at delivery, (182.3 per 10,000), followed by Asian/Pacific Islanders (169.5 per 10,000) and Whites (148.4 per 10,000). In 2012, severe maternal morbidity was more likely among deliveries with Medi-Cal as the expected source of payment (185.4 per 10,000) as compared to deliveries with other expected sources of payment (166.7 per 10,000). Nationally, in the period 2008–2009, for every 10,000 delivery hospitalizations, there were 129 delivery hospitalizations with at least one severe complication, an increase of 75% compared with 1998–1999.

Obesity is a major contributor to increases in chronic health conditions, and California has seen a rise in pre-pregnancy obesity. By race/ethnicity, reproductive-aged Black women were more likely to be obese (34.1%) compared to Hispanics (27.4%) and Whites (16.8%) in 2013. Furthermore, a greater proportion of Blacks and Hispanics who had a BMI above the normal range were obese (BMI >=30), whereas most White and Asian/PI women with a BMI above the normal range were in the overweight category (BMI from 25-29.9 percent). (FIGURE 8).

Maternal Mortality: The Healthy People 2020 objective is to reduce the number of maternal deaths to 11.4 per 100,000 live births. [37] In California, the maternal mortality rate peaked to 14.0 during the years 2006-2008, and has since been on the decline to 7.6 per 100,000 live births for the years 2010-2012 (FIGURE 9). Efforts that possibly contributed to this decline may be attributed to a CDPH/MCAH investigation of maternal deaths in 2006 known as the California Pregnancy-Associated Mortality Review (CA-PAMR). CA-PAMR identified cardiovascular disease, preeclampsia and obstetric hemorrhage as the leading causes of pregnancy-related deaths and initial findings of CA-PAMR were published in a statewide report (Spring 2011) and peer-reviewed manuscripts. Despite the reduction in overall maternal mortality rates, significant racial disparities persist with African-American women having almost three times higher occurrence of mortality than White women, 15.1 per 100,000 and 5.1 per 100,000 respectively for the year 2012 (Figure 10) .

For the 2002-2007 period, there were 51 reported suicides. This represents 4.8% of all pregnancy-associated deaths and a rate of 1.5 suicide deaths per 100,000 live births.

1. **Perinatal/Infant Health**

California has done extensive work to reduce infant morbidity and mortality and will continue the work on this concern through *Priority 2, Reduce infant morbidity and mortality*. The disparity within this population domain is most egregious in the African-American community. To address this disparity, Title V dollars support the Black Infant Health (BIH) program in communities experiencing the most significant number of African American births and disparities. BIH aims to improve health among African-American mothers and babies and to reduce the Black: White disparities by empowering pregnant and mothering African-American women to make healthy choices for themselves, their families, and their communities. The HP 2020 objective is to reduce the rate of infant deaths to 6.0 per 1,000 live births, the rate of neonatal deaths (among infants < 28 days) to 4.1, and the rate of post-neonatal deaths (among infants 28 days to 1 year) to 2.0. [37] California has met all of these objectives. From 2000 to 2012, the infant mortality rate decreased from 5.4 per 1,000 live births to 4.5, the neonatal mortality rate decreased from 3.7 to 3.1, and the post neonatal mortality rate decreased from 1.7 to 1.3 (FIGURE 11). CCS works to reduce this disparity by working with stakeholders to develop statewide NICU standards, improve NICU care through bundles to

decrease central line infections, and implement newborn hearing and congenital heart disease screening before neonates leave the hospital.

Infant Morbidity: MCAH addresses National Performance Measure 3 through its emphasis on low birth weight (LBW) and preterm births which are strong predictors of infant mortality. [37] The HP 2020 objective is to reduce the proportion of LBW births to no more than 7.8%. [38] California has met this objective. However, the percent of LBW births increased from 6.2% in 2000 to 6.7% in 2012, and remained relatively unchanged from 2005 through 2012 on (FIGURE 12). Due to the size of the birthing population in California, the burden of LBW is large. There were nearly 33,657 LBW births in 2012 and nearly half were among Hispanic women. The percent of LBW births among Black women (12.0%) is nearly double the percent among Hispanics (6.1%). At 7.9%, Asian women also have higher rates of LBW compared with Hispanics.

Infant Mortality In 2012, infant mortality rates were lowest among Asian women (2.9) and highest among Black women (9.8) (FIGURES 13-7 & 14). Although the disparity in the infant mortality rate primarily affects Black women and infants, the burden in California is largely experienced by Hispanics because of the size of the Hispanic birthing population.

Between 2000 and 2011, the perinatal mortality rate decreased from 5.9 to 5.4 per 1,000 live births plus fetal deaths. This rate is lower than the HP 2020 objective of 5.9. In 2011, the perinatal mortality rate was lowest among Asian women (3.9) and highest among Black women (11.1) (FIGURES 15 & 16).

Breastfeeding: MCAH has consistently worked on NPM 4 through addressing breastfeeding using internal and external stakeholders. Newer focus areas include promoting lactation accommodation for the low-wage worker and developing breastfeeding-friendly clinics. The HP 2020 objective is to increase to 46% the proportion of mothers who breastfeed exclusively through three months. [1] California's rate in-hospital breastfeeding initiation increased from 90.8% to 92.9%, while exclusive breastfeeding rates increased from 56.6% to 64.6% (FIGURE 17). Although improvements were seen across all racial/ethnic groups during this time period, disparities in infant feeding practices persist. In 2013, Black women had the lowest in-hospital breastfeeding initiation rates (84.0%) and less than a third of Black women breastfed exclusively. Although 92.7% of Hispanic women breastfed their infants in the hospital, over one third gave their infants formula during the hospital stay, while only 15 percent of breastfeeding White women supplemented with formula (FIGURE 18).

1. Child Health

The first few years of life is a particularly critical period in the life course; therefore, MCAH includes *Priority 3, improve the cognitive, physical, and emotional development of all children*. To achieve measures associated with *Priority 3*, State MCAH works with Local MCAH to provide direct services to the child population. In addition, State MCAH partners across governmental agencies to address unintentional injuries, child abuse/neglect, and developmental screening. Enabling services, including promotion and implementation of evidence-based practices such as Nurse-Family Partnership and Healthy Families America, are closely monitored by state MCAH. While funding for these two home visiting programs is distinct from Title V, state and local MCAH Title V programs work closely with these programs. Other examples of braided funding are California's Project LAUNCH and the California Early Childhood Comprehensive Systems project, both of which inform public health services and systems that support a more cohesive response to California's children. For example, developing a solid infrastructure for developmental screening has been an emphasis for both programs, in collaboration with Title V, local, and state MCAH.

As with all MCAH populations, the effect of ACA on the health status of California's children is yet to be realized. By

selecting NPM 15, MCAH can further support ACA efforts. Local MCAH programs, as described here, link families to health insurance, a critical component to public health, as evident in the wellness disparity. Children aged 0-5 had the highest percentage of adequate health insurance (78.7%) compared with 73.9% of children aged 6-11. [39] Nationwide, 54.4% of children aged 0-17 receive coordinated, ongoing, comprehensive care within a medical home. [39] In California, this percentage is lower at 44.7%. White children had the highest percent who received care within a medical home (63.9%), compared with 50.6% of Black children and 46.5% of "Other" have a medical home. Only 34.1% of Hispanic children had a medical home (FIGURE 19).

The local needs assessment process emphasized that mental health continues to be a health concern across all MCAH populations, particularly children. MCAH plans on addressing this need under *Priority 7, Increase access and utilization of health and social services*. HP 2020 set a goal of 75.8% of children with mental health problems to receive treatment. [37] Nationwide in 2012, 43.4% of children ages 2-5 years, and 62.6% of children ages 6-11 years with a mental/behavioral condition received treatment. [39] A similar percentage of California children with a mental/behavioral condition received treatment during this same time (40.4% and 65.2%, respectively). The percentage of children and adolescents (ages 2-17) with a mental/behavioral condition who received treatment varies across income levels, with the lowest percentage not receiving treatment in households with income at or below 199% of the federal poverty level (45.4%) (FIGURE 20). The percentage of children aged 2-17 receiving treatment also varies by race/ethnicity, with only 15.7% of Black children with a mental/behavioral condition receiving treatment compared to 59.2% of Hispanic children, 66.4% of White children, and 87.4% of children from "Other" race/ethnicity groups (FIGURE 21). The percentage of children with private insurance receiving treatment (73.4%) was higher than those children with public insurance (44.5%). A large increase in the percentage of children ages 6-11 with a mental/behavioral condition who received treatment occurred between 2003 (45.5%) and 2012 (65.2%). For adolescents aged 12-17 there has been little change in the parentage of those with a mental/behavioral condition receiving treatment from 2003 (64.3%) to 2012 (64.9%).

Immunizations: HP 2020 set a goal of increasing the percentage of children aged 19-35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine combined series of vaccines) from a baseline of 44.3% to a target of 80.0%.[37] Of California's children aged 19-35 months, 66.8% received the combined series of vaccines in 2012, a very close to the national percentage of 68.4. [37] The percentage of children who have received the combined series of vaccines has fluctuated slightly during the 2000 to 2012 time period while overall decreasing slightly (FIGURE 22).

Nutrition and Physical Activity:
In 2011-12, 32.6% of children ages 2-11 were physically active for at least one hour every day in the past week, excluding school and 52.6% ate five or more servings of fruit and vegetables daily. Black children were much more likely to participate in daily physical activity and to consume fruits and vegetables than children of all other races/ethnicities (FIGURE 23).

Child Morbidity and Mortality:
One of the 2016-2020 priorities is to intervene early by addressing healthy weights in the MCAH population. The disparity is substantial. In 2011-2012, 13.6% of California children ages 2-11 were overweight. White (8.7%) and Asian/PI (4.5%) children were less likely to be overweight than Black (19.9%) and Hispanic (17.5%) children (FIGURE 24).

Unintentional injuries are consistently among the top reasons for hospitalization among California children/adolescents. Healthy People 2020 set a target goal of 555.8 non-fatal injuries per 100,000. MCAH will address *NPM 7* in collaboration with other state agencies responsible for injury control. In 2012, the rate of non-fatal

intentional and unintentional injuries among children ages 0 – 9 years was 201.6 per 100,000(FIGURES 25 & 26).

4. CSHCN

Although MCAH has worked with several partnerships and collaborations to address NPM 6, developmental screening, overall screening rates in California have remained low over recent years. Additionally, the percent of children with a developmental disorder has increased. In 2012, 28.5% of California children were screened in the previous 12 months for being at risk for developmental, behavioral or social delays using a parent-reported standardized screening tool during a health care visit. The 2012 rate of 28.5% is more than double that of children screened in 2007 (14.0%), showing a substantial improvement in screening rates. [39] The percent of children who received a developmental screening using a parent-completed screening tool was similar across income levels but varied across race/ethnicity groups, with Black children having lower screening rates (FIGURE 27).

There are an estimated 1,000,000 Children and Youth with Special Healthcare Needs (CYSHCN) in California. CCS is the 'insurance entity' for approximately 180,000 clients. It is notable that the number of clients enrolled has remained relatively unchanged, despite large changes in the health care delivery system in CA, including the spread of managed care; managed care now covers the non-CCS health needs of approximately 75% of all CCS clients; As described below, the needs assessment findings suggest that CCS focus on two major priorities: *Priority 4 provides a whole-child approach to serve Children with Special Health Care Needs* and *Priority 5, to improving access: ensuring the right patient to the Right Place.* (See Table 1). These priorities indicate the focus on NPM 11, related to a medical home and NPM 12, transition to adult health care.

Overall, families expressed a high degree of satisfaction with CCS, with 82% of respondents to the family survey giving CCS an 8 or above on a scale of 0-10. There was also a fairly high level of satisfaction with case management services (66% of those families that know they have a CCS case manager are very satisfied, 25% are satisfied, 5% have no opinion and only 4% are dissatisfied). Coordination of care is an area suggested where improvement is needed; 62% of families report that their children's services were always or usually coordinated in a way that makes them easy to use.

CCS administrative processing times of service authorization requests (SAR) to providers have shown improvement since the last needs assessment, with 79% of requests for services authorized within 2 weeks (vs. 61% in 2009).

Gaps in the program exist related to care coordination, including communication. Family focus groups identified issues related to communication with families in the area of covered services, and eligible diagnoses. Family survey results also indicate family perceptions of inadequate county support for transportation to and from appointments and at hospital discharge.

Although 94% of respondents to the family survey indicated that their child has a primary care provider (PCP), these PCPs are not providing all the services and supports, including care coordination and robust communications with the other entities also serving the child (i.e. special care centers, regional centers, medical therapists, mental health providers, schools), to be considered true medical homes. Physician survey and focus group respondents indicated that more resources, including enhanced reimbursement, are needed to be able to provide medical homes for CCS clients.

Seventy percent of respondents to the CCS Administrators Survey and 69% of respondents to the physician survey indicate that fragmentation of services could be reduced by having one program cover the whole child instead of just

the child's CCS eligible medical condition. Administrators reported in focus groups and surveys that coordinating systems of care between CCS providers and Medi-Cal managed care plans is a challenge.

Under one approach to increase access to CCS paneled specialists, telehealth was expanded in 2013 with state legislation designed to remove barriers to telehealth. Use of the method remains limited, however. Administrators and medical consultants agree that it would be very helpful to expand telehealth options for CCS children, particularly in rural areas (42%).

There are some successes including county-based transition fairs and county CCS parent liaisons that work with families to identify community resources. In addition, some counties have implemented transition case management. Despite these positive developments, California ranks 45th in the nation for transition to adulthood, based on the NCSHN transition item. Families, physicians and CCS administrators all indicated that when a child grows up and ages out of CCS, there are significant challenges finding adult primary and specialty care providers. Over 80% of physician respondents to the survey believed that children would benefit by CCS helping to find adult providers. Of the respondents to the family survey with a child age 14 or older, 15% reported CCS helping them to find adult providers, and 80% of those helped report success. Families reported not enough education and information available to clients, families, and providers as to how to go about transitioning CCS clients to adult care. Providers report 'There are no places that want to receive these kids.'

Approximately 62% of respondents to the CCS family survey indicate their services are usually or always organized in a way that makes them easy to use, while 64.8% of CSHCN in the state (data from the NSCSHCN 2009/2010) report that their services are organized so they are easy to use. Some CCS county administrators report delays in authorizing services as local CCS and the health plans covering the child's non-eligible CCS condition determine which entity is responsible for coving various services (42% report always or frequently delays and 36% report occasionally experiencing delays. Included in the whole-child approach is increasing the percentage of CCS clients whose care is coordinated in a family centered health home that includes the promotion of transition to adult health services, California ranks 44th in the nation for health homes and 45th in the nation for CSHCN transition to adulthood, based on the NCSHCN. For CCS clients, family survey data indicate that only 28% of respondents with a child 14 or older report providers talking to them about how their child's health care needs will be met when he/she turns 21 and that only 15% of CCS case managers assisted families with youth over age 14 with finding an adult provider.

Although CCS has an effective regionalized system of care, there are areas which can be improved (see Table 1.) Four such areas needing improvement are:
1. Access to specialty providers for clients who reside long distances from specialty clinics through telehealth or other modalities.
2. Access to a primary care provider with the necessary skills to coordinate care for a special needs child.
3. Access to necessary durable medical equipment (DME), pharmacy and home health services.
4. Access to consistent high quality specialty care from county to county one region to another.

1. Adolescent Health

Promoting and advancing adolescent health is a consistent interest at both the local and state level. *Priority 6, promote and enhance adolescent strengths, skills, and supports to improve adolescent health* is supported by State MCAH and Local MCAH in a number of current and proposed efforts. Although funding has always been a concern, the ACA is expected to benefit the adolescent population; and as stated in the Child Health category, MCAH will address NPM 15 in this category as well. Because of the ACA's recent rollout, it is too early to assess

the rates of health care coverage among adolescents; however, currently, 71% of adolescents between the ages of 12-17 were adequately insured. [39]

Well-Visit: HP 2020 set a goal of increasing the proportion of adolescents who have had a wellness check-up in the past 12 months from the baseline of 68.7% to the target of 75.6%.[37] In California, this percentage is slightly lower than the HP 2020 goal with 75.1% of adolescents ages 12-17 having one or more preventive visits in the last 12 months. There was an overall increase in the percentage of adolescents who have had a preventive services visit since 2003 (63.6%). Percentages of children and adolescents (ages 0-17) with a preventive service visit vary across income levels. The higher the income level, the higher the percentage of children and adolescents who have had a preventive care visit in the last 12 months. Percentages of children and adolescents (ages 0-17) that have had a preventive services visit are similar across Hispanic (80.2%), White (80.0%), Black (88.3%), and "Other" (83.1%) racial groups (FIGURE 28).
Similar percentages of children and adolescents (ages 0-17) with public and private insurance had a preventive services visit in the past 12 months (80.8% vs. 84.7% respectively) (FIGURE 29). However, far fewer children and adolescents without insurance had a preventive services visit (48.5%). Immunizations are another measure of whether routine preventive care is being received. Nationwide, 53.8% of adolescents aged 13-17 have at least one dose of the HPV vaccine. [40] California's percentage is higher, with 65.0% of adolescents having received at least one dose of the HPV vaccine.

Nutrition and Physical Activity: As with the child health domain, MCAH will continue to support nutrition and physical activity through *Priority 8: increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.* Only 16.1% of adolescents age 12-17 reported physical activity lasting at least one hour per day in a typical week. Hispanics (15.1%) were less likely to report daily physical activity compared with Blacks (23.1%) and Whites (18.3%) (FIGURE 30). In 2011-2012, 15.8% of 12-17 yea-olds were obese (BMI ≥ 95 percentile for age and gender) and 32.4% were overweight or obese. Significant racial and ethnic disparities have developed since 2001 with an obesity rate of 28.6% for Black, 19.7% for Hispanic, and 9.4% for white children 12-17 (FIGURE 31).

Mental Health: As in the child health population, California is challenged to meet the mental health needs of the adolescent health population. HP 2020 set a goal of increasing the proportion of children with mental health problems who receive treatment from the baseline of 68.9% to the target of 75.0%.[41] Nationwide, in 2011/2012, 64.1% of adolescents, ages 12-17 years of age with a mental/behavioral condition received treatment. [42] The MCAH local needs assessments supported national data in identifying bullying as a focus area; thus NPM 9, related to bullying was identified as a state need.

Sexual and Reproductive Health: The Office of Adolescent Health has funded a new evidence-informed intervention for the Adolescent Family Life Program (AFLP) which is now undergoing outcome evaluation. This Title V-funded program, in addition to non-Title V programs, highlights California's work in teen pregnancy prevention. The adolescent birth rate in California was slightly lower than the national rate at 25.7 per 1,000 females aged 15-19. Adolescent birth rates vary greatly by race/ethnicity. Disparities exist particularly with the Hispanic females who have the highest adolescent birth rate at 38.9 births per 1,000. (FIGURE 32). Across all races and ethnicities, the adolescent birth rate has overall decreased over time as shown in FIGURE 33. In 2000, it was 46.7 births per 1,000 females. In 2005, it dropped to 38.6 births per 1,000 females. In 2007, the teen birth rate increased slightly to 40.1 but dropped again in 2008 (40.2) and has continued to decline to the current (2012) rate of 25.7 per 1,000 females. [43]

In 2012, CA female adolescents aged 15-19 had a Chlamydia rate of 2,355 per 100,000 while CA male adolescents

had a Chlamydia rate of only 562.7 per 100,000 (FIGURE 34). [44] Black adolescents had the highest Chlamydia rate, 4075.3 per 100,000 adolescents. This is approximately four times higher than the next highest group, American Indian/Alaska Native, at 1068.8 per 100,000 adolescents. Asian/Pacific Islander adolescents had the lowest incidence rate of Chlamydia in 2012, 292.7 per 100,000 15-19 year-olds (FIGURE 35). Rates of Chlamydia have slightly increased since 2000; however, 2012 rates were lower than 2011 for both male and female adolescents.

6. Cross-cutting Issues

A strong predictor of health status across the life course is socioeconomic status, the combination of one's social, economic, and physical environment. MCAH tracks socioeconomic status through proxy measures such as poverty, income, employment and education. Despite the strong infrastructure for life course investments, there are areas in need of great improvement in California. Many of these areas are beyond the immediate influence of MCAH, but form the foundation upon which our programs and initiatives are anchored; with this understanding, we form partnerships and collaborations to address the social determinants of health and use this information to help target our outreach and tailor our information to the emerging and ongoing needs of communities.

Attempting to impact cumulative influences across the life course is not a new framework; however, reconsidering social programs through the lens of life course effects requires greater efforts to build interdisciplinary partnerships, expand the universe of program outcomes, and extend the evaluation time frame. The idea underlying the life course framework is that socioeconomic-based health inequalities compound throughout life and can be useful in determining health status and future health trajectories. The health differences across socioeconomic statuses reflect social disparities of health.

MCAH understands that these areas are deeply entrenched and will require the passage of several generations to make significant progress, but we include them to provide context to our work and to explore the implications of our work that extend beyond the five-year budget cycle. MCAH monitors social disparities of health under three categories: economic experiences, family well-being, and community well-being as well cross-cutting issues such as obesity and health care access.

Economic Experiences

Poverty Rate Among Women: The population of women of reproductive ages 15-44 with incomes below the poverty level is 20 percent, or about 1.5 million. Examining the poverty rate by race/ethnicity reveals that Black (27.9%) and American Indian/Alaska Native (27.1%) women are twice as likely to be in poverty as are White women (13.5%) (FIGURE 36): Percentage of reproductive age women 15-44 in California that are below 100 percent of Federal Poverty Level (FPL) by race/ethnicity.

In 2011, 43.8% of mothers in California with a recent live birth had incomes ≤ 100% of the FPL. FIGURE 37 shows that compared to the state average, many more Black women (61.4%) and Hispanic women (62.9%) incomes ≤ 100% of the FPL, than White women (22.4%) and Asian/PI women (13.3%).

Poverty Rate Among Children: An estimated 23% of California children under age 18 lived below the Federal Poverty Level (FPL). For example, FIGURE 38 shows that 33% of Black, 31% of Hispanic, and 27% of American Indian/Alaska Native children lived below the FPL, compared to 13% of Asian and 11% of white children.

Housing Cost Burden: High housing cost burden is a threshold percentage of income that a family spends on housing above which it becomes more difficult to afford other nondiscretionary items such as food, clothing,

toiletries, healthcare and retirement. In 2012, about half of California children aged 0-17 (51%) lived in households with a high housing cost burden (FIGURE 39).

Early Reading on Health: In California in 2012, 39.1% of children aged 0-5 are read with every day, down from 44.6% in 2003 but up from 36.5% in 2007. The percentages of children read to every day vary by race/ethnicity group in 2012, with a greater percentage of White children (62.9%) being read to than Multi-racial/ethnic (43.4%), Black (40.4%) and Hispanic (28.3%) children (FIGURE 40). A greater percentage of children with private insurance (50.6%) were read to every day compared to children who were uninsured (38.7%) or had public insurance (26.9%).

Community Well-Being

A growing body of literature shows discrimination raises the risk of many emotional and physical problems (FIGURE 41). [45]

In 2011, 5.3% of mothers with a recent live birth reported that they had neither practical nor emotional support. The lack of support differed by race/ethnicity: more Hispanic (7.4%) and Asian/PI women (6.7%) lacked support compared with Black (3.1%) and White women (1.2%) (FIGURE 42).

Among 504,000 live births, 33.1% (167,000) occurred to residents living in areas of concentrated poverty. [46] Blacks and Hispanics had the largest proportions of live births in poverty areas (48.4 percent and 46.0 percent, respectively) (FIGURE 43).

Only 60% of Latino children live in a neighborhood that have amenities that include parks, sidewalks, recreation centers and libraries, lower than Whites (73%), Blacks (87%) and “Other” Race (71%). There was a stepwise increase in availability of all four amenities in the neighborhood as income increased.

Family Well-Being

A number of factors affect the well-being of families. Physical health, including oral health and tobacco use, impacts short- and long-term health outcomes.

Oral health: Dental care is the most prevalent unmet health care need of children; the condition of children’s teeth in California was ranked the third worst in the country. [47] In 2012, the percent of children with a preventive dental visit in the last year was 54.3% for ages 1-5, 87.6% for ages 6–11 and 81.3% for ages 12–17.

In 2013, the percent of non-pregnant women aged 18-44 who had a dental visit in the past year was 64.5%, with variation by household income levels, race/ethnicity, and health insurance provider type (FIGURE 44).

- By income (%FPL): 0-99% (49.7%); 100-199% (52.9%); 200% or greater (78.9%).
- By race/ethnicity: White (73.6%); Hispanic (56.8%); Blacks (55.1%)
- By insurance type: Medi-Cal (47.9%); other insurance providers (68.1%)[48]

In 2012, 42.1% of all women with a live birth reported receiving dental care during pregnancy, a 25% increase since 2002 (33.8%) (FIGURE 45). Visiting the dentist was similar for Medi-Cal (30.5%) and uninsured women (31.7%). White (55.7%) and Asian/PI women (51.3%) had a higher percent compared with Black (43.9%) and Hispanic (39.3%) women.

Tobacco: During 2008-2010, the percentage of 11th graders who reported any cigarette use in the past month was 13.2%, higher than both 9th (9.1%) and 7th (5.1%) graders. American Indian/Alaska Natives had the highest and Asian students reported the lowest rate of cigarette use in the past month (FIGURE 46).

In 2012, the prevalence of smoking during the 3rd trimester of pregnancy was higher among Black (9.1%) and White (4.4%) women, compared with Hispanic (1.2%) and Asian/PI (0.7%) women (FIGURE 47). Smoking was also more common among women with incomes ≤ 100% of the FPL (4.9%) compared with women with incomes >400% of the FPL (0.2%). The prevalence of third trimester smoking decreased from 4.8% in 2000 to 2.6% in 2012, however, the prevalence has not changed since 2007, when it was also 2.6% (FIGURE 48)

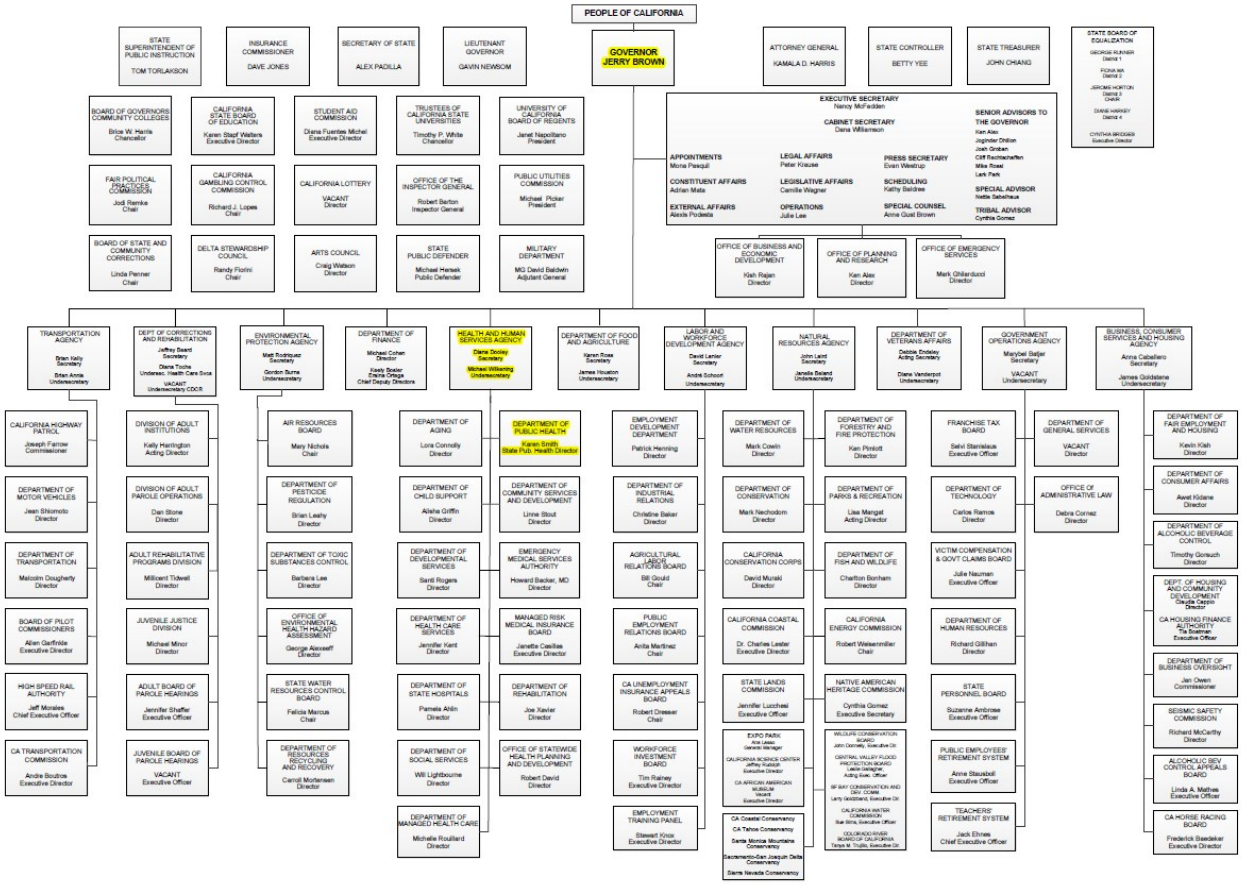
II.B.2.b Title V Program Capacity

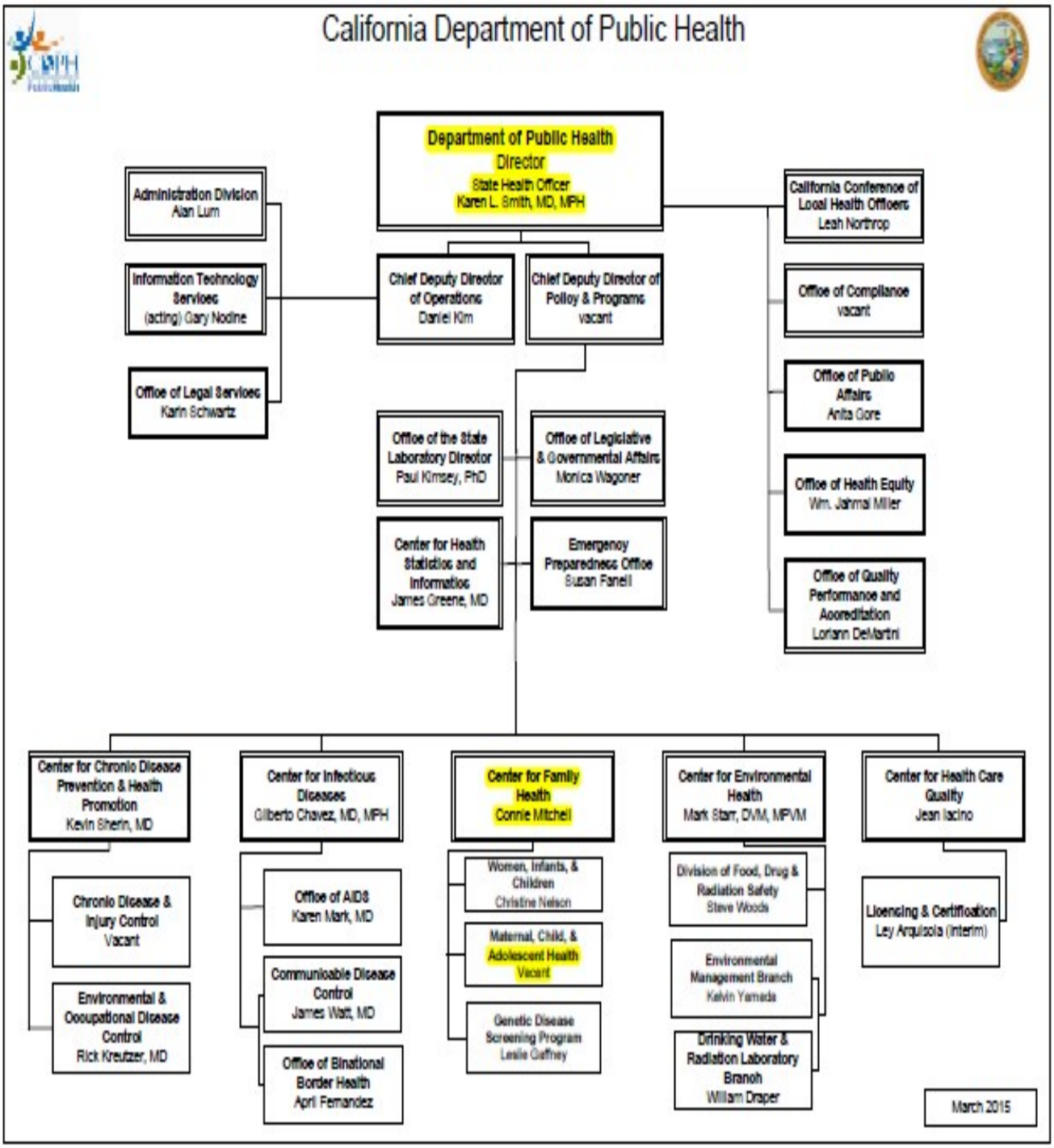
II.B.2.b.i. Organizational Structure

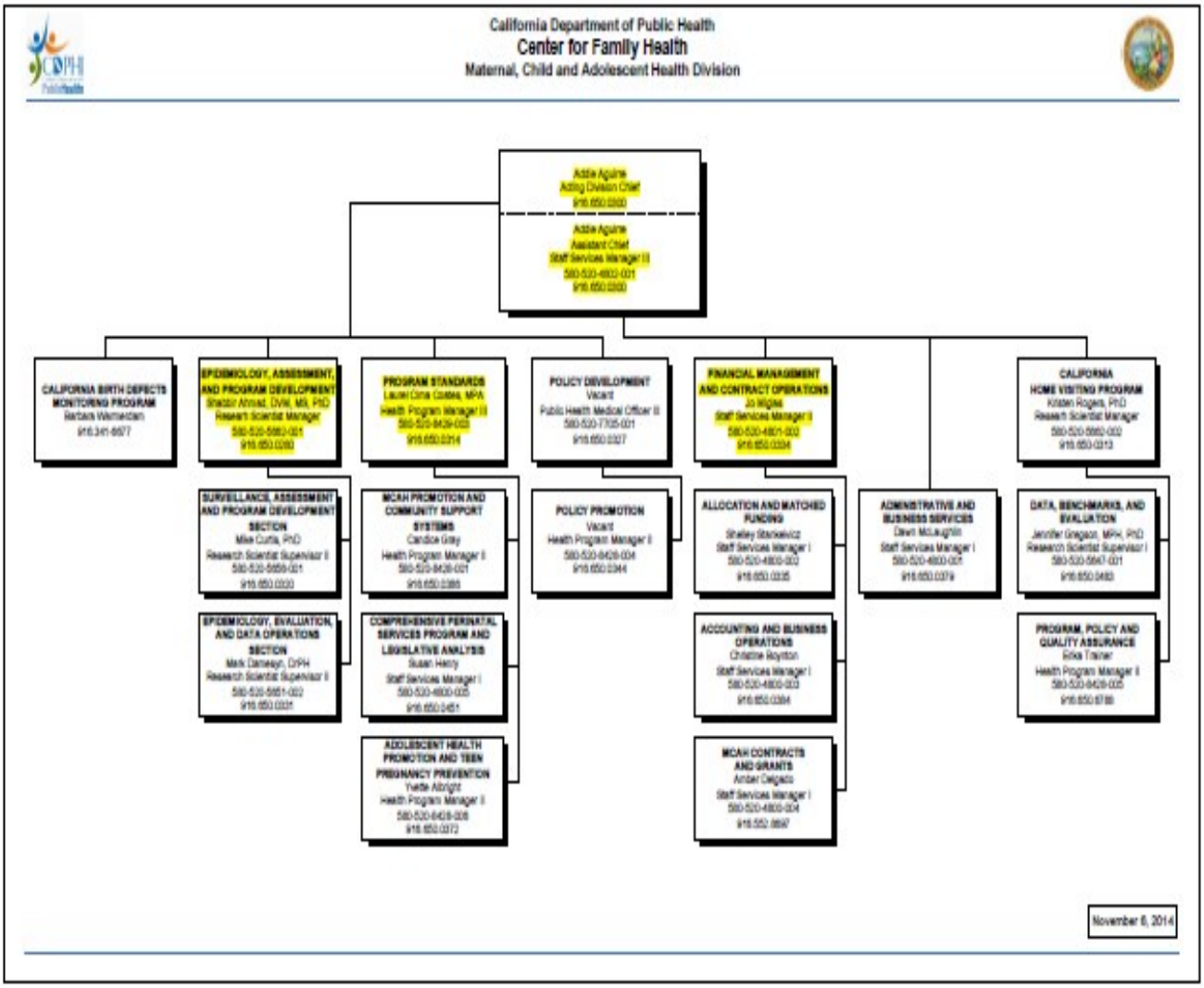
The Governor oversees the Health and Human Services Agency which is responsible for CDPH and DHCS; MCAH Title V Block Grant resides under CDPH; and SCD which oversees CSHCN in the CCS program, resides under DHCS. The Acting Chief of the MCAH is the California Title V Director and is responsible for the administration of Title V programs. Attachment 1 provides the Title V Organization Chart. Attachment 2 describes Title V programs.

3.2.15

CALIFORNIA STATE GOVERNMENT – THE EXECUTIVE BRANCH




California Department of Public Health
Department of Public Health
Director
State Health Officer
Karen L. Smith, MD, MPH
Administration Division
Alan Lum
Information Technology Services
(acting) Gary Nodine
Office of Legal Services
Karin Schwartz
Chief Deputy Director of Operations
Daniel Kim
Chief Deputy Director of Policy & Programs
vacant
California Conference of Local Health Officers
Leah Northrop
Office of Compliance
vacant
Office of Public Affairs
Anita Gore
Office of Health Equity
Wm. Jahmal Miller
Office of Quality Performance and Accreditation
Lorlann DeMartini
Office of the State Laboratory Director
Paul Kimsey, PhD
Office of Legislative & Governmental Affairs
Monica Wagoner
Center for Health Statistics and Informatics
James Greene, MD
Emergency Preparedness Office
Susan Fanell
Center for Chronic Disease Prevention & Health Promotion
Kevin Sherin, MD
Chronic Disease & Injury Control
Vacant
Environmental & Occupational Disease Control
Rick Kreutzer, MD
Center for Infectious Diseases
Gilberto Chavez, MD, MPH
Office of AIDS
Karen Mark, MD
Communicable Disease Control
James Watt, MD
Office of Binational Border Health
April Fernandez
Center for Family Health
Connie Mitchell
Women, Infants, & Children
Christine Nelson
Maternal, Child, & Adolescent Health
Vacant
Genetic Disease Screening Program
Leslie Gaffney
Center for Environmental Health
Mark Starr, DVM, MPVM
Division of Food, Drug & Radiation Safety
Steve Woods
Environmental Management Branch
Kelvin Yamada
Drinking Water & Radiation Laboratory Branch
William Draper
Center for Health Care Quality
Jean Iacino
Licensing & Certification
Ley Arquiola (interim)
March 2015


California Department of Public Health
Center for Family Health
Maternal, Child and Adolescent Health Division
Addie Aguirre
Acting Division Chief
Addie Aguirre
Assistant Chief
Staff Services Manager II
CALIFORNIA BIRTH DEFECTS MONITORING PROGRAM
Barbara Wahrendorf
EPIDEMIOLOGY, ASSESSMENT, AND PROGRAM DEVELOPMENT
Shabbir Ahmad, DVM, MS, PhD
Research Scientist Manager
PROGRAM STANDARDS
Laurel Dina Costes, MPA
Health Program Manager III
POLICY DEVELOPMENT
Vacant
Public Health Medical Officer II
FINANCIAL MANAGEMENT AND CONTRACT OPERATIONS
Jo Migliaccio
Staff Services Manager II
CALIFORNIA HOME VISITING PROGRAM
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Vacant
Health Program Manager II
ALLOCATION AND MATCHED FUNDING
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Staff Services Manager I
ADMINISTRATIVE AND BUSINESS SERVICES
Dawn McLaughlin
Staff Services Manager I
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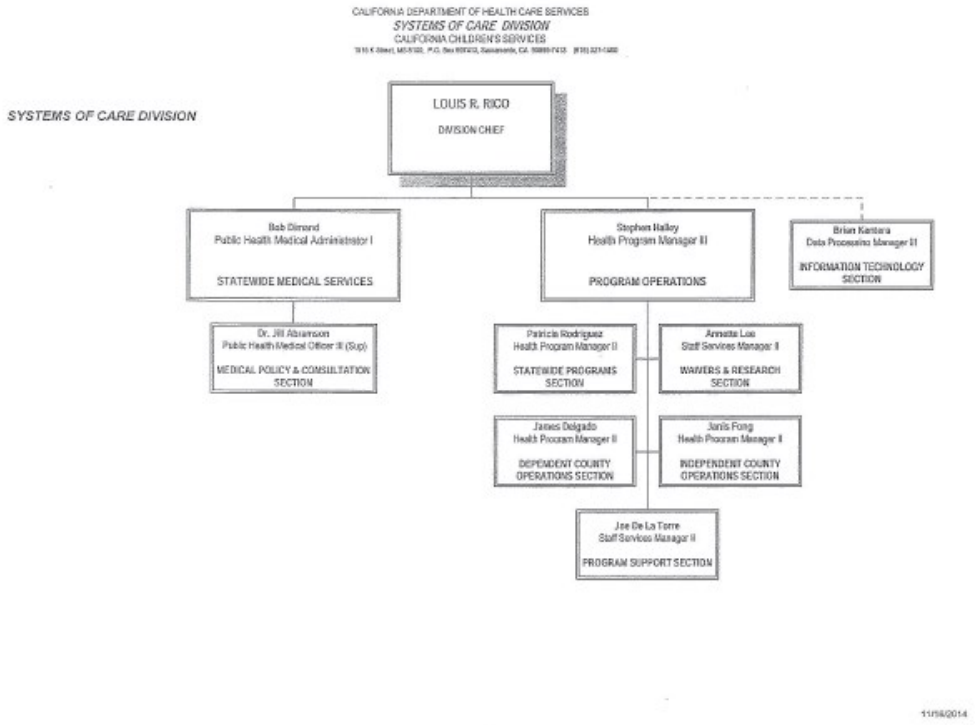
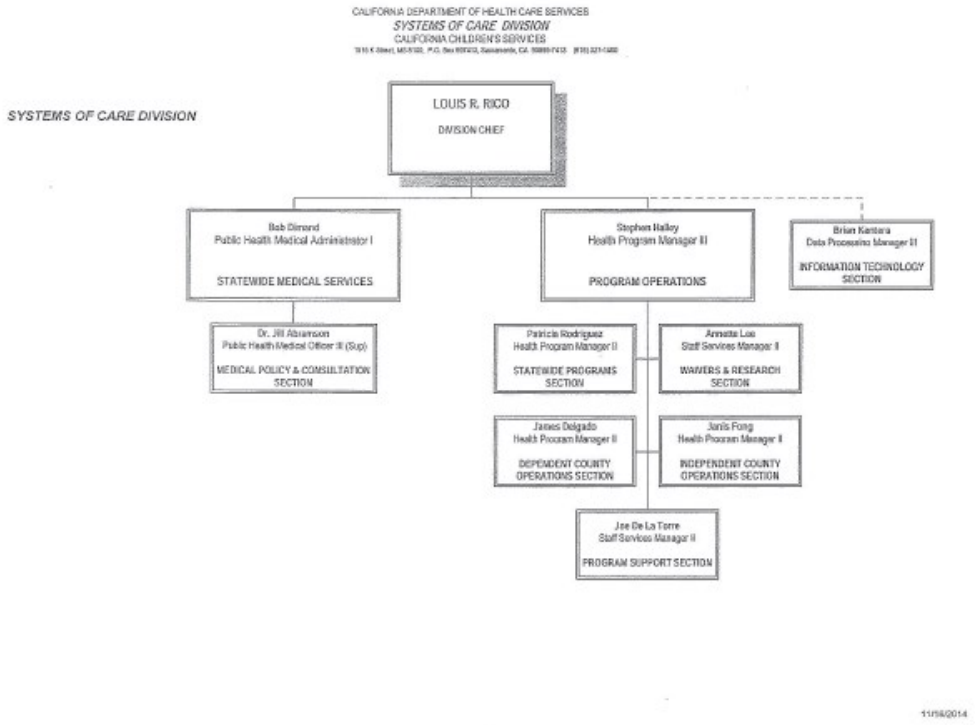
Health Program Manager II
ADOLESCENT HEALTH PROMOTION AND TEEN PREGNANCY PREVENTION
Yvette Albright
Health Program Manager II
MCAH CONTRACTS AND GRANTS
Amber Delgado
Staff Services Manager I
November 6, 2014





II.B.2.b.ii. Agency Capacity

MCAH Public Health Nurses (PHNs) oversee the work of LHJs which is the umbrella program for Title V programs. Each MCAH LHJ has an MCAH Director, who has the general responsibility and authority to plan, implement, evaluate, coordinate, and manage all MCAH services within the LHJ. Depending on the size of the county, the MCAH Director is a PHN or physician or Masteral level in Public Health. There are 61 LHJs funded by Title V, local funds, and Title XIX matching.

MCAH PHNS and other MCAH public health professionals monitor the LHJ work in the delivery of services to the six population health domains. To optimize public health influence, MCAH integrates evidence-informed and evidence-based interventions to address the population health domains. For example, one program that addresses the infant population across local MCAH is the Sudden Infant Death Syndrome's (SIDS) Safe to Sleep Campaign; promotion of the campaign exists in Local MCAH, AFLP, and BIH programs.

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

Local CCS programs provide case management and care coordination services to help families navigate the system. Family and consumer partnerships are another area of strength for the CCS program. Local (county) CCS programs maintain parent liaisons through Family Voices of CA Member Agencies. These liaisons train CCS staff on family perspectives, help families access services and provide conflict resolution assistance for CCS staff and family members. Families have participated in NICU quality workgroups and hospital length of stay workgroups in collaboration with CPQCC. CCS has been working on family representation on technical advisory groups but is seeking a way to offer legal protection to advisory group members.

See Attachment 3 that depicts MCAH's approach to the six population health domains.

The MCAH Director ensures the performance of the core public health functions of assessment, policy development, assurance, and evaluation. Annual reports and regular contact with MCAH staff from the Program Standards Branch assure that activities are completed and that outcome measures respond to MCAH program goals that are included in the MCAH SOW. MCAH SOW in Attachment 4 provides a detailed description of LHJ activities that respond to the following goals.

Goal 1: Improve Outreach and Access to quality health and human services (All populations)
Goal 2: Improve Maternal and Women's Health
Goal 3: Improve Infant Health
Goal 4: Improve Nutrition and Physical Activity (among maternal, child and adolescent populations)
Goal 5: Improve Child Health
Goal 6: Improve Adolescent Health

II.B.2.b.iii. MCH Workforce Development and Capacity

MCAH programs boast a cadre of highly qualified public health professionals. These professionals total a full-time equivalent of 791 staff positions from throughout California funded by Title V, Title XIX, California State General Funds, and local agency funds that include public and private sources. See Attachment 6 for detailed descriptions of staff requirements for Local MCAH programs.

MCAH is led by the Division Chief who also serves as the Acting Title V Director, supported by four managers responsible for the policy, program, evaluation, and fiscal administration of Title V activities:

Addie Aguirre, the Assistant Division Chief who currently serves as the Acting Division Chief and Acting Title V Director, is the lead administrative staff in state and federal public health initiatives.

Laurel A Cima Coates, MPA, Chief, Prevention, Policy and Program Standards Branch, has 20 years of experience in administering state and federal public health policy and programs, including CDC Prevention Funding, Title V, MIECHV, SAMHSA Project LAUNCH, Early Comprehensive Childhood Systems, Office of Adolescent Health/ Positive Youth Development

S**habbir Ahmad, PhD**. Chief, Epidemiology, Assessment and Program Development Branch, has over 10 years of experience in managing and leading a team of public health professionals, researchers and analysts for MCAH surveillance and program assessments.

Jo Miglas, Chief, Financial Management and Contract Operations Branch assumes the contract monitoring functions for MCAH, including fiscal forecasting, budget-related work, management of over 200 contracts, and working with Department of Finance and other control agencies.
At the MCAH Division, located in Sacramento, California, these key positions oversee 118 Title V funded positions and 47 contract staff funded by multiple federal funding sources.

DHCS/SCD Workforce Development and Capacity
The primary use of Title V funds is for administrative case management. This work is shared between the state and county professionals. These professionals total approximately 1,400 full-time equivalent staff positions from throughout California funded by Title V, Title XIX, California State General Fund, and local agency funds that include public and private sources.

SCD is led by the Division Chief, supported by seven managers, and 58 counties responsible for the administrative case management, policy, program, evaluation, and fiscal administration of Title V activities:

Louis Rico, Chief of SCD, is the lead on the CSHCN Block Grant and ultimately responsible for service provided by staff in the Division.

Dr. Robert Dimand, Chief Medical Officer, is responsible for all medical aspects of SCD programs.

For information on workforce development, see section II.F.2 , MCH Workforce Development.

II.B.2.c. Partnerships, Collaboration, and Coordination

The Title V Five-year Needs Assessment findings emphasize the importance in continuing current collaborations and coordination with other entities that share MCAH Title V population outcomes.

MCAH has addressed the child health domain through its leadership role in the development of a coordinated and comprehensive early childhood system in California and has worked to strengthen partnerships with key early childhood initiatives and agencies. One example is the implementation of California's Early Childhood Comprehensive Systems (ECCS) grant. The ECCS Leadership Team represents early childhood system stakeholders that include First 5 California, First 5 Association, California Departments of Social Services (Office of

Child Abuse Prevention) and Education (Race-to-the-Top), and the California Head Start Association. MCAH participates in the State Interagency Team - a multi-state agency group for Children, Youth and Families - that consists of high-ranking state level partners. Most recently, and in response to unmet needs, new partnerships have been forged between MCAH, California Maternal, Infant, and Early Childhood Home Visiting program (MIECHV), and the California Department of Health Care Services (DHCS) to identify mental health services and Medi-Cal reimbursement mechanisms for home visiting families. All of California's MIECHV are under the oversight of the Local MCAH Director.

The California Adolescent Sexual Health Work Group (ASHWG) - comprised of representatives from CDPH/Office of AIDS, CDPH/Sexually Transmitted Disease Branch, CDE, universities and non-governmental organizations – addresses the sexual and reproductive health issues of California adolescents. ASHWG develops adolescent health competencies, coordinated data tables, and content expertise on adolescent health constructs such as positive youth development.

The formation of the Preconception Health Council of California (PHCC) was founded in May 2006 by MCAH and the California Chapter of the March of Dimes (MOD). Through PHCC, MCAH partners with organizations and stakeholders across the state to provide direction for the integration of preconception care into public health and clinical practice and promote preconception health messaging for women of reproductive age. In partnership with the American Congress of Obstetricians and Gynecologists (ACOG) and MOD, the Council developed the Interconception Care Project of California, providing clinical guidance to providers on critical health issues to address in the postpartum visit for women with maternal morbidities.

Local CCS programs maintain parent liaisons through Family Voices of CA Member Agencies. These liaisons train CCS staff on family perspectives, help families access services and provide conflict resolution assistance for CCS staff and family members. Families have participated in NICU quality workgroups and hospital length of stay work groups in collaboration with CPQCC. CCS has been working on family representation on technical advisory groups but is seeking a way to offer legal protection to advisory group members.

Current State Collaboration and Coordination

MCAH and CSHCN programs have taken several steps to ensure a statewide system of services that reflect the principles of comprehensive, community-based, coordinated, family-centered care. Examples of MCAH collaborating with other state agencies include the following:

- Linkage of WIC and Birth file data to inform targeting of program services, understand prenatal WIC enrollment patterns, and profile the characteristics of WIC participants and eligible non-participants.
- MCAH, Genetic Diseases Screening Program (GDSP) and WIC collaborate with UC San Francisco to implement and disseminate the Maternal and Infant Health Assessment (MIHA) survey data to local public health partners and to inform development and implementation of statewide programs.
- The SCD and the Immunization (IZ) Branches collaborate with the Vaccines for program by providing vaccination coverage and modifications through the Child Health and Disability Prevention (CHDP) program, including: tetanus, diphtheria and acellular pertussis vaccine; FluMist; meningococcal conjugate; measles, mumps, rubella, and varicella; hepatitis A, hepatitis B, Haemophilus influenzae type B vaccine, rotavirus, influenza, human papillomavirus, and meningitis vaccines.
- California Nutrition, Physical Activity and Obesity Prevention Program/ Champions for Change, MCAH, and CMS collaborate on conference presentations.
- MCAH collaborates with the Safe and Active Communities (SAC) on injury prevention activities, including local training programs, SIDS and the Child Death Review Team (CDRT), SAFE-KIDS California Advisory

Committee, and the Strategic Coalition on Traffic Safety. MCAH Title V support data collection and prevention work of the local CDRTs.

MCAH and SCD support communities in a number of ways. For example, local MCAH programs coordinate the facilitation of enrollment into medical assistance programs, such as those available through Covered California and CCS' Early Periodic Screening and Testing program. Additionally, local programs integrate health education into their outreach and referral efforts for high-risk MCAH clients such as health fairs, forums, toll-free telephone line, and referrals regarding prenatal and child health issues, including childhood safety and injury prevention. Additionally, many urban, suburban and rural MCAH programs provide transportation for MCAH population to access prenatal care and other medical and dental services.

More intensive interventions are also available for high-risk populations through case management provided by PHNs and community outreach workers. Case managers conduct assessments; monitor infant and child development; provide health education; and provide referrals to medical, dental, nutrition, behavioral health, and social services.

LHJs provide extensive outreach and education activities in the community as described above, and as required in the local scope of work. Capacity needs related to enabling services were identified by 80% of LHJs in the areas of linking clients to health and community services and in informing and educating the public about MCH issues. Examples related to capacity needed to link clients to services include improved collaboration across agencies to overcome barriers, respond to the needs of changing populations, and increase cultural competence in outreach approaches. Examples of health education capacity needs include improved breastfeeding education, increased cultural competence of health education materials and approaches, parent education related to preventive care, and collaboration with businesses to increase penetration of health education messages into the community. A comprehensive list of collaborators is shown in Attachment 5.

Mechanism for Multiculturalism

MCAH's mechanisms to assure multiculturalism across Title V programs include 1) staff development; 2) the analysis of the national and state MCAH population health indicators, including preconception health indicators and life course metrics by self-identified race and cultural designations; 3) development and implementation of policies and programs reflective of the data.

Local programs funded with Title V dollars have scopes of work that include multicultural objectives. MCAH has led and collaborated with organizations and agencies to reduce the health disparities and ensure appropriate delivery of health services, information and health care using culturally sensitive engagement techniques.

MCAH data analyses result in the development of strategic policies and programs. For example, the disproportionate rates of infant mortality in the Black community drove MCAH to develop an intervention that is governed by Black cultural competence as one of its core values.

Another example is the MCAH adolescent health programs that are developed and implemented to address the unique cultural nuances in the Latino community which represents the majority of California's adolescents. All youth programs are tailored to support the cultural and linguistic needs of the Spanish-speaking youth

II.C. State Selected Priorities

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1	Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age	Continued	
2	Reduce infant morbidity and mortality	Continued	
3	Improve the cognitive, physical, and emotional development of all children	Continued	
4	Provide high quality care to all CYSHCN within an organized care delivery system.	Continued	
5	Increase access to CCS paneled providers such that each child has timely access to a qualified provider of medically necessary care.	Continued	
6	Increase conditions in adolescents that lead to improved adolescent health	Continued	
7	Increase access and utilization of health and social services	Continued	
8	Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.	Continued	

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

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

2016-2020 PRIORITY NEEDS	Closely related 2011-2015 PRIORITY NEEDS	New(N), Replaced (R) or Continued (C) for 2016-20

Priority 1.**Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age**	2011 Priority 4. Improve maternal health by optimizing the health and well-being of girls and women across the life course. 2011 Priority 6. Reduce maternal morbidity and mortality and the increasing disparity in maternal health outcomes. 2011 Priority 7. Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy.	C- Closely related to the 2011-2015 priority statements 4, 6 and 7; the current priority is on improving women's health in general with emphasis on primary prevention, particularly for women of reproductive age.
Priority 2. **Reduce infant morbidity and mortality**	2011 Priority 7. Reduce infant mortality and address disparities by promoting preconception health and health care and by preventing causes such as birth defects, low birth weight/prematurity, SIDS, and maternal complications in pregnancy.	C- Closely related to the 2011-2015 priority statement 7; priority need for infant health has been expanded to include strategies to address infant morbidities.
Priority 3. **Improve the cognitive, physical, and emotional development of all children**	2011 Priority 8. Support the physical, socio-emotional, and cognitive development of children, including the prevention of injuries, through the implementation of prevention, early identification and intervention strategies.	C- Closely related to the 2011-2015 priority statement 8; priority need and strategies to address this priority is carried forward for 2016-2020.
Priority 4.**Provide high quality care to all CYSHCN within an organized care delivery system**	2011 Priority 1. Modify the California Children's Services (CCS) program, with appropriate funding, to cover the whole child. 2011 Priority 3. CCS will work with appropriate partners to define and create and implement standards for Medical Homes for CCS children.	C- Closely related to the 2011-2015 priority statements 1 and 3;
Priority 5. **Increase access to CCS-paneled providers such that each child has timely access to a qualified provider of medically necessary care**	2011 Priority 2. Expand the number of qualified providers of all types in the CCS program.	C- Closely related to the 2011-2015 priority statements 2 and 3; problem need is to address access to care for CSHCN.
Priority 6. **Increase conditions in adolescents that lead to improved adolescent health**	2011 Priority 9. Promote positive youth development strategies to support the physical, mental, sexual and reproductive health of adolescents.	C- Closely related to the 2011-2015 priority statements 9; problem need to address adolescent physical, mental and sexual health is carried forward for 2016-20.
Priority 7. **Increase access and utilization of health and social services**	2011 Priority 10. Link the MCAH population to needed medical, mental, social, dental, and community services to promote equity in access to quality services.	C- Closely related to the 2011-2015 priority statement 10; strategies developed in 2011-2015 will continue through 2016-2020.

Priority 8. **Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight**	2011 Priority 5. Promote healthy nutrition and physical activity among MCAH populations throughout the lifespan beginning with exclusive breastfeeding of infants to six months of age	C- s Closely related to the 2011-2015 priority statement 5; strategies developed in 2011-2015 will continue through 2016-2020.

Local needs assessments were conducted in all 61 LHJs where input from 3,126 community stakeholders and representatives were obtained. A list of the 25 most commonly reported health issues identified in the local needs assessment was created and criteria for prioritization of these health issues were developed. The health issues were ranked and common themes were identified to define a problem need for each population domain. Ranking of the 25 health issues was done using the following criteria:

1. Relevance as it relates to state and national priority needs
   - Is the health issue reflective of the Title V national performance measure priority areas?
   - Is this a health issue with sub-optimal performance for California in the America Health Rankings?
   - Is this problem need identified in the California Governor's Let's Get Healthy California Strategic Plan?
   - Does the California Health and Safety Code mandate state health programs to address this health issue?
   - Is the health issue a focus area in the CDPH California Wellness Plan?
   - Is the health issues identified as a quality assurance focus area in the DHCS Baseline Assessment of Quality Improvement Activities?
   - Are there significant racial or socioeconomic disparities related to this health issue?

2. Ability to be addressed by existing resources and opportunities
   - Did the LHJs identify strategies/ activities in their community to address this health issue?
   - Does California's Title V programs have existing activities or strategies that will address the upstream risk factors that affect this health issue?
   - Are there Title V resources earmarked to address this health issue?
   - Is there expertise in the Title V-funded workforce that can implement and monitor evidence based interventions to address this health issue?

3. Ease in monitoring progress in addressing the health issue
   - Are there existing indicators or measures collected at the local and state level to monitor progress toward addressing this health issue?
   - Compared to national statistics, is California performing worse with regard to the health issue?
   - Is the overall trend for this health issue worsening in California?

4. Impact on the population
   - Based on current statistics, are there a lot of individuals affected by this health issue?
   - Based on scientific literature does this health issue have a profound impact on downstream health issues?
   - Based on surveys conducted, did stakeholders or the general public identify or perceive this as an emerging or unmet health issue that needs to be prioritized?

   The highest ranking health issues specific to a population domain were identified and translated into goal statements for a given population domain. Given the goals identified by population domain, an overarching

problem needs statement was stated for each population domain.

For the CSHCN Population Domain, identification of problem needs was augmented by a more in-depth needs assessment of CSHCN enrolled in CCS. A contractor was hired by SCD to conduct the CCS-focused CSHCN needs assessment. The stakeholder process began with an initial meeting at which the concepts of the needs assessment were introduced, and stakeholder subcommittees were convened to provide input on the various needs assessment tools, including key informant interviews, surveys, and focus groups. Sixteen key informant interviews were conducted representing county CCS programs, Medical Therapy Programs (MTPs), Regional Centers, specialty care physicians, primary care physicians, children's hospitals, university-based researchers, professional organizations and family advocates.

Family satisfaction, administrator, physician and provider surveys were conducted, which include topics related to access to medical care and durable medical equipment (DME), barriers to physician and DME providers participating in CCS and strategies to address the barriers, case management and the coordination of services, county variations in CCS services, conditions covered by CCS, transitioning of youth who age out of CCS, telehealth and palliative services, and access to and overall satisfaction with the CCS program. A final qualitative data source was focus groups. The focus group process was guided by a combination of subcommittee input, stakeholder coordination, and assessment of feasibility. The development and refinement of the focus group discussion guides created for each group category was informed by the findings from the key informant interviews and with input from the stakeholder subcommittees. Also primary and secondary data from NSCHCN, and CMS Net, the case management data system and provider tracking system of CCS was analyzed. Priority needs and goals were developed to address weaknesses specific to the CCS program that were identified in the needs assessment.

Quantitative and qualitative data collected for the needs assessment were analyzed and shared with stakeholders who then generated a list of 23 potential priority needs. Stakeholders used the following list of previously agreed upon criteria to rank all the priorities:

1. Does addressing the issue positively affect families, providers, and the program?
2. Does addressing the issue reduce disparities in health outcomes?
3. Does addressing the issue enhance the continuity and coordination of care?
4. Does addressing the issue increase the administrative timeliness and efficiency of providing care to CCS families to promote the quality of care and adherence to CCS standards?
5. Does addressing the issue enhance family-centered care?
6. Are there evidence-based/best practices to address the issue that will improve the health outcomes of the child enrolled in CCS?

Using the top ranked priority needs, goals were developed for SCD to address weaknesses specific to the CCS program that were identified in the needs assessment.

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

NPM 1-Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	65.3	65.3	65.3	65.3	65.3

NPM 3-Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	81.4	81.4	81.4	81.4	81.4

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	95.2	95.2	95.2	95.2	95.2

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	28.8	28.8	28.8	28.8	28.8

NPM 6-Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	29.9	29.9	29.9	29.9	29.9

NPM 9-Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14.0	14.0	14.0	14.0	14.0

NPM 11-Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	37.4	37.4	37.4	37.4	37.4

NPM 12-Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.2	39.2	39.2	39.2	39.2

NPM 15-Percent of children ages 0 through 17 who are adequately insured

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	81.9	81.9	81.9	81.9	81.9

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

For the Maternal/Women's Health domain, our goals are to decrease intimate partner violence and the burden of chronic disease in this population. NPM 1, the percent of women with a past year preventive medical ,was selected as a performance measure since clients are screened for intimate partner violence and chronic diseases in preventive visits.

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

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

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

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

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

The table shown here cross-references the 2016-2020 goals for each priority statement by population domain, their related 2016-2020 national performance measures The eight selected national performance measures are italicized and bolded in the table and the rationale for selection was included.

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

2016- 2020 State Priority Needs	**Related Goals**	**Closely Related NPM (2016-20)**	**NPM Selection Rationale**
(Domain Mother/ Women' s Health) Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age	1: Decrease unintended pregnancy		
	2: Decrease intimate partner violence	***NPM #1*** *Well-woman visit (Percent of women with a past year preventive medical visit*	NPM 1 plays a role as a sentinel health marker in the mothers/women's health domain for receipt of preventive screening for chronic disease and intimate partner violence, risk factors for adverse life course events among women of reproductive age.
	3: Decrease burden of chronic disease		
(Domain: Perinatal/ Infant Health) Priority 2: Reduce infant morbidity and mortality	1: Reduce pre-term births and infant mortality	NPM #2 Percent of cesarean deliveries among low-risk first births	
		NPM # 3 Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU	VLBW infants account for 53% of all infant deaths. NPM 3 was selected as a measure since VLBW infants are less likely to die if they are born/cared for in a sub-specialty facility that is appropriately staffed and equipped facility with a high volume of high-risk admissions.
	2: Increase breastfeeding initiation and duration	*NPM #4A Percent of infants who are ever breastfed* *NPM #4B Percent of infants breastfed*	Improvements in this performance measure is indicative California has a statewide goal to make breastfeeding the normal method of infant feeding for at least the first year of life of success in implementing strategies to achieve California's statewide goal to make breastfeeding the normal method of infant feeding for at least the first year of life.

		exclusively through 6 months	
	3: Increase safe sleep practices	NPM # 5 Percent of infants placed to sleep on their backs	
Domain: Child Health) Priority 3: Improve the cognitive, physical, and emotional development of all children, including children with special health care needs	1:Reduce unintentional injuries	NPM # 7 Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents ages 10 through 19	
	2: Reduce child abuse and neglect		
	3: Provide developmental screening for all children	*NPM #6 Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool*	NPM 6 was selected because developmental screening is designed to identify problems or delays during normal childhood development. When properly applied, screening tests for developmental or behavioral problems in preschool children allow improved outcomes due to early implementation of treatment.
(Domain: CSHCN) Priority 4: Provide a whole-child approach to services to Children with Special Health Care Needs	1. Increase systems that support CSHCN		
	2. : Increase access to Medical Homes for children with special health care needs	*NPM #11 Percent of children with and without special health care needs having a medical home*	NPM 11 was selected since one of the goals specific to CSHCN is to increase access to medical homes.
	3. Improve transition services to children with special health care needs	*NPM # 12 Percent of adolescents with and without special health care needs who received services necessary to*	NPM 12 was selected because strategies to increase systems that support CSHCN include enhanced service delivery of transition services.

		make transitions to adult health care	
Priority 5: Improve access: ensuring the right patient to the Right Place	1: Increase access to high quality care		
	2 Maintain and support regionalization of care		
	3: Improve consistency of services across the state		
(Domain: Adolescent Health) Priority 6: Increase conditions in adolescents that lead to improved adolescent health	1: To decrease teen pregnancies		
	2: To reduce teen dating violence, bullying and harassment	*NPM #9 Percent of adolescents, ages 12 through 17 years, who are bullied or bully others*	• Healthy relationships consist of trust, honesty, respect, equality, and compromise. Any violence in the form of bullying, harassment or dating violence in adolescence can negatively influence the development of healthy sexuality, intimacy and identity as a youth grows into adulthood and can increase the risk of physical injury, poor academic performance, binge drinking, suicide attempts, unhealthy sexual behaviors, substance use, negative body image and self-esteem and violence in future relationships.
(Domain: Cross-cutting/ Life Course) Priority 7 Increase access and utilization of health and social services	1: Increase access to oral health services	NPM #13A Percent of women who had a dental visit during pregnancy NPM # 13B Percent of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year	
	2: Increase access to	NPM #10 Percent of	

	preventive health services	adolescents, ages 12 through 17, with a preventive medical visit in the past year	
		NPM #15 Percent of children 0 through 17 years who are adequately insured	Having health insurance coverage is intricately linked to having access to a regular source of care and timely and less costly medical services. From a lifecourse perspective, having health insurance for children is an important investment in improving the quality of life. Maximizing a child's potential is possible if it is not hindered by an underlying medical condition or impaired by a medical emergency.
	3: Increase screening and referral for mental health and substance use services	NPM 14A. Percent of women who smoke during pregnancy	
		NPM # 14B Percent of children who live in households where someone smokes	
Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.	1: Increase consumption of a healthy diet		
	2: Increase physical activity	NPM # 8 Percent of children ages 6 through 11 years and adolescents ages 12 through 17 years who are physically active at least 60 minutes per day	

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

California will identify and establish three to five state performance measures and their performance objectives as part of the FY 2017 Application/ 2015 Annual Report and will begin submission of state performance data starting with the FY 2018 Application/ FY2016 Annual Report. Although not required, California may consider including one or more state outcome measures based on the MCH priorities established.

II.F. Five Year State Action Plan

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

The process used to develop the State 5-Year Action Plans was as follows: managers identified appropriate staff to create action plan workgroups for each priority; these workgroups reviewed the goals and priorities and developed Specific Measureable, Achievable, Realistic, Time-Related (SMART) objectives for each priority goal and identified promising or evidence-based strategies to address the objectives, and proposed activities to implement the strategies. The core Title V team members then selected appropriate performance process and outcome measures and the CDPH/MCAH and Systems of Care (SCD) leadership finalized the Action Plan proposals. Each priority area was assigned a lead of several team members consisting of program, policy and epidemiological staff. Staff were trained on the needs assessment process, identification of the priority needs, purpose of developing 5-Year Action Plans, relationship of the Action Plans to our current and future efforts and target goals, and were also provided technical assistance during the planning and writing of the Action Plans.

State Action Plan Table		
Domain: Women/ Maternal Health		
State Priority Needs	**SMART Objectives**	**Key Strategies**
Priority 1: Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age.	1. By June 30, 2020, increase the percent of Title V funded programs (i.e., AFLP, BIH and LHJs MCAH Programs) to adopt a policy to address intimate partner violence (IPV), including reproductive and sexual coercion from 40% (2013/14 MCAH Annual Reports) to 60%	i. Provide technical assistance to Title V funded programs to adopt a policy that addresses IPV and reproductive sexual coercion and incorporates quality assurance and quality improvement plans into policies
		ii. Develop a collaboration of internal and external partners to help Title V programs identify and respond to IPV and reproductive and sexual coercion using the confidentiality, universal education, and ongoing support (CUES) framework.
		iii. Develop trauma-informed programmatic practices to address vicarious trauma to staff and current victimization, and establish a specialized Employee Assistance Program to support this initiative.
		iv. Partner with Office of Health Equity, Health in all Policies Taskforce (HiAP) to develop policies and initiatives to address community risk factors for intimate partner violence.
		v. Partner with Safe and Active Communities (SAC) Branch to offer programmatic policy recommendations, training and resources to enhance the capacity of Title V funded programs in community engagement efforts to promote safe and healthy relationships to prevent domestic, sexual , and teen dating violence, including child maltreatment.
		vi. Title V-funded program staff will receive enhanced education skills, strategies and tools to support clients on the connection between violence and trauma ,self care, healthy relationships and parenting to increase resiliency.
		vii. Promote data collection and develop quality improvement tools, resources, and ongoing training related to self-care strategies and supports, reflective supervision, trauma informed programming and

		other supports for providers working with trauma.
	2. By June 30, 2020, reduce the prevalence of mistimed or unwanted pregnancy among Black and Latina women with live births from 45.4% and 38.2% (2012 MIHA) to 43.4% and 37.1% respectively.	i. Broadly disseminate the concept of a Reproductive Life Plan by developing or disseminating culturally and linguistically appropriate tools for integrating into existing MCAH programs and public health departments.
		ii. Integrate One Key Question (OKQ) into Title V program toolkits and partner programs to promote appropriate contraception counseling to match pregnancy desire and timing.
		iii. Standardize the content of the postpartum visit with the following resources: a. The Interconception Care Project of California provider algorithms b. The Before, Between and Beyond Pregnancy Clinical Guidance training modules
		iv. Partner with the Comprehensive Perinatal Services Program (CPSP), local health jurisdictions (LHJs), Women, Infants and Children Program (WIC), Text 4 Baby, Medi-Cal Managed Care and hospital partners to promote the postpartum visit during prenatal care and labor/delivery.
	3. By June 30, 2020, reduce the prevalence of hypertension, diabetes, cardiovascular disease and mental illness among women at labor and delivery from 8.0%, 10.0%, 0.54% and 4.4% (2013 OSHPD PDD) to 7.4, 9.5%, 0.51% and 3.9% respectively.	i. Partner with disease-specific organizations to target prevention outreach to women of reproductive age for cardiovascular disease, hypertension, diabetes, and chronic mental illness to ensure prevention strategies are culturally, linguistically, and age appropriate and match literacy level.
		ii. Partner with Office of Health Equity, HiAP Taskforce to develop policies and initiatives to address community risk factors for chronic disease (e.g. healthy food availability, built environment, community safety, education quality) and ensure applicability to women of reproductive age.
		iii. Disseminate standard of care tools to standardize screening and follow-up practice to ensure women with risk factors receive appropriate interconception care.
		iv. Ensure that existing MCAH tobacco prevention and data collection for smoking as a risk factor for chronic disease include appropriate references to e-cigarettes.
		v. Increase the number of non-pregnant women of reproductive age who access routine preventive health services through regular well women visits.
Domain: Perinatal/ Infant Health		
State Priority Needs	**SMART Objectives**	**Key Strategies**
Priority 2: Reduce infant morbidity and mortality.	1. By June 30, 2020, decrease the percentage of preterm births less than 37	i. Define new and existing partnerships with state and local agencies, community-based organizations, academia, provider networks and hospitals to maximize resource capacity in addressing preterm birth reduction.

	completed gestational weeks from 8.8% (2013 BSMF) to 8.3%.	ii. Develop a plan to ensure coordination of existing perinatal program efforts and avoid duplication of services.
		iii. Establish a defined collaborative relationship between local MCAH and the Regional Perinatal Programs of California (RPPC).
		iv. Integrate prematurity prevention evidence-based practices in relevant MCAH program curricula and activities with a focus on reduction of preterm births in the African-American population which is also a focus of the new California Prematurity Summit.
		v. Assist local agencies/partners in developing policies to educate pregnant women/women of reproductive age on the signs and symptoms of preterm labor
	2. By June 30, 2020, increase the percentage of women who report exclusive breastfeeding at 3 months from 26% (2012 MIHA) to 27.5%	i. Conduct research, surveillance and evaluation on breastfeeding outcomes, trends and quality of maternity care related to breastfeeding.
		ii. Encourage the utilization of culturally congruent approaches to promote breastfeeding to mothers, fathers and grandmothers
		iii. Maintain collaborations at national, state and local level to provide mother-to-mother and peer counseling and thereby minimizing the impact of formula marketing.
		iv. Provide technical support within DHCS Medi-Cal (including provisions of Affordable Care Act regarding lactation support and equipment) to develop a breastfeeding-friendly health care system that promotes continuity of care between hospitals/clinics and community services (i.e., training and technical).
		v. Support the development and dissemination of best practices for child care providers regarding feeding infants in collaboration with the California Emergency Services Authority
		vi. Provide guidance and support on California laws, policies and regulations that promote and protect breastfeeding, including the reduction of racial and ethnic disparities.
	3. By June 30, 2020, reduce the rate of Sudden Unexpected Infant Deaths (SUIDs) from 54.4 (2013 BSMF) to 50.3 per 100,000.	i. Provide the latest American Academy of Pediatrics (AAP) guidelines on infant safe sleep practices/Sudden Infant Death Syndrome (SIDS) risk reduction through two SIDS trainings each year, and the Annual SIDS Conference for SIDS coordinators, public health professionals, and emergency personnel.
		ii. Update the curriculum on infant safe sleep/SIDS risk reduction for hospital staff, health professionals and childcare provider training sessions.
		iii. Promote up-to-date safe sleep/SIDS risk reduction health education materials/messages to outreach and engage fathers regarding safe sleep strategies.
Domain: Child Health		
State Priority Needs	**SMART Objectives**	**Key Strategies**
Priority 3: Improve the cognitive,	1. By June 30, 2020, reduce motor vehicle injury hospitalizations	i. Increase cross-system collaboration and coordination with traditional and non-traditional partners such as the SAC Branch, WIC, Department of Social Services (DSS), Department of Developmental

physical, and emotional development of all children.	from 11.1 per 100,000 (2013 OSHPD PDD) to 10.6 per 100,000 for children ages 0-5 years.	Services (DDS) California Highway Patrol (CHP), California Department of Education (CDE) and Department of Transportation to develop shared policies or protocols aimed at increasing the proper use of car seats in children ages 0-5 years, including reducing disparities
		ii. Promote workforce development and training of public health professionals and staff to increase knowledge of best and promising practices in promoting proper car seat usage, including effective strategies to reduce disparities for car seat usage such as targeted bilingual car seat safety programs
		iii. Work with LHJs and stakeholders to identify and apply for funding for culturally and linguistically appropriate community education programs that promote best practice strategies for proper use of car seats.
	2. By June 30, 2020, reduce substantiated child abuse from 13.0/1000 for children 0 to 5 years of age (2013 CWDRS) to12.3 per 1000.	i. Increase cross-system collaboration and coordination with traditional and non-traditional partners such as SAC Branch, WIC, DSS, DDS, CHP, CDE to identify and implement a multi-prong approach to reduce child abuse and neglect, especially for at-risk sub-populations.
		ii. Collaborate with appropriate state agencies to identify and provide best-practices, promising practices and culturally and linguistically appropriate materials to share with local LHJs, partners, and stakeholders.
		iii. Assist Title V funded programs, the Adolescent Family Life Program (AFLP), Black Infant Health (BIH) and LHJs MCAH Programs to develop and adopt policies that aim to reduce child abuse and neglect; and to incorporate quality assurance and quality improvement plans into child abuse prevention policies.
	3. By June 30, 2020, increase the rate of children ages 10 months s to 5 years creened for being at risk for developmental, behavioral and social delay, using a parent-completed standardized developmental behavioral screening tool during a healthcare visit from 28.5 percent (2010/11 NSCH) to 29.5 percent.	i. Collaborate with partners such as California Department of Public Health (CDPH), Department of Health Care Services (DHCS) Systems of Care Division, California First Five, AAP, child health advocates, consumers, Regional Center representatives and early interventionists, Help Me Grow, Family Resource Centers and other state partners, stakeholders and community groups to improve behavioral, social, and developmental screening and linkage to needed services for all children and youth, especially for at-risk sub-populations.
		ii. Promote the use of Birth to 5: Watch Me Thrive! or other appropriate materials and support LHJs to develop protocols and pathways to refer children needing services to evidence-based screening and referral systems to ensure children and youth with special health care needs (CYSHCN) are identified early and connected to needed and ongoing services
		iii. Assist LHJs MCAH Programs to develop and adopt policies to provide developmental screening, referral and appropriate linkages for all children and youth in MCAH Programs using a parent completed screening tool or other validated tool; provide technical assistance to incorporate quality assurance and quality improvement plans into

		policies and tools.
		iv. Support LHJs to establish networks and connections among MCAH clinical service programs, primary care providers, Federally Qualified Health Centers, Rural Health Clinics, CCS, CHDP, community clinics, and other pediatric providers to support developmental screening at or in close connection with healthcare providers.
Domain: Children and Youth with Special Health Care Needs (CYSHCN)		
State Priority Needs	**SMART Objectives**	**Key Strategies**
Priority 4: To provide high quality care to all CYSHCN within an organized care delivery system	1. By June 30, 2020, increase the children in CCS who receive primary and specialty care through a single system of care by 20%	i. Through the California Children's Services (CCS) Redesign stakeholder process, refine the selected whole child approach to optimize access to qualified providers.
		ii. Develop ability to track organization of care in CMS Net, the CCS case management system.
		iii. Conduct surveys of CCS families and providers to assess satisfaction with organized care delivery system.
	2. By June 30, 2020, increase the number of CCS clients who receive coordinated ongoing comprehensive care within a family centered medical home by 20%, as measured by the NationalSurvey of Children's Heath.	i. With CCS redesign stakeholder workgroup, review existing national, state and local medical home models and tools and identify best method(s) for CCS to promote medical homes for CSHCN.
		ii. Explore integration of ACA health home concept with the medical home concept.
		iii. Develop and disseminate materials to facilitate medical home implementation of tools that promote medical homes, including medical home binders and medical home standards.
		iv. Identify the number of counties with family advisory council, parent health liaison, family centered care workgroup or other role supporting CSHCN including CCS.
		v. Develop and implement policies to increase the number of counties with individual or workgroup serving in an advisory capacity to CCS.
	3. By June 30, 2020, increase by 20% the number of 20 year old CCS clients with selected conditions* who report having an identified adult subspecialist to assume specialty care. *congenital heart disease, cystic fibrosis, respiratory failure, T1 DM, hemophilia, ALL, sickle cell disease, cerebral palsy, s/p organ transplant	i. Explore current CCS transition practices including transition fair, parent liaisons, et. al. and RSAB transition workgroup findings.
		ii. Increase parent liaisons providing input into local transition practices
		iii. With RSAB workgroup, review options for CCS clients to have a visit with adult physician through managed care.

State Priority Needs	SMART Objectives	Key Strategies
	4. By June 30, 2020, increase the rate of CYSHCN who had a preventive medical visit in the last year from 88.8% (2010/11 NSCH) to 93.2 percent.	i. Participate in collaboratives or activities with relevant and applicable partners to increase access to a yearly preventive medical visit for CYSHCN
		ii. Promote workforce development to improve knowledge regarding the needs of CYSHCN, using resources such as the California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health, Help Me Grow, Children Now, Lucille Packard Foundation for Children's Health and the California Map to Inclusion & Belonging, and Birth to Five: Watch Me Thrive.
		iii. Work with state partners and other relevant partners to develop strategies and promising practices to connect CYSHCN to a yearly preventive medical visit and needed treatment or additional services
		iv. Work with State partners to identify solutions to lack of qualified treatment providers.
		v. Support State and local efforts by providing technical assistance, information, education, and resources related to CYSHCN.
		vi. Identify and participate in existing collaboratives, councils and advisory boards to improve services for CYSHCN.
Priority 5: to increase access to CCS paneled providers such that each child has timely access to a qualified provider of medically necessary care.	1. By June 30, 2020, increase the percent of CCS families reporting that their child always saw a specialist when needed from 72% to 90%, based on CCS/FHOP survey	i. With RSAB, explore strategies to increase access to CCS paneled providers, with focus on rural areas, including streamlining process and developing reports of shortage areas.
		ii. Based on the findings of the Title V needs assessment, define issues associated with non-participation in CCS of DME, pharmacy, home health and behavioral health providers, and explore methods to increase their participation in CCS.
		iii. Review the criteria for providers to be CCS paneled with the goal of increasing numbers of paneled providers while maintaining quality standards.
	2. By June 30, 2020,100% of CCS counties will report on client use of telehealth services	i. Develop a system within CMS Net to track use of telehealth services for CCS clients.
		ii. Establish CCS telehealth workgroup with stakeholders including families, to build upon previous work assisting DHCS in telehealth implementation
		iii. Develop a telehealth survey of CCS providers.
		iv. Promote telehealth use through CCS provider and Special Care Center trainings on telehealth including e-consultation, consistent with the triple aim, CCS Redesign, and CCS infrastructure.
Domain: Adolescent Health		
State Priority Needs	**SMART Objectives**	**Key Strategies**
Priority 6:	1. By June 30, 2020,	i. Target all MCAH adolescent sexual health programs to high need

Increase conditions in adolescents that lead to improved adolescent health	decrease the adolescent birth rate from 23.2 per 1000 teens, 15-19 years of age (2013 BSMF) to 19.8 per 1000.	and/or historically underserved populations to reduce disparities.
		ii. Implement evidence-based, community-informed interventions in all MCAH funded adolescent sexual health programs aimed at educating adolescents on preventing pregnancy and sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV).
		iii. Educate adolescents in all MCAH funded adolescent sexual health programs regarding the use of long-acting reversible contraceptives (LARCs), condoms and other birth control methods.
		iv. Provide adolescents participating in MCAH funded adolescent sexual health programs information on reproductive health services that are affordable, accessible, confidential, and youth-friendly.
		v. Identify gaps in the availability of youth-friendly reproductive health services on an ongoing basis.
		vi. Develop and implement youth-informed programs to empower parents and caregivers with skills and knowledge to strengthen effective communication with adolescents regarding sexual health.
		vii. Develop tools and standards to incorporate Positive Youth Development (PYD) principles, resiliency framework and training on healthy coping skills in program implementation and materials.
	2. By June 30, 2020, increase the rate of AFLP clients enrolled in school from 77.6 percent (2015 AFLP MIS) to 81.5 percent.	i. Develop policies for the AFLP grantees to incorporate the PYD/Resiliency framework into programs that serve adolescents
		ii. Train state and local staff on the principles of PYD, resiliency and healthy coping skills for adolescents.
		iii. Develop surveillance strategies to measure resiliency in adolescents.
		iv.Develop and implement training and technical assistance for state and local partners to standardize and integrate PYD principles and strategies into the program..
Domain: Cross-cutting/ Life Course		
State Priority Needs	**SMART Objectives**	**Key Strategies**
Priority 7: Increase access and utilization of health and social services.	1. By June 30, 2020, decrease the rate of Medi-Cal eligible women and children who are uninsured from 8.3% and 36.5% (2011/12 CHIS) to 7.9% and 34.7%, respectively.	i. Collaborate with LHJs to provide appropriate client outreach materials and resources to promote Medi-Cal enrollment for eligible families and establish a baseline number of families/clients to be assisted.
		ii. Ensure that LHJ staff inform all eligible and enrolled clients of current available dental benefits offered by Medi-Cal.
		iii. Ensure that LHJ staff assists enrolled clients to find Medi-Cal dental homes by using the Medi-Cal warm transfer service through 1-800 customer service phone number or other referral services.
	2. By June 30, 2020, increase the rate of	i. Develop an oversight protocol for LHJs to ensure all persons referred for insurance enrollment complete an appointment.

	women of reproductive age with appropriate preventive care, including: i) Increase the rate of preventive visits from 61.9% (2013 BRFSS) to 65.3%. ii) Increase the rate of first trimester prenatal care initiation from 83.6% (2013 BSMF) to 87.9%. iii) Increase the rate of postpartum visits from 88.3% (2012 MIHA) to 92.9%.	ii. Partner with DHCS and Health Benefit Exchange to explain and market no-cost preventive services to newly enrolled women of reproductive age, including early entry into prenatal care.
		iii. Provide technical assistance to LHJs regarding development of adequate community referral resource networks to help perinatal providers address barriers to early entry into prenatal care.
		iv. Finalize development and pilot test the IRIS (Internal, Reproductive, Integrative, Skin) designation for preventive care visits for young women's health care (a clinician training program to increase utilization of preventive health services by young women, especially low income).
		v. Partner with CPSP, LHJs, WIC, Text 4 Baby and hospital partners to schedule and discuss the importance of the postpartum visit during prenatal care and/or labor/delivery.
	3. By June 30, 2020, increase the rate of children, ages 0 to 17 years, attending one or more preventive visits in the last 12 months from 80.6% (2012 NSCH) to 84.6%.	i. Develop an oversight protocol for LHJs to ensure all persons referred for insurance enrollment complete an appointment.
		ii. Integrate preventive care concepts for children and adolescents into MCAH program curricula to educate parents, including importance of administering immunizations according to the recommended schedule.
	4. By June 30, 2020, increase the rate of women with pre-pregnancy health insurance from 75.3% (2012 MIHA) to 79.5% and the number of children and adolescents (age 0-17) with health insurance from 74.4% (2012 NSCH) to 78.2%	i. Develop an oversight protocol for LHJs to ensure Title V MCAH program participants are referred to Medi-Cal and receive follow-up on enrollment
		ii. Develop a protocol for all MCAH partners to refer eligible clients for health insurance enrollment in Covered California.
		iii. Develop an oversight protocol for LHJs to ensure eligible Title V MCAH program participants are referred to WIC for ancillary services.
		iv. Partner with the California Health Benefit Exchange Board—an independent public entity within state government—to provide input on regulations that impact insurance enrollment and referral for women of reproductive age and their dependents.
	5. By June 30, 2020, decrease the rate of postpartum women without health insurance from 16.7 percent (2012 MIHA) to 16.2 percent	i. Develop an oversight protocol for LHJs to ensure all Title V MCAH program participants enrolled in Medi-Cal prenatally receive counseling on postpartum insurance continuation.
	6. By June 30, 2020,	i. Provide training on grief/bereavement support services to public

	100% of parents/caregivers experiencing a sudden and unexpected infant death or an infant death due to an unsafe sleep environment will receive grief/bereavement support services (MCAH Annual Report).	health professionals who respond to sudden unexpected infant deaths to public health professionals and emergency personnel.
		ii. LHJs contact families who experience a sudden unexpected infant death from which a referral was received from the local coroner's office to provide grief/bereavement support.
		iii. Contact local coroner offices to remind and encourage referral of parents of all babies who die suddenly and unexpectedly regardless of circumstances of death.
		iv. Make grief/bereavement support materials and peer support organizations available on the State CDPH, MCAH and California SIDS Program websites.
	7. By June 30, 2020, decrease the rate of mental health and substance use hospitalizations for persons age 15-24 from 1436 per 100,000 and 1754 per 100,000, to 1318 per 100,000 and 1570 per 100,000, respectively.	i. Increase cross-system collaboration and coordination with traditional and non-traditional partners, such as the Department of Justice (DOJ), DOE, Department of Transportation (DOT), DSS, DDS, DHCS, County Behavioral Health Directors Association of California (CBHDA), the Mental Health Services Act (MHSA), Covered California, the Office of Statewide Health Planning and Development, Medi-Cal, the American Congress of Obstetricians and Gynecologists (ACOG), AAP, First 5, providers, consumers, faith-based organizations, non-governmental organizations, and persons who have overcome mental health/substance use challenges and their families to provide mental health and substance use consultation support for staff and to facilitate service provision for clients.
		ii. Partner with the California Home Visiting Program (CHVP), Early Childhood Comprehensive Systems (EECS), and the CHVP State Interagency Team (SIT) Workgroup to identify and address service gaps in mental health for families and young children.
		iii. Assist LHJs to develop culturally and linguistically appropriate policies and protocols to reduce discrimination, disparities, and stigmatization in the workplace, schools, community, and among health and social service providers.
		iv. Provide technical assistance to LHJs to implement a strength-based approach to improving mental health and reducing discrimination and disparities.
		v. Develop and implement screening and brief intervention policies that require all Title V-funded programs and initiatives to screen participating women and adolescents to determine if they are at risk for mental health and substance use disorders and refer, link, and provide a brief intervention to those who screen positive.
		vi. Provide workforce development training opportunities for clinicians, teachers, caregivers, and MCAH staff on: - Screening initiatives such as free Screening, Brief intervention, Referral to Treatment (SBIRT), and substance use screening - Early childhood mental health (for example, using California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health) - Infant mental health

		- Social and emotional development strategies - Trauma-informed practice
	8. By June 30, 2020, increase the rate of children ages 3-11 years, with a dental visit in the last year from 75.3 percent (2011/12 NSCH) to 79.1 percent.	i. Under the guidance of the CDPH Oral Health Director, MCAH and Chronic Disease and Injury Control Division will collaborate together to develop the State's oral health plan to identify priorities, goals, objectives and key strategies.
Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and physically active lifestyle.	1. By June 30, 2020, reduce obesity among reproductive age women from 22% (2013 BRFSS) to 20.7%	i. Conduct research and evaluation on maternal weight status and dietary intake including assessment of trends and disparities.
		ii. Interface with the Office of Health Equity, Health in all Policies Task Force and the California Department of Education Nutrition Services Division to support efforts, e.g. better food in workplaces and early childhood education centers as well as schools.
		iii. Support clinicians in implementing weight assessments, counseling and referrals for all women and children according to clinical practice guidelines for obesity prevention, including provisions of the Affordable Care Act.
		iv. Develop and disseminate easy-to-understand information and tools to help women meet the Dietary Guidelines for Americans (e.g. MyPlate).
		v. Promote the MCAH systems and environmental change toolkit for increasing optimum nutrition and physical activity within the MCAH population.
	2. By June 30, 2020, increase the percent of women with recommended weight gain during pregnancy from 34.3% (2013 BSMF) to 36.1%.	i. Develop and disseminate culturally responsive approaches to promote the Institute of Medicine (IOM) guidelines for optimum pre-pregnancy weight and maternal weight gain in MCAH programs (e.g. AFLP, BIH, California Diabetes and Pregnancy Program (CDAPP), CPSP, health care clinics, WIC).
		ii. Develop and disseminate resources to promote a healthy weight of a mother before and during her pregnancy –including in adolescence.
	3. By June 30, 2020, reduce overweight/ obesity among low-income children (ages 2 to 5) from 32.7% (2011 PedNSS) to 31.4%.	i. MCAH and WIC will develop a consistent measure of overweight and obesity among low-income children.
		ii CHDP provides training to providers on pediatric overweight and obesity and use of the Body Mass Index (BMI) and appropriate nutrition and physical activity counseling recommendations.
	4. By June 30, 2020, increase the percentage of women who took a vitamin containing folic acid every day of the week during the month before pregnancy from 34% (2012 MIHA) to 35.9%.	i. Continue to provide , messaging and guidelines to MCAH programs and contacts.

	5. By June 30, 2020, increase the rate of meeting the age-specific guidelines for physical activity from 30.4%, 16.2% (2011-12 CHIS) and 24% (2013 BRFSS) to 31.9%, 17% and 25.3% for children ages 6-11, adolescents 12-17, and women ages 18-44 respectively.	i. Conduct research and evaluation on maternal, child and adolescent physical activity practices, trends, and racial –ethnic disparities.
		ii. State MCAH will promote implementation of the "Physical Activity Guidelines for Americans" by incorporating into MCAH Program guidelines and providing resources to local health jurisdictions MCAH Directors or leadership.
		iii. Promote the utilization of culturally congruent approaches to promote physical activity within early care organizations, schools, and state and local agencies.
		iv. Utilizing community engagement, promote and facilitate access to safe, accessible, and affordable places that support an active lifestyle for maternal, child and adolescents in particular, in underserved areas. (e.g., Systems and Environmental Change Toolkit).
		v. Maintain and expand collaborations with National, State and local stakeholders to promote physical activity (including CDE, WIC, the Nutrition, Education and Obesity Prevention Branch, Caltrans, HiAP and Indian Health Program).

Women/Maternal Health

Women/Maternal Health - Plan for the Application Year

The relevant goals for this population domain are to decrease unintended pregnancy with an equity focus on Black and Latina women, to decrease the burden of chronic disease among women of reproductive age, and to decrease intimate partner violence (IPV). While maternal smoking, binge drinking and birth spacing are not explicitly stated as SMART objectives, they are relevant intermediate targets for the new priority and goals; MCAH will continue monitoring and reporting on these measures.

For the first year of these new five-year goals, MCAH will carry out some developmental activities to lay the groundwork for these goals. For the first year MCAH will work with LHJs to identify what protocols are in place to address IPV and select a staff stress management protocol to implement in all LHJs by the end of the period. For a more upstream preventive approach to IPV, MCAH will implement a protocol to screen program clients for known risk factors for IPV perpetration or victimization through partnerships with the CDPH Safe and Active Communities Program.

Because of the twofold gap in mistimed and unwanted pregnancy among Black and Latina women in California, several activities have been identified to address this health inequity. In the first year, MCAH will review its Reproductive Life Planning tools for cultural and linguistic appropriateness. MCAH will disseminate the approved tools and work to develop additional tools to fill existing gaps. As a more upstream approach, the Preconception Health Council of California (PHCC) will receive training on One Key Question from Oregon Department of Public Health and develop a plan to integrate and evaluate its implementation statewide. As a first step to addressing the disparate rates of postpartum visit attendance, MCAH will work with MMCD to identify an evaluation plan for efforts and then meet with identified partners to determine opportunities for coordination of the postpartum visit message. To ensure providers have adequate education regarding interconception health and birth spacing, an online module with continuing medical education credits is being developed for self-paced instruction to coincide with the Interconception Care Project of California. The module will include instructions for developing a follow-up plan for women with lifestyle or behavioral issues identified in pregnancy that pose a risk to their health and subsequent pregnancies.

Hypertension, diabetes, and cardiovascular disease are increasing among childbirth hospitalizations; data for mental illness is less reliable, but the prevalence is substantial. Given the burden of chronic disease, MCAH will undertake several activities to address the prevalence and increase the data infrastructure for public health surveillance of chronic disease. In the first year, MCAH will partner with chronic disease to identify and compare population-based methods for measuring chronic disease among pregnant women and non-pregnant women of reproductive age. This will be a first step to developing capacity for ongoing surveillance of both groups. MCAH will also begin exploring the ways it can account for the new onset of e-cigarettes in its outreach materials and surveillance mechanisms). At the legislative level, MCAH will collaborate with the California Tobacco Control Program (CTCP) to monitor their new local laws and ordinances database. MCAH will explore opportunities to examine smoking trends in relationship to changes in local legislation.

MCAH will strengthen its ability to address social determinants of health by partnering with the Office of Health Equity, Health in All Policies Taskforce. This taskforce includes members of diverse non-health related government branches that collaborate on initiatives to promote health. Community risk factors for intimate partner violence are poverty, overcrowding, low social capital, mass incarceration, and recidivism; community risk factors for chronic disease are healthy food availability, built environment, community safety, and education quality. Starting in Year 1, MCAH will attend taskforce meetings to provide insight in project development that will addresses the unique identified needs of the MCAH population.

Women/Maternal Health - Annual Report

NPM 1 - Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	65.3	65.3	65.3	65.3	65.3

- Maternal Smoking
  In 2013, 2.5 percent of women aged 15 years and older who had a recent live birth reported smoking in the last trimester of pregnancy. In 2013, African American and White women had the highest prevalence of smoking in the last trimester of pregnancy (5.5 and 4.4 percent, respectively) compared to Latina (1.4 percent) women. Less than 1% of Asian/Pacific Islander women reported smoking in the third trimester. Reported smoking declined in each of these groups since 2008, with the exception of Latina women, whose prevalence did not substantially change.

  LHJs continued smoking cessation activities, including outreach, education, referrals, data collection, and data analysis. Similarly, AFLP/other teen programs, BIH, and CPSP continued activities to promote smoking cessation and as necessary, update health education and training materials.

  PHCC continued to provide information, tools and resources, including the preconception and interconception guidelines, to local communities focusing on the importance of achieving optimal health before pregnancy. Messages emphasize refraining from tobacco use and avoiding relapse triggers.

  CTCP supported the Smokers' Helpline as well as other projects that facilitate community norm change and support local tobacco control efforts. The PHCC is a primary partner for the Medi-Cal smoking cessation program and Smokers' Helpline and distributed the new promotional materials highlighting the free nicotine patch incentive offer, the new Helpline web-based referral system, and recommended outreach ideas for health

care providers.

MCAH continued efforts to prevent and reduce tobacco use by pregnant women and women of reproductive age, with a special emphasis on efforts to prevent postpartum smoking relapse in conjunction with SIDS prevention efforts. Coordination with existing programs and initiatives, such as those developed nationally by the CDC and statewide and locally via CTCP, and SIDS prevention efforts can also be explored.

The Medi-Cal expansion and Covered California health exchange enrollment continued to expand the number of Californians with health insurance coverage. This expanded coverage includes preventive services without cost sharing, including smoking cessation for adults, with expanded counseling for pregnant women.

At the January 2014 Association of Maternal and Child Health Programs Conference, MCHB announced that the Collaborative Improvement and Innovation Network (CoIIN) to reduce infant mortality and improve birth outcomes will be implemented in all regions by the end of 2014. One of the state-identified priorities is increasing smoking cessation among pregnant women; California however decided to choose other priorities because of the low statewide smoking rate. One of those strategies, social determinants of health, will address some of the upstream factors that are community risk factors for smoking and smoke exposure.

- Binge Drinking
  In 2013, 14.7 percent of mothers with a recent live birth reported binge drinking during the three months prior to pregnancy. In recent years, binge drinking has fluctuated, reaching a high of 15 percent in 2010 and a low of 13.1 percent in 2011. This prevalence differed by racial and ethnic group. White women (20.7%) were most likely to binge drink during the three months prior to pregnancy, followed by Hispanic (14.3%), Black (14.1%) and Asian/Pacific Islander women (5.2%).

  LHJs continued 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 developed and implemented coordinated and integrated systems of care to address perinatal substance use prevention. MCAH participated in the FASD Task Force and continued its efforts on preconception health education and promotion, including augmenting and monitoring its preconception health website.

  MCAH continued ongoing quality improvement and education efforts to learn about emerging best practices for reducing binge drinking. Because California has unique alcohol consumption patterns arising from the popularity and cultural significance of locally produced wine, MCAH continued to explore ways to find culturally appropriate strategies to reduce heavy consumption patterns and prevent illegal consumption by minors by engaging the newly acquired Teen Prevention Programs (TPP), Intervention and Education (I&E) and the California Personal Responsibility Education Program (CA PREP), and strengthening their ability to include substance abuse prevention as a teen pregnancy prevention strategy.

- Birth Spacing
  In 2013, 11.9 percent of women whose live birth occurred less than 24 months after a prior birth, decreased slightly from 12.0% in 2012. Of the four race/ethnic groups with the largest birthing population in 2013, African American women were most likely to have a live birth less than 24 months after a prior birth (13.7%), followed by Hispanics (12.2%), Whites (11.9%) and Asians (9.7%).

  MCAH strengthened and expanded its interconception and reproductive life planning initiatives toward the aim of ensuring adequate birth spacing and reducing repeat teen births. Adolescent programs performed

continuous quality improvement of their life planning tools to ensure they were sufficient to address repeat births to teens. Programs that target pregnant women provided up-to-date messaging about birth spacing and overall preconception/interconception health.

CHVP continued to promote appropriate pregnancy spacing with contraceptive education, counseling, and referral to clinical services beginning in the final trimester of pregnancy and extending throughout the postpartum period.

The California Family Health Council continued its implementation efforts to expand its reproductive life planning demonstration project to all clients of Title X-funded clinics by 2015.

MCAH will continue to educate at-risk groups about contraception and birth spacing and will explore the best strategies to effectively engage younger and electronically-inclined populations, empowering them to make healthy reproductive decisions. The social media toolkit will be pilot tested and revised for full-scale implementation.
PHCC pursued a pilot project to provide preconception education at the time of a negative pregnancy test and to pilot test an in-store pharmacy promotion in Sonoma County in conjunction with the California Pharmacists Association. Despite a promising development, this project was not selected by First Response and received pushback from provider groups. It was later abandoned due to lack of political will.

MCAH continued to share national resources, including the preconception campaign materials developed by the CDC and Preconception Peer Educators materials provided by the federal Office of Minority Health.

MCAH publicized the preconception and the Interconception Care Project of California (ICPC) guidelines as clinical tools available to providers who connect with women of reproductive age, either in their well-women visit or postpartum visit (for women who just had a baby). These clinical visits are critical opportunities to help women prevent or delay pregnancy until they are ready.

- Maternal Mortality

With the release of 2010-2013 maternal mortality data, California has seen a sustained decline in maternal mortality since 2008. The maternal mortality rate in 2013 was 7.3 deaths per 100,000 live births, which represents a reduction of 57% from the peak in 2006 when the rate was 16.9 deaths per 100,000 live births. While California's maternal mortality rate has been rapidly descending, the U.S. maternal mortality rate has been rising dramatically to a rate of 22.0 deaths per 100,000 live births in 2013; three times California's rate.

Possible explanations for the decline in California Maternal Mortality rates are:
1) Improved attention to the issue of maternal mortality by public health officials and maternity care providers;
2) Shifts in late postpartum deaths being seen as due to a chronic disease (i.e., cardiovascular disease) are playing a more prominent role in maternal deaths.
CA-PAMR found cardiovascular disease to be the leading cause of death in California from 2002-2007 and similar trends have been reported by the Centers for Disease Control through 2010.

Perinatal/Infant Health

Perinatal/Infant Health - Plan for the Application Year

CPSP provides opportunities to local MCAH to build collaborative partnerships with different agencies to educate

staff and refer clinical high-risk pregnant women to appropriate resources; staff education on addressing non-compliant diabetics and appropriate clinical referrals to specialty clinics; identify evidence-based tools for screening and interventions shared with providers, or partner agencies, and partnering with non-profit organizations such as faith-based organizations and schools to help identify vulnerable maternal populations needing health care access and services. Local MCAH's partnership with local Medi-Cal Managed Care Health Plans allowed shared activities and goals through a workable and functional Memorandum of Understanding (MOU). DHCS, MMCD, requires local Medical Managed Care Health Plans (MMCHP) to enter into an MOU agreement with local MCAH regarding maternal and infant health. This policy helped develop, define and facilitate improved partnerships between local public health and the medical health care system to improve perinatal and infant care. For example, Sonoma and Shasta Counties participate in quality assurance activities with their local health plans. As a result, there is better care coordination and access to organized resources.

MCAH continues to collaborate with MMCD in providing training and resources. For example, MMCD presented at the 2014 Perinatal Services Coordinators' annual meeting on how LHJs can partner with the local health plans to impact early prenatal care and timely postpartum visits. MCAH plans to present in the quarterly statewide meeting of local health plans about the different services offered by MCAH and strategize on how to strengthen and make an established MOU functional and effective.

BIH is implementing a standardized curriculum in July 2015. This will facilitate program evaluation and measurement of program outcomes. AFLP will gradually incorporate Positive Youth Development in all AFLP counties. The Regional Perinatal Programs of California (RPPC) continues to work closely with the California Maternal Quality Care Collaborative (CMQCC) and CPQCC to disseminate quality improvement toolkits and resources to improve maternal and neonatal care.

MCAH and SCD continue to collaborate with MOD and the Association of State Health Officers (ASTHO) on the Healthy Babies Challenge/Prematurity Campaign. The MCAH Scope of Work for LHJs continues to include prematurity prevention specific objectives.

Perinatal/Infant Health - Annual Report

NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	81.4	81.4	81.4	81.4	81.4

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	95.2	95.2	95.2	95.2	95.2

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	28.8	28.8	28.8	28.8	28.8

MCAH monitors best practices in the LHJs and shares these statewide to improve performance. LHJs continue to monitor access to early prenatal care, , conduct targeted outreach to women of childbearing age and pregnant women, provide appropriate linkages and streamline processes for presumptive eligibility to increase access to early prenatal care for pregnant women. LHJs continue to offer the toll-free line and web information to MCAH populations.

CPSP, AFLP, and BIH continue to provide case management services and linkages to medical care for their target populations and educate clients regarding the importance of receiving early prenatal care for future pregnancies.

Local CPSP coordinators continue provider recruitment and work with providers to improve pre/interconception education during the preconception and postpartum periods. MCAH and LHJs undertake these activities to ensure the availability and effectiveness of CPSP services and to achieve improvements in first trimester entry into prenatal care. MCAH is working on improving data on beneficiaries, paid claims, birth outcomes, and hospital discharge to develop baseline data on the efficacy of CPSP services. MCAH continues to work closely with MMCD to improve the timeliness and quality of obstetric services for Medi-Cal-eligible pregnant women.

AFLP continues to implement the Positive Youth Development component into existing services. BIH continues 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.

RPPC and the California Perinatal Transport System (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.

SCD and CPQCC continue to respond to member questions, analyze data for CCS-approved NICUs, and address outliers and concerns about quality of care. RPPC, with the Office of Vital Record (OVR), continue to present Birth Data Trainings emphasizing collaboration among administration, nurses and birth clerks to obtain and accurately report birth data. RPPC Directors continue to explore opportunities for nursing staff to work with birth clerks on enhanced birth data reporting in continuing efforts to improve data quality.

Los Angeles County (LAC) maintains its Partnership to Eliminate Disparities in Infant Mortality Action Learning Collaborative (ALC) website to provide information on resources and best practices relating to infant mortality and undoing racism. With its multidisciplinary local partners, LAC 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. The ALC plans to hold more health disparities training workshops for healthcare providers.

RPPC, CMQCC and CPQCC continue to provide technical assistance to hospitals and LHJs who wish to use the Elimination of Non-Medically Indicated (Elective) Deliveries <39 Weeks Gestation Toolkit, as well as the other maternal and neonatal quality improvement toolkits and resources developed by these collaboratives.

MCAH participates in the ASTHO Healthy Babies Challenge, which aims to prevent premature births and reduce infant mortality. In partnership with MOD, ASTHO challenged states to reduce their percent of premature births by 8%

by 2014, using 2009 data as baseline. The percent of premature births in California was 10.4% in 2009, decreasing to 9.6% in 2012, thus achieving the target 2014 goal in 2012. This accomplishment earned California the “A” grade in the MOD 2013 Premature Birth Report Card. California received the MOD Franklin Delano Roosevelt Prematurity Campaign Leadership Award for achieving the premature birth rate of 9.6%, which is the MOD 2020 goal, on March 19, 2014. In addition, California was also awarded the MOD Virginia Apgar Prematurity Campaign Leadership Award on March 17, 2015, for achieving the 8% decline in premature birth rates.

Child Health

Child Health - Plan for the Application Year

MCAH will develop shared policies or protocols with relevant State and Local Agencies to incorporate evidence-based interventions proven to prevent unintentional injuries in children ages 0-14 into existing activities. In order to meet this objective, MCAH plans to implement the following strategies for the next five years:
1. Increase cross-system collaboration and coordination with traditional and non-traditional to develop shared policies or protocols
2. Promote workforce development and training to improve knowledge of unintentional injury prevention strategies;
3. Provide technical assistance (TA) to LHJs to integrate best-practices, promising practices and culturally and linguistically appropriate prevention strategies in local MCAH programs and activities;
4. provide support to increase awareness of unintentional injuries among children, such as motor vehicle injuries, drowning, car seat use, texting while driving, into MCAH programs and activities; and
5. Identify a QA process to measure progress. MCAH will continue to engage local MCAH and share effective experiences that can be applied in other local agencies. MCAH will support individualized interventions based on the needs of the population, taking into consideration the community’s strengths, resources and cultural factors.

MCAH strongly supports trauma- informed care, derived from the Adverse Childhood Experiences study. MCAH will develop shared policies or protocols with relevant State and Local Agencies to reduce child abuse and neglect. Proposed strategies for the next 5 years include but are not limited to the following:
a. Increase cross-system collaboration and coordination with traditional and non-traditional partners to identify and implement a multi-prong approach to reduce child abuse and neglect, especially for at-risk sub-populations;
b. Identify and provide best-practices, promising practices and culturally and linguistically appropriate materials to share with local LHJs, partners, and stakeholders;
c. Identify and participate in the implementation of a social marketing or community awareness campaign or encourage LHJs to implement an awareness campaign to improve the well-being of families/caregivers of children in order to reduce child abuse and neglect

MCAH will continue its efforts to communicate with local partners’ new state initiatives and community practices performed by other agencies that are found to be effective and perceived to be favorable within the community.

Other updated MCAH activities to promote children’s health include the following:
1. Promote and develop a plan to support the MCAH Directors in promoting physical activity;
2. Develop poster and brief on maternal weight and incorporate the effect it has on the life course for offspring;
3. Collaborate with the California Women, Infants and Children Program (WIC) to develop a consistent measure of overweight and obesity among low-income children; and
4. Continue to promote Systems and Environmental Change approaches as noted in the related MCAH online toolkit.

Child Health - Annual Report

NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	29.9	29.9	29.9	29.9	29.9

For Fiscal Year, 2013-2014, majority of the local MCAH activities related to children's health included reduction in unintentional injuries, reduction of child abuse and neglect, increase in immunization rates and promotion of physical activity to prevent obesity.

In 2013, the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes was 1.4 per 100,000, showing no change from the rate in 2012. Local MCAH activities addressing injury-related mortality and morbidity in children revolves around public awareness and education on appropriate car seat installation and application. Local MCAH staff performs education via return demonstration with families and provides discounted car seat vouchers following appropriate and safe demonstration and installation of car seats. Other local MCAH have coordinated with local agency partners to perform safe children car seat installation.

There have been numerous active outreach initiatives regarding safe and correct car seat installation. Examples of outreach activities performed include conducting car seat demonstrations in highly publicized child safety seat checkup to promote correct usage at community events, such as parks, shopping centers, car dealers, preschools, or open houses at police or fire departments. San Benito County promoted safe car seat installation through the use of fliers, emails, postings and announcements through their partnership with the Child Injury Prevention Coalition.

Other educational topics presented by local MCAH to the community to reduce unintentional injuries included the following: Safe to Sleep, Poisoning/Poison Control, Home Safety, Age appropriate safety education, water/bathing safety, heat stroke/not leaving child in hot car, electrical outlet safety, leaving baby on bed and texting while driving.

Other LHJs have integrated injury prevention awareness and education within the local HVPs using visual toolboxes, pictures and graphics to identify hazards within the child's environment and educate the family on how to minimize and prevent accidents.

Majority of LHJs worked with their community-based organizations to promote outreach and increase community awareness on abuse and neglect. Based on the 2013-2014 LHJ Annual Reports, fifteen LHJs participated in a collaborative that coordinated and promoted activities and community awareness regarding prevention of child abuse and maltreatment. For instance, Yolo County worked with the Child Abuse Prevention Council to align messaging and review patient education materials to increase child abuse awareness. In Ventura County, PHNs provided comprehensive bio-psychosocial assessments, education and linkage to community resources through home visitation. Covered topics included health and wellness, parenting, child development, pregnancy, and postpartum care.

MCAH supports current local initiatives regarding informing community partners on trauma-informed care, such as Adverse Childhood Experiences and practices and screenings, to recognize, prevent and heal the debilitating effects of violence to the health and quality of life of a family.

The 2013 immunization rates increased from 73.5% in 2012 to 81.9% in 2013. Local MCAH's activities related to increasing immunizations include community education and outreach to child care facilities, immunization clinics, school-based health clinics, and local advisory groups. Engagement with community partners occur during shared participation in different community events such as different immunization months for toddlers, health and dental fairs, flu campaign or designated vaccination week for targeted recipients. For example, Alameda County reached Medi-Cal eligible families through the Family Justice Immunization Clinic. In addition, education was also provided via phone calls that involved approximately 780 calls every year. This activity became an opportunity for Alameda to

refer callers to care as appropriate. El Dorado County worked directly with parents and school nurses and educated them on recommended immunization schedule and safety of vaccines. In addition, discussions were also conducted to address barriers to timely immunization. In Sierra County, immunization ads were placed in their biweekly newspaper.
The percent of uninsured children in California was 15.7% in 2000 and has steadily declined since then. In 2012, 10.2% of children were uninsured. The percent of children with no insurance has significantly dropped to a low of 8.0% in 2013. Effective January 1, 2014, ACA expanded dental benefits to new eligible children based on FPL. Children 1-6 years of age from families with 0-133 per cent FPL receive full scope Denti-Cal. Children, 1-6 years of age from undocumented families with FPL 0-133 per cent, receive emergency Denti-Cal coverage. Infants 0-1 year of age from family with 0-200% FPL receive full scope Dent-Cal. Infants 0-1 year of age from undocumented family with FPL 0-200 per cent receive emergency Denti-Cal coverage.

Several LHJs are proactive in promoting community awareness and linking Medi-Cal eligible families, including children to dental care. In addition, partnerships have been created with the school system, Rural Health Care Centers and Federally Qualified Health Centers regarding educating parents on the importance of healthy eating, tooth decay prevention for children, proper gum care for babies until the first tooth arrives, early detection of child hood carries, and establishing a dental home. San Joaquin County has coordinated round table discussions with providers regarding the importance of dental care. Alameda County continues to implement a dental care service program, where children and families receive anticipatory guidance, screening assessments, fluoride applications and case management assistance to a dental home at selected WIC sites. This dental initiative was also offered at the Native American Health Center. In addition, Alameda County has organized school-based/school-linked dental programs emphasizing prevention (including fluoride varnish, sealants, outreach and case management services, as appropriate, to obtain insurance assistance and access to a dental home) that served low income, (Medi-Cal eligible and/or enrolled) racially and ethnically diverse students. Small rural counties identified the lack of dental providers who serve Medi-Cal clients. In addition, transportation has also been a barrier in accessing dental services.

MCAH provided education on healthy lifestyle, proper diet and nutrition, and reduction of childhood obesity. Obese children and adolescents are defined to be those who are overweight and whose Body Mass Index is at or above the 85th percentile. MCAH provided input into the nutrition curriculum and supportive on-line tools for the Preventive Health and Safety Practices (PHSP) training for licensed childcare facilities. Effective January 2016, those receiving licenses (or their designees) are required to take the training. The training will include the following topics:
1. Healthy nutrition on the developing child and on the overall health of children ages 12 and younger;
2. Basic information about California's Healthy Beverages in Child Care Law (AB 2084);
3. Best practices for feeding infants and toddlers including breast milk, iron fortified formula, and introducing first foods;
4. Age-appropriate healthy foods that are based on current Dietary Guidelines for Americans;
5. How to cut back on foods high in solid fats, added sugars, and salt;
6. Using food labels to assist make healthy choices; and
7. Best Practices for Building Healthy Eating Habits in Children, including the division of responsibility.

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

Modoc County conducted 184 presentations with nutrition messages to preschool and school age children. The

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

Adolescent Health

Adolescent Health - Plan for the Application Year

Thirteen AFLP sites have been identified to undergo a federal evaluation funded by the Office of Adolescent Health to build evidence for AFLP PYD. MCAH launched the revised PYD intervention with select sites, which was informed by the formative evaluation in fiscal year 2014 described above.

Adolescent Health - Annual Report

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14	14	14	14	14

MCAH continue to monitor grantees in 30 California counties with the highest teen births. MCAH provides the infrastructure to support program implementation across all their adolescent health programs including training, technical assistance, and systems development for data collection, monitoring and evaluation.

MCAH continues to fund and monitor AFLP. The number of AFLP sites has declined from the original 41 in 2009, down to 32 in 2013, and now 31 in 2014. MCAH worked to complete the formative evaluation of the AFLP Positive Youth Development (PYD) to revise the standardized intervention that is based on PYD principles integrated with life planning. Intervention tools were translated into Spanish, piloted and evaluated to ensure linguistic, cultural and developmental appropriateness.

Children with Special Health Care Needs

Children with Special Health Care Needs - Plan for the Application Year

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

One of the identified priorities for the next five years for this population is to improve the cognitive, physical, and

emotional development of all children, including CSHCN and to improve the systems that support CSHCN. The following strategies are among those proposed:
1) identify and establish collaborations with other state partners, stakeholders and other community groups to increase the practice of social-emotional and developmental monitoring and screening and linkages to needed services for all children, especially at-risk populations;
2) develop shared policies with state partners to increase alignment among systems and practices to increase rates of culturally and linguistically appropriate social-emotional and developmental screening, referral, and linkages;
3) promote the use of Birth to 5: Watch Me Thrive materials, and support LHJs to develop protocols and pathways to refer children needing services to local evidence-based screening and referral systems, including using a parent completed screening tool, to ensure CSHCN are identified early and connected to needed services; and
4) support LHJs to establish networks and connections among MCAH programs, primary care providers, Federally Qualified Health Centers, Rural Health Clinics, CCS, Child Health and Disability Prevention Programs, community clinics, and other pediatric providers to support developmental monitoring and screening at or in close connection with healthcare providers.

Other priority efforts involve improving services for youth with special health care needs (YSHCN) as they transition to adult services, including adult health care, work and independence. Proposed strategies include identifying gaps and barriers in existing services for YSHCN transitioning to adult services, partnering with relevant agencies and working with CCS to improve local coordination between CCS and MCAH and assisting to develop processes and resources for YSHCN that ensure continuity of medical care, continued skill building, and access to other community supports.

With regard to the Bridge to Reform Section of the 1115 Waiver to have all care for CCS clients organized within one system, a second demonstration project is expected to be implemented in Fiscal Year (FY) 2015-16 as an Accountable Care Organization Model with Rady Children's Hospital-San Diego (RCHSD). DHCS developed and is currently preparing to administer a family satisfaction phone survey to assess the families' knowledge and satisfaction with the demonstration, knowledge and satisfaction with their care coordinator, access and satisfaction with providers, satisfaction with the medical services provided, and to establish a baseline of information to compare against future surveys. In addition, DHCS will conduct site visits to the demonstration project (DP) sites to identify "lessons learned and best practices" and explore the successful components as well as the challenges San Mateo County and HPSM encountered in the first year of the demonstration model.

Children with Special Health Care Needs - Annual Report

NPM 11 - Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	37.4	37.4	37.4	37.4	37.4

NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.2	39.2	39.2	39.2	39.2

MCAH supports LHJs by providing training for program development, implementation, evaluation, and quality improvement to LHJs as they implement activities and programs to identify and serve CSHCN, particularly those children not served by California Children's Services (CCS). For example, Contra Costa County provided developmental screening for all infants (n=71) in their Prenatal Care Guidance home visiting program and the 4 infants identified with positive screens were further assessed and referred to treatment. Kern County

MCAH staff participate in the Medically Vulnerable Care Coordination Partnership project. The goal of the project is to utilize coordinated services to measurably improve outcomes for Kern County infants and children, 0–5 years, at risk of costly, lifelong medical and developmental issues. Kern County reported that 91.7% of identified infants discharged from the Neonatal Intensive Care Unit and no longer eligible for CCS were referred to and enrolled in Medi-Cal. San Joaquin County screens all children in families participating in case management for developmental delays and refers children who screen positive for further assessment; 272 children received a comprehensive screen and seven children were referred for additional assessment. In Alpine County, MCAH collaborated with First 5 of CA, Choices for Children, Behavioral Health Services, and Live Violence Free to provide weekly "Nurturing Parenting" discussions and child play groups for young children and their caregivers. The City of Pasadena provided professional development on infant health and teen parent interconception health to a local high school staff serving pregnant and parenting teens. There were 93 attendees and 79% indicated they will incorporate what they learned into their daily work. Several other LHJs are providing information or education, developmental screening and referral services and participating on collaboratives to identify and serve CSHCN, with a focus on non-CCS children and youth with special health care needs.

Additional child health-related initiatives performed by local MCAH included provider education and awareness on the use of developmental screening tools to detect early signs of developmental delays for children. Some local MCAH programs have also partnered with school systems, child care centers and child advocate agencies, "Early Head Start", and "Help Me Grow" to increase awareness of normal child development, identify gaps, detect developmental concerns, and appropriately refer for treatments or interventions. Several HVPs monitored by the local MCAH Directors are using evidence-based screening tools to screen such as the Ages and Stages Questionnaire (ASQ) and ASQ Social-Emotional.

In an effort to improve outreach, identification of and services for CSHCN, especially non-CCS eligible children, MCAH conducted a survey of MCAH Directors at the 61 LHJs. This was a requirement for the State 2016-2020 Title V Needs Assessment and all of the LHJs participated. The survey examined the status of current programs and services for CSHCN. A summary of the results are below.

For CSHCN, results of September 2013 survey completed by local MCAH indicated that the majority of LHJs link or refer CSHCN to needed services (n=58). Fourteen local MCAH Directors are also the local CCS Director. Of those who do not have this dual role, many local MCAH Directors oversee their local CCS program. Only two LHJs reported not having a local CCS program.

LHJs reported that MCAH partnered with local organizations that provided services to CSHCN. Local partners include the California Children's Services County Office (n=55), Head Start (n=54), Family Resource Centers (n=52), Regional Centers (Department of Developmental Services) (n=50), Local Educational Agencies (n=50), and Early

Start (n=47). Other reported partners were Federal Qualified Health Clinics (FQHCs), hospitals, school nurses, First 5 Initiative, and the Nurse Family Partnership Program.

Thirty percent of LHJs (n=14) reported that the local MCAH program provides support for youth with special healthcare needs during transition from CCS to adult services. Fourteen of the LHJs that do not provide transition services explained that this function is performed by the local CCS.

The results suggest that most LHJs have a mechanism in place for two-way communication between health care providers and case managers. Among the LHJs with existing case management programs (CMPs) or home visiting programs (HVPs), the majority (n=35) receive referrals from the local health care providers that screen and identify CSHCN. The majority of LHJs (n=30) also reported that the CMPs and HVPs outreach to inform healthcare providers of available services for CSHCN.

Forty two LHJs identified the need for improved coordination between CCS offices and the MCAH program at the local level. Two functional needs were most commonly identified: a mechanism for the local MCAH Program to better inform local health care providers of its existing services for CSHCN and a referral mechanism whereby providers refer patients to these programs. Although the need for improved coordination was reported frequently, most respondents rated the existing level of coordination as moderate to high.

SCD continues to focus on modifying the CCS program, with appropriate funding, to cover the whole child. This priority was a key factor in developing models for the CSHCN portion of the 1115 Waiver of 2010–2015. One of these demonstrations to implement the CCS Program's portion of the Waiver began April 2013 in San Mateo County with an existing MCO: Health Plan of San Mateo. The goal was to have all care for the CCS Program client organized within one system.

- CCS Program Redesign

  A stakeholder advisory board composed of individuals from various organizations and backgrounds with expertise in both the CCS Program and care for CYSHCN was created. DHCS, together with the stakeholder advisory board, led a stakeholder process. The goals of the process include maintaining a patient and family-centered approach, provide comprehensive treatment for the whole child, improve care coordination through an organized delivery system, improve quality, streamline care delivery, and maintain cost neutrality.

  CCS efforts to better organize care also include the Pediatric Palliative Care Waiver (PPCW), which provides intensive care coordination for CCS clients under 21 years of age with life threatening conditions. An independent evaluation of the PPCW found that the program was effective in improving quality of life for clients and families and significantly cost-saving.
  The Children's Hospice and Palliative Care Coalition which supports pediatric palliative care in California, including PPCW, convenes an annual meeting with CCS participating counties, PPCW providers, referring providers and family members to examine program successes and opportunities for improvement. Services, family satisfaction, claims, adherence to policy including time to services and provider qualifications are monitored by SCD periodically. Pediatric palliative care and CCS Program staff and agencies receive program training from the state PPCW team. The PPCW efforts align with National Performance Measure (NPM) #5, as care coordination allows clients and families in the program to use community-based service systems more easily.

  To expand the number of qualified providers of all types in the CCS program, CCS improved the provider

paneling process, developing systems to receive and process provider applications electronically.

CCS updated and modernized the facility site review process, which has resulted in an increased number of site visits to Hospitals, Pediatric Intensive Care Units (PICUs), Neonatal Intensive Care Units (NICUs), and Special Care Centers (SCCs) by state CCS staff. Several standards were re-written and are being used in the site visits. Site visits include questions about transition to adulthood. Site visit tools based on CCS Program standards and facility type have also been developed. Currently, there are approximately 12-15 CCS Program site visits conducted per year and since 2012, 51 new facilities (Hospitals, NICUs, PICUs and SCCs) have been approved and 23 facilities (Hospitals, NICUs, PICUs and SCCs) have been recertified. The goal of the visits is to increase access to high quality care by providing constructive guidance to centers to improve the quality of specialty care by following the CCS Program standards.

Improvements in the CCS Program align with National Outcome Measure (NOM) 17.3, Percent of CSHCN receiving care in a well-functioning system.

DHCS is currently submitting to Centers for Medicare and Medicaid Services (CMS) a proposed revised waiver which would increase available services and provider types. To facilitate the expansion including increase in provider participation, the SCD is working with partners to simplify and improve the payment process.

The PPCW Program is scheduled to expand to seven additional counties in FY 2015-16, and continues to work closely with stakeholders.

- Telehealth

  This Program most closely aligns with NPM #3, medical home and NPM #5, systems organized so that clients can use them easily.

  On January 6, 2014 the SCD released CCS Numbered Letter 14-1214, Telehealth Services for CCS and GHPP Programs, which informed local CCS programs and providers of the telehealth advancement act of 2010. Subsequently, an additional release about telehealth code updates of the CCS Program's "This Computes!" #446, Telehealth Codes and Modifiers, was released as well as a series of Frequently Asked Questions about telehealth and CCS and GHPP programs. In addition to these policy updates, SCD staff communicate regularly with stakeholders about telehealth policy and billing issues that affect local CCS programs, providers, and clients.

Cross-Cutting/Life Course

Cross-Cutting/Life Course - Plan for the Application Year

- Mental Health and Substance Abuse:
  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. The Federal Office of Minority Health established an Advisory Board to Preconception Peer Educators at California Community Colleges and Universities and will partner with LHJs

and local organizations to plan campus and community outreach campaigns and events to promote harm reduction strategies to reduce preconception alcohol exposure and prenatal alcohol exposure. These outreach strategies will include social media.

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

- Oral Health:
  MCAH is not renewing its contract with UCSF School of Dentistry for a dental hygienist to serve as the MCAH Oral Health Policy Consultant. However, CDPH will have a new State Dental Director and an oral health epidemiologist to be associated with the Oral Health Unit (OHU). It is anticipated that MCAH will collaborate with OHU and the State Dental Director on oral health issues and future projects. A collaborative agreement to fund a position with Chronic Disease and Injury Control's Oral Health Unit and Dental Director is currently in process. MCAH will be working collaboratively with the new Dental Director on the State's Oral Health Plan with an emphasis on improving the oral health of pregnant women and young children. which aligns with Health People 2020 objectives? For example, with the assistance of MCAH, A Burden of Oral Disease Report is being prepared by OHU for release in 2015 to identify populations within the state at the greatest risk for preventable dental diseases. This report will raise awareness of specific statewide needs and provide a foundation for a state oral health plan, which will guide efforts to prevent and treat oral diseases.

  MCAH is collaborating with DHCS to develop a State Action Plan to address two national Medicaid goals for oral health improvement in children. The first goal is to increase by 10 percentage points the proportion of children enrolled in Medicaid that receive a preventive dental service, over a 5-year period. The second goal is to increase by 10 percentage points the proportion of children ages six to nine enrolled in Medicaid that receive a dental sealant on a permanent molar tooth. Proposed activities include working with local CHDP programs to identify and assist children in need of dental services; increasing the number of school-based programs providing sealants; aiding FQHCs in reporting dental services; encouraging Head Start and WIC programs to bill for fluoride varnish applications; and allowing registered dental hygienists (RDHs) to become Denti-Cal billing providers.

  AB 1174 was passed to expand Medi-Cal reimbursements to tele-dentistry services in 2015. The bill emulates the Virtual Dental Home pilot project at the University of the Pacific's School of Dentistry. Under the program, RDHs in alternative practice, RDHs working in public health programs and registered dental assistants can keep people healthy in underserved community settings by providing education, preventive care, interim therapeutic restorations triage, and case management. Radiographs, dental charts, and pictures are transmitted to collaborating dentists who diagnose and prescribe all treatment. After a consultation, these allied dental professionals perform certain services without a dentist's supervision, such as applying temporary fillings. The law also calls for dental assistants and hygienists wishing to perform these duties to complete approved training programs

  In addition to the embedded pediatric dental plans mentioned earlier, the Board of the CA Health Benefit Exchange has decided to offer in 2016 optional stand-alone family dental plans, which includes dental coverage for adults.

- Breastfeeding, Nutrition and Physical Activity:
  The overall emphasis for the breastfeeding, nutrition, and physical activity plans for the next year is to target racial and ethnic disparities. Rather than targeting all women, the goal is to tailor limited resources to address persistent health inequity.
  Planned strategies and activities related to breastfeeding promotion include:

1. Provide technical assistance for increasing the number of labor and delivery facilities that provide recommended care for lactating mothers and their babies.
2. Support RPPC as quality improvement experts for hospital breastfeeding policies.
3. Provide technical assistance for increasing the number of community health clinics that provide professional and peer support for breastfeeding.
4. Provide technical input for planning the 2016 Breastfeeding Summit.
5. Convene a workgroup to collaborate on increasing workplace lactation accommodation for low wage earners
6. Advocate for improved lactation accommodation for CDPH employees.
7. Revise the current Model Hospital Breastfeeding Policies.
8. Continue to encourage and enquire within DHCS to develop guidance on lactation services that support the ACA. If MCAH participates on a DHCS committee to address breastfeeding, MCAH will enquire about involving the Office of the Patient Advocate.
9. Promote International Board Certified Lactation Consultant services to be available when needed within the HVP.
10. Complete a set of statewide recommendations and supportive documents that protect, promote, and support breastfeeding and safe infant/child feeding across the preparedness and response continuum.
11. Maintain the Local Breastfeeding Coordinators roster and distribute resources to assist them in completing their jobs.
12. Maintain the CDPH breastfeeding web page (including the Birth and Beyond California page)
13. Develop and distribute an annual letter with breastfeeding initiation data and resources to labor and delivery hospitals.
14. Continue to coordinate breastfeeding interventions
15. Meet with state WIC, Genetic Disease Screening Program (GDSP), SCD and HiAP quarterly to coordinate nutrition, breastfeeding and physical activity activities.
16. Ensure MCAH Program Breastfeeding guidelines and educational materials, resources and assessment forms exist and are utilized by CDAPP: Sweet Success, CPSP, AFLP, and BIH.
17. Support DHCS in including medical nutrition therapy in its benefits packages.

Planned strategies and activities related to nutrition promotion include the following:

1. Explore mechanism to monitor fruit and vegetable consumption for MCAH target populations.
2. Maintain list serve and provide support and technical assistance to perinatal nutritionists working with MCAH programs.
3. Ensure MCAH Program Nutrition and weight gain guidelines and educational materials, resources and assessment forms exist and are utilized by CDAPP: Sweet Success, CPSP, AFLP, and BIH.
4. Maintain the MCAH Nutrition and Physical Activity (NUPA) web page
5. Develop and disseminate resources to promote a healthy weight of a mother before and during her pregnancy
6. Promote a Systems and Environmental Change approach for increasing optimum nutrition and physical activity within the MCAH population.
7. Maintain quarterly meetings to coordinate with WIC, GDSP, Systems of Care for consistent MCAH related nutrition messaging (also includes breastfeeding and physical activity)
8. Develop and disseminate resources to promote daily preconception intake of 400mcg folic acid.

Planned strategies and activities related to physical activity promotion include the following:

1. Promote walking as an easy, low impact, frequently available option for physical activity
2. Promote a "Systems and Environmental Change" approach for increasing physical activity
3. Provide technical support for LHJs in working on Pedestrian Safety and Walkability
4. Coordinate physical activity promotion activities with the CDPH Physical Activity Collaboration Team.
5. Ensure MCAH Program physical activity guidelines and educational materials, resources and assessment forms exist and are utilized by CDAPP: Sweet Success, CPSP, AFLP, and BIH.
6. Maintain the MCAH NUPA web
7. Through collaboration with external partners, promote pedestrian safety and walkability strategies.
8. Maintain quarterly meetings to coordinate with WIC, GDSP, SCD and HiAP for consistent MCAH related nutrition messaging (also includes breastfeeding and physical activity)

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

  In the next year, two trainings should be planned—for the Adolescent Health Work Group Conference and another statewide or national conference. In preparation to implement additional strategies in the coming years, MCAH will develop a work plan with the California Health Benefit Exchange Board, CPSP, WIC, and Text 4 Baby to develop a plan to promote health insurance enrollment and timely utilization.

Cross-Cutting/Life Course - Annual Report

NPM 15 - Percent of children ages 0 through 17 who are adequately insured

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	81.9	81.9	81.9	81.9	81.9

Substance Abuse Prevention:
MCAH's efforts related to substance use prevention are conducted through partnerships and collaboration, by activities conducted in the local health jurisdictions and MCAH programs, such as BIH and AFLP.

Many MCAH LHJs have identified substance use, particularly perinatal substance use, prevention as a priority need. Many are working to develop coordinated and integrated systems of care to address issues of perinatal substance use. They have engaged in activities to improve community mobilization and capacity building, and are working with providers to implement screening, referral and linkage to appropriate treatment programs. Community-based prevention programs such as AFLP, BIH and CPSP identify at-risk mothers and refer them for treatment services. LHJs continue to develop and strengthen coalitions with public/private agencies and providers to assess women at

risk and develop appropriate referrals to resources including the statewide FASD Taskforce. MCAH works to improve birth outcomes for women at risk for alcohol abuse through screening and referral for treatment services.

MCAH representatives participate in the FASD Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. MCAH also participates in the State Interagency Team FASD workgroup, composed of members from the MCAH, Department of Social Services, California Department of Education, Department of Developmental Services and Arc of California acting as lead. The goal of the workgroup is to identify interagency and systems issues that provides potential opportunities for prevention/intervention of FASD.

MCAH staff collaborated with Centers for Disease Control and Prevention (CDC) to develop 7 proposed Healthy People 2020 measures that combined data from the Pregnancy Risk Assessment Monitoring System and the Maternal Infant Health Assessment Survey (MIHA) to allow tracking of key MCAH indicators, including infant sleep position, substance use and weight gain during pregnancy, postpartum smoking, and preconception/interconception care, many of which are otherwise unavailable from other data sources, and will represent approximately 85% of all births in the United States. MIHA data from 2013 are the first year to reflect these changes.

MCAH staff members participate in and provide expertise to the California Behavioral Risk Factor Surveillance System Workgroup which is composed of many, cross-sectored partners such as the Department of Health Care Services Substance Use Disorders Prevention, Treatment, and Recovery Services Division, CDPH Women, Infants and Children program, CDPH Office of Health Equity, and the CDC.

Mental Health:

MHSA funding is dedicated to statewide suicide prevention programs which are currently being implemented by Cal MHSA. MCAH continued to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer clients at risk for mental health disorders 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 abuse, 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.

DHCS administers grants to local programs under MHSA. Local programs provide direct services.

MCAH programs address mental health needs and access to mental health services as part of a comprehensive approach to health. MCAH acknowledges that there has been a push to screen women for depression, both during pregnancy and the postpartum period. For this reason, our programs deliver enhanced services that include nutrition, psychosocial and health education, in addition to standard obstetrical services. Many of our direct service programs (i.e., CHVP, AFLP & BIH) use the validated Edinburgh Postnatal Depression Scale (EPDS) to identify women with postpartum depression. Although the EPDS is typically used at a single time point to identify women with probable depression, many of our programs are now using the EPDS to routinely screen pregnant and postpartum women. Women with high EPDS scores are referred to a mental health provider for further evaluation.

More specifically, AFLP is a case management-based program that offers services to pregnant and/or parenting youth throughout 30 California counties and 32 local agency sites. The program addresses the mental health needs of its pregnant and/or parenting youth through several screening tools. Upon entering the program, participants complete the Comprehensive Baseline Assessment (CBA). The CBA asks six questions designed to alert case

managers to immediate mental health issues. Following the CBA, program participants complete one of the following depression screenings: Patient Health Questionnaire (PHQ-9); PHQ-9 Modified for teens; or the Edinburgh Postnatal Depression Scale screening tool. AFLP also screens for substance use using CRAFFT, a six-question behavioral health screening tool recommended by the American Academy of Pediatrics' Committee on Substance Abuse for use with adolescents. Case managers will refer clients with mental health needs to the appropriate community resources available in the county, based on the results of their screening. Many local health jurisdictions address perinatal mood and anxiety disorders, including screening and linkage to appropriate services as part of their priorities.

For the 2002-2007 period, there were 51 reported suicides among women while pregnant or within one year postpartum. Preliminary estimates suggest these deaths represent 4.8% of all pregnancy-associated deaths and a rate of 1.5 suicide deaths per 100,000 live births. PAMR's current goals are to assess the magnitude of suicides, determine whether rates of suicide are higher among pregnant or recent postpartum women compared to women in the same age bracket, describe the mental health profile of the women, describe timing of suicide in relation to the pregnancy, and identify any warning signs that may have been amenable to intervention. PAMR identifies the deaths from suicides reported on the death certificate and also screen deaths reported as drug overdose and homicides to look for potential suicides. To date, PAMR has collected death certificates, linkage to birth or fetal loss, Coroner, Medical Examiner

Oral Health:

Dental care is the most prevalent unmet health care need of children; the condition of children's teeth in California was ranked the third worst in the country. In 2012, the percent of children with a preventive dental visit in the last year was 54.3% for ages 1-5, 87.6% for ages 6 – 11 and 81.3% for ages 12 – 17. The percent of children, six to nine years of age who are eligible for Early and Periodic Screening, Diagnostic and Treatment for 90 continuous days receiving a dental sealant on a permanent molar tooth dropped from 16.4% in federal fiscal year (FFY) 2012 to 10.9% in FFY 2013.

Preschools and K-12 schools in CA are considering permitting oral health professionals to bring preventive and treatment services on-site. MCAH and OHU collaborated with CA Department of Education to create a webpage with information and guidance on mobile dental facilities for school administrators when entering into contracts with private dental vendors. The webpage contains links to policy issues, guidelines, laws, insurance enrollment information and additional resources.

During 2013-14, about 45% of LHJs actively provided education, screenings, referrals and limited dental services for children and pregnant women. LHJs also relied on collaboration with local oral health coalitions to bring outreach programs and preventive services to MCAH target populations.

Beginning May 1, 2014, partial dental benefits were restored to Medi-Cal beneficiaries age 21 and older including examinations, radiographs, dental cleanings, complete dentures, restorations, limited crowns and anterior root canals. Then in October, 2014, pregnant beneficiaries, regardless of age, aid code, and/or scope of benefits, will be eligible to receive all dental procedures listed in the Dental-Cal Manual of Criteria that are covered by the Medi-Cal program so long as all procedure requirements and criteria are met.

In 2013, the percent of non-pregnant women aged 18-44 who had a dental visit in the past year was 64.5%. In 2012, 42.1% of all women with a live birth reported receiving dental care during pregnancy, a 25% increase since 2002 (33.8%).

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. In addition, the oral health policy consultant has encouraged public health nurses within LHJs to promote and apply fluoride applications for children aged 1-5 years. One area of interest is the pediatric dental benefits offered by CA Health Benefit Exchange under the ACA. Dental benefits for children younger than 19 years are embedded into all medical plans offered by Covered CA for 2015.

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

OHU collaborated with MCAH to provide a one-time funding opportunity for oral health activities at the local level. The funding, $450,000, was provided by the Preventive Health and Health Services Block Grant to OHU and was allocated to 10 counties. Completed oral health activities fall under the following goals: design a comprehensive, integrated approach to meet local oral health needs; strengthen a community fluoridation program; prevention of dental caries through local targeted early intervention; promote perinatal dental care and programs among pregnant women; promote oral health messages among targeted population, such as WIC centers and preschools.

Obesity:
In 2013, the prevalence of obesity in this population was 22.0%, up slightly from 21.6% in 2012.
Black (34.1%) and Hispanic (27.4%) women were more likely to be obese than White (16.8%) women.

MCAH will continue to collaborate with state programs and agencies, experts and local MCAH directors to reduce overweight and obesity among women of childbearing age. MCAH programs will offer counseling, such as guidance on dietary intake and physical activity, which is tailored to client circumstances/stage of change.

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 continued to inform women of the importance of conceiving at a normal BMI as part of the preconception initiative, encourage women to limit their weight gain during pregnancy based on the revised IOM guidelines, and make the most current resources on pregnancy weight gain available on the MCAH website.

MCAH helps to maximize use by women of Affordable Care Act provisions for well-woman care and obesity screening/counseling for all adults by partnering with Covered California and Medi-Cal. MCAH publicized resources that support healthy weight to healthcare providers and public health professionals and encourage their use during well-woman and prenatal care. Among these resources are the Interconception Module and the clinical toolkit on the Before, Between and Beyond website.

Breastfeeding:
In 2013, 65.4% of mothers reported that they were still breastfeeding their infants at three months post-partum.
African American (48.2%) and Hispanic (60.6%) mothers were less likely than White (74.2%) and Asian/PI (69.8%) mothers to breastfeed their infants at three months of age.

MCAH maintained its lead with 59 Baby-Friendly certified hospitals in the U.S. MCAH is providing resources on the CDPH web page to implement CA Health & Safety Code SS123366, the Hospital Infant Feeding Act and SS123367 (2013) which requires all general acute care hospitals and special hospitals that have a perinatal unit shall adopt the "Ten Steps to Successful Breastfeeding," by 2025 per the Baby-Friendly Hospital Initiative, or an alternate process adopted by a health care service plan that includes evidenced-based policies and practices and targeted outcomes, or the CA Model Hospital Policy Recommendations.
MCAH collaborated with the Office of Emergency Preparedness to develop an infant feeding policy with recommended tools that focus on keeping the mother-infant dyad together and supporting breastfeeding as the preferred and safest infant feeding method.

MCAH attended and supported conferences/meetings such as the Hospital Breastfeeding Summit, and Childhood Obesity Conferences and continues to have a representative on the U.S. Breastfeeding Committee and the Association of State Public Health Nutritionists. MCH Nutrition Council which address breastfeeding strategies. The MCAH representative participates in the following USBC workgroups: Emergency Preparedness, Media/Public Relations and the Reduce Infant Formula Marketing. MCAH collaborates on promoting breastfeeding within CDPH via a Center for Family Health Nutrition Coordination Workgroup and the Obesity Prevention Group.

LHJs have developed 5-year Action Plans to promote breastfeeding with activities that include developing a lactation accommodation plan that addresses current national and state laws; adopting practices that support the exclusive initiation of breastfeeding within labor and delivery facilities as per state law; adopting practices that support breastfeeding within health centers; expanding breastfeeding support within MCAH programs and including breastfeeding support within emergency preparedness plans

SCD provided specialized assistance in support of the quality improvement project to increase breastfeeding rates among CSHCN.

Insurance:
The percent of uninsured children in California was 15.7% in 2000 and has steadily declined since then. In 2012, 10.2% of children were uninsured. The percent of children with no insurance has significantly dropped to a low of 8.0% in 2013.

California conducted outreach and education to encourage and facilitate enrollment in Covered California, Medi-Cal and other health insurance. Each year Covered California and state and local partners continue to enroll eligible residents into Covered California health plans or refer to Medi-Cal to complete the enrollment process.

Local MCAH programs continue to provide outreach and referrals to health insurance coverage for pregnant women, infants, and families and provide supportive activities to ensure continuous access to recommended health care services. These activities include identification of high risk populations, targeted outreach, case finding and care coordination for women, children and adolescents who are not linked to a source of care. Other high risk groups targeted are 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. SCD analyzes CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.

Appropriate Care Facility Deliveries:
NPM 17, the percent of Very Low Birth Weight < 1500 grams (VLBW) infants delivered at facilities for high-risk deliveries and neonates, was 79.8% in 2013. This was an increase from the 77.5% in 2012, yet still short of the Healthy People 2020 objective of 83.7%. There is some variation by race/ethnicity in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. In 2013, American Indians had the lowest percentage of VLBW deliveries at NICU facilities at 72.0. Pacific Islanders had the highest percentage (86.4), followed by Asians (83.4), African Americans (79.9), Hispanic (79.4), and Whites (77.8).

RPPC and CPeTS continued 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.

SCD and CPQCC responded to member questions, analyzed data for SCD-approved NICUs, and address outliers and concerns about quality of care. RPPC, with OVR, will continue to present Birth Data Trainings emphasizing collaboration among administration, nurses, and birth clerks to obtain and accurately report birth data. 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.

Other Programmatic Activities

MCAH is participating in the Infant Mortality CoIIN, a national initiative that emerged as a response to needs identified by the states of the U.S. Health and Human Services (HHS) Regions IV and VI at their Infant Mortality Summit in January of 2012. The CoIIN spread to HHS Region V in 2013 and has since expanded to the rest of the nation. The lead organizations are the Maternal and Child Health Bureau of the Health Resources and Services Administration and the National Institute for Children's Health Quality. Organizations providing support and technical assistance include the Association of State and Territorial Health Officials, Association of Maternal and Child Health Programs, and MOD. On July 21-25, 2014, the National Expansion Infant Mortality Summits for HHS Regions VII-X (California belongs to Region IX) and HHS Regions I-III were held at Arlington, VA.

On June 14, 2012, HHS Secretary Kathleen Sebelius announced the creation of the nation's first ever national strategy to reduce infant mortality. The Infant Mortality CoIIN expansion is a key component of this strategy. This multiyear national initiative ending in September 2016 engages federal, state, and local leaders, public and private agencies, professionals and communities to employ quality improvement, innovation, and collaborative learning to address infant mortality reduction. Participants of CoIIN learn from national experts and one another, share best practices and lessons learned, and track progress toward shared benchmarks. CoIIN has technology-enabled teams that tackle a common problem. The originator of the term describes a CoIIN as a "cyber team of self-motivated people with a collective vision that innovatively collaborate by sharing ideas, information, and work enabled by technology".
The IM CoIIN has six topical National Learning Networks, namely, Safe Sleep, Smoking Cessation, Social Determinants of Health (SDOH), Pre/Interconception Care, Preterm/Early Term Births, and Risk Appropriate Perinatal Care. States choose up to 3 topics to address during the 18-month timeline for IM CoIIN efforts. California is addressing Safe Sleep, Risk Appropriate Perinatal Care, and SDOH. MCAH is the CoIIN lead. Members of the state team include MCAH staff, and representatives from partner organizations, including MCAH Action, MOD, CMQCC, CPQCC, and Best Babies Zone.

For Safe Sleep, MCAH has developed an Intervention Protocol that will be implemented in two pilot BIH intervention sites located in counties that have the highest disparities in African American: White Sudden Unexpected Infant Death rates among all LHJs. Implementation of the protocol will coincide with the implementation of the

standardized BIH curriculum which will begin in July 2015.

For Risk Appropriate Perinatal Care, MCAH plans to form a task force comprised of representatives from CPQCC, CMQCC, RPPC, CPSP, MOD, SCD, MCAH Action, and other relevant partners/stakeholders to implement an environmental scan of CCS-approved neonatal intensive care units to assess the status of Regional Cooperative Agreements with CCS/SCD. The proposed task force will also work on developing educational materials (e.g. an infographic) on neonatal and maternal levels of care to properly inform healthcare providers and hospital staff.

The SDOH Learning Network has just completed its Learning Session. Participating states are working on developing strategies that will fit the 18-month timeline of CoIIN efforts.
CHVP SIT Workgroup's purpose is to improve the quality, efficiency, and effectiveness of home visiting through interagency collaboration. Focus areas include: program implementation; training and technical assistance; continuous quality improvement; interagency efforts to improve referrals; interagency coordination and data sharing; and collaboration with other early childhood sectors at the state and local levels. In addition to CHVP staff leads, the SIT Workgroup consist of the following stakeholder members:

DSS, Office of Child Abuse and Prevention
CDE, Child Development Division and Special Education Division
DDS, Early Start Program
First Five California
California Head Start Collaboration Office
DHCS, Substance Use Disorder Prevention, Treatment and Recovery Division
DHCS, American Indian Infant Health Initiative
DHCS Systems of Care Division (representing Child Health Disability Prevention, and California Children's Services)
CDPH, WIC
CDPH/State and Local Injuries Control
Domestic Violence Leadership Group
MCAH LHJs representing urban and rural counties
American Academy of Pediatrics, California District
California Project LAUNCH
ECCS
Family Resource Center

Most recently, and in response to unmet needs, new partnerships have been forged between MCAH, CHVP, and the DHCS to identify mental health services and Medi-Cal reimbursement mechanisms for home visiting families. It is important to note that local CHVP sites fall under the oversight of the Local MCAH Director.

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

II.F.2 MCH Workforce Development and Capacity

MCAH workforce development activities target state and local MCAH staff; program- specific staff; CDPH staff; and future public health professionals.

- Workforce Development for MCAH staff
  Within this category, there are two major activities: (1) MCAH Discussion Group and (2) MCAH Trainings conducted in collaboration with our contractor, the Family Health Outcomes Project (FHOP).

  The MCAH Discussion Group provides a forum for discussion regarding current topics and emerging issues in MCAH. These forums increase staff communication across all branches within MCAH, facilitates planning for MCAH Division tasks, and assists staff in executing their job functions more efficiently.

  MCAH & FHOP collaborative trainings are intended to provide state and local MCAH staff with webinar based trainings on specific topics identified based on state and local needs. Overall, staff was pleased with the training and health topic, and survey results report that the information was 'useful' and 'very useful'. Some comments included: (1) helped us clarify some of the collaborative efforts in our community; (2) helped identify areas of need; and (3) role of MCAH field nursed with the young California Children's Services children is invaluable. Webinar topic included:

  In addition, from 2013-2015, MCAH & FHOP held twice monthly Title V Needs Assessment Technical Assistance Calls with the local MCAH Directors regarding the Title V Needs Assessment. Feedback was very positive and fostered better collaboration with other agencies.

- Workforce Development for program specific staff
  BIH provides a group-based intervention with case management services to improve birth outcomes for African-American women in California. The two main areas of workforce developments have been regional trainings that allow for smaller groups of staff to improve specific skills to improve service delivery (e.g. improved critical thinking, enhancing group facilitation skills, etc.). These trainings have received very positive evaluations reporting that they help put theory into practice. The second area of workforce development is the BIH has annual meetings which bring all of the BIH sites together. These meetings focus primarily on standardized program implementation and the use of best practices.

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

  CPSP provides a wide range of culturally competent services to Medi-Cal pregnant women, from conception through 60 days postpartum. There are two main workforce development activities. The professional development meeting held annually for the local Perinatal Services Coordinator which focuses on key topic areas critical to their improved performance. Recent topics presented were maternal mental health, perinatal substance use, and adverse childhood events. In addition, to the annual meeting, CPSP Provider Trainings

are offered online and in-person to enhance professional skills. The results of the meetings and trainings were positive, and provided an opportunity to collaborate and share best practices with their colleagues in other LHJs.

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

- CDPH Workforce Development activities for CDPH staff

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

To address unintended pregnancy, staff will receive training on One Key Question and a postpartum visit protocol to help case managers and providers with appropriate care provision. To create analytic capacity for chronic disease monitoring, partnerships with the Maternal Quality Indicators Work Group, Chronic Disease Branch, and MCAH epidemiology staff will familiarize each other with their skill sets to improve the capacity for surveillance beyond pregnant women, but for non-pregnant women of reproductive age.

Like MCAH, CDPH is also committed to improve the quality of the workforce. Two efforts of note are the Center for Family Health (CFH) Equity Initiative. The Initiative is intended to provide all staff, including administrative staff, with a basic understanding of health equity. Central to that effort was a Health Equity 101 webinar conducted by the CDPH Office of Health Equity. The CFH also held an all-staff meeting to provide a presentation by Paula Braveman, MD, MPH on 'How to integrate health equity into their work'. The response from staff was positive and the initiative will continue using the Dreyfus Model for Skill Acquisition to encourage continued integration of health equity.

CDPH annually convenes a series of webinars on trending issues. This year's four session series is on health insurance and medical care delivery

- Developing Public Health Professionals
  MCAH has a history of developing future public health professionals through its long-standing relationships with public health schools. These relationships have created opportunities for internships in program, policy and epidemiology.

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

  MCAH has provided input and letters of support to training grant applications submitted by the University of

California, Berkeley and the University of California, Los Angeles to the National Institute of Health and the Maternal Child Health Bureau. These training grants fund training programs that could serve the ultimate workforce needs and research priorities of the local, state and federal MCH agencies.

II.F.3. Family Consumer Partnership

California's Title V has established and maintained working partnerships with other MCHB awardees, Medi-Cal, local and state education and health and human service agencies, community based organizations, professional health organizations, providers, community advocates, community members and other stakeholders that have a vested interest in promoting the health of the MCAH population.

Family members, former clients, caregivers, and interested lay persons provide valuable input and perspective in the planning, development, implementation, and evaluation of MCAH and SCD's CSHCN programs, services and policies. MCAH and SCD are committed to improving family and consumer involvement and engage community members in discussions related to the allocation and management of resources and community ownership to sustain collaborative efforts. We continue to promote the value that families and consumers offer to the development and delivery of culturally and linguistically appropriate services and insight on how to address gaps and barriers.

. Many locally developed MCAH programs and strategies are informed by feedback received from clients, former clients and families. As part of the 2016-2020 Title V Needs Assessment activities, LHJs were instructed to focus on meeting with stakeholders/community partners, including families and consumers that represented their community's populations and health challenges. Stakeholder involvement was encouraged to help LHJs review data, identify and prioritize problems and target populations, review problem analyses to identify intervention strategies and new stakeholders/community partners and promote community support. There were a total of 3,216 stakeholders providing input in the needs assessment in 61 LHJs; 26 LHJs reported a total of 398 individuals or families participating; and 8 LHJs reported 47 individual youths participating as stakeholders.

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

Examples of family/consumer partnership at the State level include the California Sudden Infant Death Syndrome (SIDS) Advisory Council which consists of nine members appointed by the CDPH Director. The advisory council has three members who represent the SIDS parents' groups. About 18 parents/family members attended the 2014 Annual SIDS Conference.

Parents of FASD-affected individuals attend the quarterly FASD Task Force meetings and participate in the discussion of agenda items. They are usually active members of task force member organizations such as Arc of California-Riverside.

SCD seeks to involve families in multiple aspects of policy making and care for CCS Program clients and are coordinated through Family Voices of California (FVCA), Children's Regional Integrated Services System (CRISS) and the Los Angeles Partnership for Special Needs Children/ CCS Workgroup.

CCS participates in FVCA webinars and the FVCA annual Health Summit. , FVCA collaborated with DHCS and

other partners on various committees, taskforces, senate hearings, and stakeholder groups related to the 1115 Bridge to Reform Waiver, the CCS Program redesign, and the Title V Needs Assessment, ensuring that parents and community members are involved in these processes. Some FVCA Council Member Agencies renew their Parent Health Liaison contracts with their local CCS train CCS Program staff on family perspectives, and provide conflict resolution assistance.

CRISS is a coalition of more than 50 organizations including local CCS, family support organizations, and pediatric providers and hospitals in a 27-county region of Northern California with the goal of creating a seamless care for CCS clients. CRISS has been an active participant in the CCS Program redesign effort, the Title V Needs Assessment, and the 1115 Bridge to Reform Waiver stakeholder process. CRISS works on supporting medical homes and on transition issues through both the CRISS Family-Centered Care and MTP CRISS is monitoring implementation of Covered California's CSHCN services and its impact on families' out-of-pocket costs and limits to durable medical equipment and other In addition, rural counties in California recently moved to mandatory enrollment in Medicaid managed care, and CRISS is monitoring the impact on CSHCN.

The goal of the Los Angeles Partnership for Special Needs Children, the oversight entity for Los Angeles, is to improve the system of care for CSHCN. Members include health plans, hospitals, regional centers, providers and parents, including participant members from family resource centers and the Family Centered Care Committee.

II.F.4. Health Reform

Covered California, the marketplace for the ACA is overseen by a five-member board, appointed by the Governor and the Legislature (https://www.coveredca.com/PDFs/CC-health-plans-booklet-rev4.pdf.). Covered California helps individuals compare health insurance plans and choose the plan that works best for their health needs and budget. Additionally, individuals can learn if they qualify for federal financial assistance that can lower the cost of health insurance and also find out if they are eligible for health programs like Medi-Cal. Most Medi-Cal recipients are enrolled in a MMCHP located in one of the 58 counties.

Beginning 2014, California expanded Medi-Cal to more low-income adults. MMCHP enrollment reports show an increasing trend of enrolled beneficiaries. By February 2015, there were 9,074,167 enrolled beneficiaries in 58 counties. This has not impacted enrollment into the CCS Program's clients under 21.

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

MCAH is involved in collaborative activities with the Department of Healthcare Services (DHCS) through stakeholder meeting participation in the "Full Scope Medi-Cal Coverage, Affordability and Benefit Program for Low Income Pregnant Women and Newly Qualified Immigrants." Discussions continue between MCAH and DHCS as the plans to implement the new eligibility and benefit requirements for pregnant women unfold. Since more beneficiaries are served by a network of providers contracted through MMCHP, a partnership was formed between MCAH and Medi-Cal Managed Care Division (MMCD), the agency that oversees California's MMCHP. MCAH with MMCHP plan to engage in quarterly meetings to achieve the following: foster information sharing; promote ways to achieve improvements in care access; facilitate improvements in local MCAH and MMCHP coordination; and, address public health issues related to maternal and infant health. In addition to MMCHP and MMCD, MCAH participates in the CHVP SIT, represented by members belonging to different state agencies, local MCAH jurisdictions, and non-profit organizations. The SIT group is represented by members from the DSS, Department of Housing and

Community Development , Center for the Study of Social Policy, Family Resource Center Network of California, American Indian Infant Health Initiative, CDE, WIC, First 5 California and Race to the Top , Early Learning Challenge, DHCS, SUD Prevention , Recovery and Treatment Services, DDS, Early Start Program and California Community of Health Agencies. MCAH is involved in the team's common goal of pursuing opportunities to improve access to services that promote and improve health outcomes for women, children and their families.

MCAH assists with the coordination, facilitation and enrollment of the MCAH population to Covered California, Medi-Cal and related services through outreach, education, referral coordination, case management, triaging, and collaborative efforts with providers, internal and external agencies and non-profit organizations.

The increase of beneficiaries enrolled into Medi-Cal Managed Care provided opportunities for LHJs to establish a Memorandum of Understanding (MOU) with a local MMCHP to coordinate and leverage resources, services, training, and shared quality improvement strategies to promote improved services to the MCAH population. For 2013-2014, 46 LHJs c reported working relationships with MMCHP network of providers. Approximately 171,370 pregnant women were referred to Covered California or Medi-Cal. Over 50 LHJs initiated efforts to develop policy and systems changes that facilitate access to Medi-Cal, Covered CA, CHDP, WIC, Family Planning, Access, Care, and Treatment and other relevant programs.

Sixty one LHJs participated in a survey that examined and assessed the role of local MCAH programs in assisting with enrollment in the Covered California and the Medi-Cal expansion. Thirty-five LHJs have a MOU with MMCHP operating within the LHJ.

Outreach and education remain sustainable activities in support ACA. In a survey completed by LHJs in September 2013 regarding the ACA implementation, 46 LHJs established a process to refer people to an enrollment entity or Covered California and 39 LHJs enrolled eligible women and children into Medi-. Twenty seven LHJs were involved with activities to increase public awareness of increased coverage for women's preventive services. The majority of LHJs have been involved in educating partner agencies, providers and beneficiaries in presumptive eligibility, access, and benefit updates.

Disseminating information and making referrals to Covered California emerged as the predominant functions of the LHJs in ACA implementation. Several LHJs felt that their role was of lead collaborative agency or were in the process of defining their role; however, most LHJs reported that MCAH was not viewed as a key participant in ACA because most of the enrollment activities were happening outside of MCAH.

In 2014, California eliminated the Healthy Families Program and shifted more than 900,000 children to Medi-Cal. California continues to promote access to care for children, especially for those no longer eligible for Medi-Cal under the Modified Adjusted Gross Income Methodology based on Assembly Bill (AB) x1 1, Chapter 3, Statutes of 2013, and recent guidance provided by the Centers for Medicare & Medicaid Services on the Affordable Care Act of 2010 (ACA), Medicaid /County Children's Health Initiative Program Section 2101(f) FAQs, dated April 25, 2013. DHCS released guidance, in April 2014, ensuring pre-ACA children are protected during the 2014 annual redeterminations of Medi-Cal eligibility until the following annual re-determination date in 2015. This policy change helped LHJs minimize disruption in child care. LHJs continue to address timely well-child visit appointments after cancellations or change in providers, or provide timely access to care for children with special health care needs through different partnerships (community-based, interagency, providers and local MMCHP).

LHJs work with their local CHDP program on in terms of care coordination, referrals to mental health and developmental services, cross-staff collaboration and training, screening resources, increasing enrollment of children into ACA and improving access to Medi-Cal related services. It should be noted that 14 local MCAH Directors also

function as local CCS Directors. For instance, through the Healthy Kids/Covered Sonoma County, local MCAH launched its 100 percent School Based Campaign pilot, attaining health coverage for over 99 percent of students at one school. In addition, CalFresh outreach to enroll and retain eligible families increased in Sonoma.

MCAH looks forward to the implementation of Medi-Cal eligibility expansion for low-income adults that will include the Full Scope Medi-Cal Coverage, Affordability and Benefit Program for Low-Income Pregnant Women and newly Qualified Immigrants, in accordance with Senate Bill 857, (Chapter 31, Statutes of 2014) and Senate Bill x 1-1 (Chapter 4, Statutes of 2013), (Welfare and Institutions (W & I) Code Sections 14102, 14148.65 and 14148.67). Implementation of this program will allow pregnant women with satisfactory immigration status and incomes up to 138% FPL to be eligible for full scope Medi-Cal Coverage. In addition, pregnant women with satisfactory immigration status and incomes between 139% and 213% FPL will be provided the option to receive premium and out-of-pocket payment assistance and accessing additional Medi-Cal services to the extent services are not covered in the Exchange QHP. Upon implementation, beneficiaries will be required to enroll in a MMCHP.. Resident beneficiaries in a county where a MMCHP is not available will be provided services under the Medi-Cal fee-for-service delivery system. Subject to federal approval, implementation of this policy will allow more opportunities for increased care coordination, resource sharing and maximizing service capacity for the maternal, infant and child population. MCAH continues to work with DHCS regarding policy changes and implications to maternal health. It is projected that there will be a one-time shift of 11,000 women to Medi-Cal Managed Care for those who are eligible for full scope Medi-Cal coverage.

The ACA offers the opportunity to obtain no-cost preventive services for women. These services address all three goals in the Maternal/Women's Health Action Plan and can be instrumental in preventing unintended or mistimed pregnancies by providing FDA-approved contraception without cost-sharing, providing annual wellness checkups that include chronic disease screening with no cost-sharing, and providing appropriate referrals for other preventive services for obesity and smoking that also do not require cost-sharing.

II.F.5. Emerging Issues

- Pregnancy Immunizations
  Pregnant women who get the flu are at increased risk for severe illnesses and their babies are also at risk. Complications from the flu can include premature labor, babies that are small for gestational age, hospitalization, and, rarely, death. It is safe, and very important, for a woman who is pregnant to receive the inactivated flu vaccine Babies younger than 6 months are too young to receive flu vaccine.

  Whooping cough or pertussis is a common illness and can be very serious for babies, even leading to death. All pregnant women should receive a dose of Tdap during each pregnancy, regardless of whether they have received Tdap in the past.

  Despite national recommendation by American Congress of Obstetricians and Gynecologists (ACOG) and CDC for influenza vaccine and Tdap vaccine during pregnancy, many pregnant women do not receive these important vaccines. It will be important to work with prenatal care providers to educate them regarding the importance of these vaccines and assess and provide strategies to overcome current perceived barriers to providing these important vaccines to pregnant women.

- Child Health Immunizations
  Healthy People 2020 set a goal of increasing the percentage of children aged 19-35 months who receive the

recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (the 4:3:1:3[4]:3:1:4 combined series of vaccines) from a baseline of 44.3% to a target of 80.0%. [37] Of California's children aged 19-35 months, 66.8% received the combined series of vaccines in 2012, a figure very close to the national percentage of 68.4. [38]

A study [39] analyzed electronic health records among children born between 2000 and 2011 with membership in Kaiser Permanente Northern California. The data revealed under-immunization clusters among children who turned 3 between 2010 and 2012 in the East San Francisco Bay from Richmond to San Leandro; in Sonoma and Napa counties; in an area between Sacramento and Roseville; in northern San Francisco and southern Marin counties; and in Vallejo. There were 5 statistically significant clusters of under immunization among children who turned 36 months old during 2010–2012. The underimmunization rate within clusters ranged from 18% to 23%, and the rate outside them was 11%. Children in the most statistically significant cluster had 1.58 (P, .001) times the rate of underimmunization as others. Underimmunization with measles, mumps, rubella vaccine and varicella vaccines clustered in similar geographic areas. Vaccine refusal also clustered, with rates of 5.5% to 13.5% within clusters, compared with 2.6% outside them.

Parental refusal and delay of childhood vaccines has increased in recent years and is believed to cluster in some communities. posing public health risks and barriers to achieving immunization quality benchmarks. Knowing precisely where such pockets of under-vaccinated populations are could help physicians and public health departments prevent illnesses. Spatial scan statistics may be a useful tool to identify locations with challenges to achieving high immunization rates, which deserve focused intervention.

- Adolescent Immunizations
  Healthy People 2020 set a goal of increasing the vaccination coverage level of 3 doses of human papillomavirus (HPV) vaccine for females by age 13 to 15 years from a baseline of 16.6% to a target of 80%. [40] Nationwide, 53.8% of adolescents aged 13-17 have at least 1 dose of the HPV vaccine. [41] California's percentage is higher, with 65.0% of adolescents having received at least 1 dose of the HPV vaccine. The percentage of adolescents who have received the vaccine varies by race/ethnicity group, with 71.9% of Hispanic adolescents having received at least 1 dose of the HPV vaccine whereas 52.2% of White adolescents have received at least 1 dose. Data is not available for other racial groups.

- Adverse Childhood Experiences
  Adverse Childhood Experiences (ACE), such as childhood abuse, neglect and exposure to violence, has been shown to be major risk factors for illness and death across the life course [42]. In 2012, the percent of California children ages 0-17 with two or more adverse family experiences was 18.2, a lower percentage than the national comparable rate of 22.6%. The percent of children with two or more adverse family experiences varies by age, with a lower percentage of younger children experiencing adverse events: 7.3% of children 0-5, 23.0% of children 6-11 and 23.9% of children 12-17.

  Percentages of children with 2 or more adverse family experiences were similar among children at the lowest poverty levels (20.5% for FPL 0-199%; 23.5% for FPL 200-299%, and 25.1% for FPL 300-399%) but much lower among children at the highest poverty levels (9.8% for FPL 400% or higher). Similarly, children with public insurance and who were currently uninsured had higher percentages (22.5% and 27.0%, respectively) than those with private health insurance (14.3%). Percentages of children with 2 or more adverse family events also vary across race/ethnicity. A much higher percentage of Black children (45.3%) experienced 2 or more adverse family events compared to White children (18.4%). Hispanic youth were similar to White youth at 18.0%. Children of other racial backgrounds had the lowest percentage at 8.7%.

There is emerging data to identify risk factors for future intimate partner violence perpetuation or victimization. One of the new objectives is to implement policies to screen for risk factors for future intimate partner violence and refer for appropriate follow up. For several years MCAH has been invested in screening for and understanding the importance of ACEs, but this is the first tangible step that MCAH programs will take to translate the research and framework into public health practice for prevention of ACEs sequelae.

- Maternal Mortality
  Medical mistakes were listed, as the 3rd leading cause of death nationally following heart disease and cancer. [43] Section 1279.1 of the California Health & Safety (H&S) Code requires all General Acute Care Hospitals to report the occurrence of defined adverse events to their local Licensing and Certification Program district office. An adverse event is defined as a medical occurrence that caused or is an ongoing threat of imminent danger of death or serious bodily harm at an acute general hospital, acute psychiatric hospital and special hospital. There are 28 "Adverse Events" defined in the California H&S code. Maternal deaths in low risk pregnancy are specifically listed as an adverse event within the law but there are many adverse events throughout this law that could be the cause of, or immediately related to a maternal death in any risk category of pregnancy. Examination of these deaths by the California Pregnancy-Related and Pregnancy-Associated Mortality Review identify very specific obstetrical services that need to be adhered to more diligently at both the individual level (e.g. nurse, physician assistant, etc.) and hospital level (performance of more trainings, system drills) to assist the provider in better equipping staff in the performance of their job and thus improve quality of care outcomes resulting in a decline in maternal mortality and morbidity rates.

  MCAH aspires to see continued improvement in declining maternal mortality rates but shares concerns with regard to the high national rates of Pregnancy-associated deaths due to violence. The editorial in the January 2015 journal Obstetrics & Gynecology- Creanga et al report [44] that more than 5,000 women died during this time period (2006-2010) from pregnancy-associated causes. According to the report, “Deaths due to motor vehicle accidents, suicide, homicide, and intimate partner violence make up the bulk of these.” [45] This would entail screening women for issues surrounding domestic violence, mental health, and substance use, providing them with the proper referrals, and to also educate them on seat belt usage and air bags.

- Maternal Morbidity
  Heart disease is the leading cause of women’s pregnancy-related deaths in California — but nearly one-third could be prevented, according to research presented at the American Heart Association’s Scientific Sessions 2013. Dr. Afshan Hameed led a research study [46] analyzing why California’s maternal death rates have nearly tripled from 5.6 per 100,000 live births in 1996 to 16.9 per 100,000 live births in 2006. In the 2.1 million recorded live births in California from 2002-2005, 732 women died from pregnancy-related deaths. Nearly 25 percent of those 732 deaths were caused by some form of cardiovascular disease. Notably, only six percent of the women had been diagnosed with a heart condition prior to their pregnancy.

  The study also concluded that in 65 percent of the pregnancy-related deaths, the diagnosis was either incorrect or delayed; 47 percent of providers had given ineffective or inappropriate treatments; and 41 percent of pregnant women were misdiagnosed. Specifically, an enlarged and weakened heart accounted for two-thirds of pregnancy-related deaths. One third of the patients who died had delayed or failed to seek care, 10 percent refused medical advice and 27 percent did not recognize their symptoms as cardiovascular. Nearly 30 percent of the expecting mothers did not recognize their symptoms as cardiovascular-related.

  “Women who have preeclampsia or gestational diabetes and preterm delivery have up to an eight to 10-fold increased risk for developing cardiac disease later in life,” says Hameed. “These women need to be identified

as high-risk patients and should have a follow-up care three to six months after delivery. If these conditions are treated appropriately, the risk of these women having future cardiac issues is greatly reduced."

Expecting mothers should stick to healthy eating and living as that will promote healthy development of their baby in utero. It's also important to keep making healthy lifestyle decisions once the baby arrives so families can keep their health and wellness on the right track."

"It is imperative that health care providers do a better job recognizing heart disease triggers such as changes in blood pressure, heart rate, or if the woman is experiencing excessive shortness of breath, fatigue, or anxiety. These may be indicators for heart disease and should be evaluated immediately." For pregnant women with multiple cardiovascular risk factors such as obesity, diabetes, high blood pressure or family history of cardiovascular disease, OB-GYNs should maintain a high index of suspicion and may consider consultation with maternal fetal medicine specialist or a cardiologist.

- Mental Health:
  This report uses the data from 2009 and 2010. Mental Health Care in California: Painting a Picture [47] provides an overview of mental health in California covering disease prevalence, suicide rates, the state's care delivery system, supply and use of treatment providers, and access to care. Key findings included:
- About half of adults and two-thirds of adolescents with mental health needs did not get treatment.
- For children and adults, the prevalence of serious mental illness varied by income, with much higher rates of mental illness at lower income levels
- Rates of serious emotional disturbance in California children showed more variation across income levels than across gender, age groups, and race and ethnic groups. One in 10 children below the poverty level suffered from a serious emotional disturbance. [48]
- Depression is one of the most prevalent mental health disorders among adolescents. Between 2005 and 2009, approximately 8% of teens in California and the US reported that they had experienced an episode of major depression in the previous year. [49]

- Climate Change
  Climate change has brought about extreme weather conditions. With California facing one of the most severe drought, MCAH may need to anticipate some of its impact on health and incorporate addressing its wide range of health effects for the most vulnerable MCAH population.

II.F.6. Public Input

California's Title V believes that our program goals cannot be fully achieved until the public and policy-makers have a shared commitment to care for issues that affect the MCAH population. It is also in our program's interest to define the public's expectations in addressing these health issues, given that MCAH-related health policies and priorities change, are complex and reflect diverse and competing interests which need to be brought together to develop a shared understanding of the problems and the possibilities.

All MCAH-funded programs have a program advisory or workgroup that were formally created. Through regular teleconferences and face-to-face meetings scheduled throughout the year, these advisory or work group members provide voice for program users or clients who tap into the services provided by MCAH programs. Recommendations and input from these groups generally serve to reaffirm our current activities and plans as well as introduce some valuable new ideas such as identifying emerging issues and provide useful feedback for program

and policy development.

MCAH keeps its stakeholders and community partners engaged by contributing to "The Stakeholder Brief", a quarterly update of CDPH activities, actions and achievements where subscription include advocacy groups, community members and organizations, local, state, regional or national coalition members, local health departments, elected officials, and policy makers and their staff at municipal, regional, state or tribal levels.

To inform the public of Title V's goals, achievements and plans, a draft version of the Title V Annual 2014 Report/2016 Application and accompanying Appendix was posted in the MCAH website and could be accessed at http://www.cdph.ca.gov/programs/mcah/Pages/MCAH-TitleVBlockGrantProgram.aspx. An announcement about the release of the Title V Annual 2014 Report/ 2016 Application was submitted for publication in " The Stakeholder Brief," The broader CDPH stakeholder groups included in the department's listservs automatically receive this update. An e-mail announcement was also sent out by MCAH to its more than 500 stakeholders announcing the availability of the Report/ Application for public comment. A request was made to share the Report/ Application with other interested parties and to provide their comments via e-mail to CaliforniaTitleV@cdph.ca.gov during the two-week open period (May 18 to May 29, 2015) for public comment. SCD shared the document with interested stakeholders, as well as other CCS Program venues. Comments were received from 4 stakeholders.

Another mechanism for encouraging public engagement is through the CDPH Open Data Portal, which allows access to data collected by various CDPH programs, including newborn screening data. The data can be used to identify strengths and areas of improvement to solve the challenging health needs of the MCAH population.. The Open Data Portal benefits policymakers, consumers and the media to leverage public health data to inform decision making.

In the past, MCAH and its partners have developed press releases directed at members of the news media for the purpose of announcing newsworthy benchmarks or to highlight health issues MCAH is addressing as part of its state priorities. These news releases are then reported by the major California dailies. With the advances in digital media, these news stories have portals to allow for ad hoc comments from the public. Relevant public input gathered from MCAH stories circulated through digital media is regularly reviewed. MCAH reviewed nine news articles. Examples of comments for the first news article are provided in the attachment. Links to the original news article and the accompanying public comments, as well as the number of public comments reviewed by news article are provided in the attachment. The comments provide insight of public awareness and perceptions on health issues confronting the MCAH population.

Responses to weaknesses and recommendations based on last year's review of the Title V 2013 Report/2015 Application, responses to comments received from the public and a list of news stories which MCAH reviewed the comments received are included in Attachment 7.

II.F.7. Technical Assistance

Interface with the States currently receiving Project Launch funds and learn how their community councils are assessing local resources and needs, creating strategic plans, and using evidence-based prevention and health promotion strategies. California could review these elements and possibly develop better methods for:

1. Screening program participants
2. Integrating mental health consultation
3. Providing additional trainings for program staff
4. Family strengthening and parenting skills training

Access to care for the MCAH population is challenging on a couple of fronts. California has approximately 22 rural counties, predominantly in the Northern and Eastern part of the State. In some case residents are actually geographically closer to services in a neighboring county than the one they reside in. In the urban areas geography is not necessarily the issue as much as: lack of transportation (including inefficient transit systems), lack of childcare, inability to take off time from work, poor family support system, cultural barriers, domestic problems, etc. Understanding better how to increase access to care among the population we serve would be welcomed.

III. Budget Narrative

	2012		2013	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 42,300,762	$ 42,239,399	$ 41,389,219	$ 35,582,819
Unobligated Balance	$ 0	$ 0	$ 0	$ 0
State Funds	$ 1,366,907,980	$ 1,211,417,353	$ 1,306,322,819	$ 1,319,869,167
Local Funds	$ 0	$ 0	$ 0	$ 0
Other Funds	$ 0	$ 0	$ 0	$ 0
Program Funds	$ 1,353,823,835	$ 1,286,837,908	$ 1,272,272,105	$ 1,366,838,589
SubTotal	$ 2,763,032,577	$ 2,540,494,660	$ 2,619,984,143	$ 2,722,290,575
Other Federal Funds	$ 14,775,679	$ 11,756,440	$ 30,690,686	$ 32,278,630
Total	$ 2,777,808,256	$ 2,552,251,100	$ 2,650,674,829	$ 2,754,569,205

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$ 35,292,014	$ 33,402,919	$ 37,731,581	$
Unobligated Balance	$ 0	$ 0	$ 0	$
State Funds	$ 1,402,450,145	$ 1,445,314,553	$ 1,535,926,539	$
Local Funds	$ 0	$ 151,226,066	$ 0	$
Other Funds	$ 0	$ 0	$ 0	$
Program Funds	$ 1,382,181,012	$ 1,604,682,820	$ 1,549,128,757	$
SubTotal	$ 2,819,923,171	$ 3,234,626,358	$ 3,122,786,877	$
Other Federal Funds	$ 30,100,239		$ 28,677,836	$
Total	$ 2,850,023,410	$ 3,234,626,358	$ 3,151,464,713	$

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016	
	Budgeted	Expended
Federal Allocation	$ 38,894,226	$
Unobligated Balance	$ 0	$
State Funds	$ 1,546,019,283	$
Local Funds	$ 181,899,900	$
Other Funds	$ 0	$
Program Funds	$ 1,652,875,731	$
SubTotal	$ 3,419,689,140	$
Other Federal Funds	$ 31,543,337	$
Total	$ 3,451,232,477	$

III.A. Expenditures

The expenditures for FY 2014 are presented in forms 2, 3a, and 3b of the Title V Block Grant application.

CDPH received $37,731,581 in Title V funds in FY 14 of which $33,402,919 were spent in FY 2014.

MCAH met the Title V requirement as specified in Section 501 (a) (1) (D): 30/30/10.
32% expended on Preventive & Primary Care for Children:$10,837,424
31% expended on Children with Special Health Care Needs: $10,421,488
5 % expended on Title V administrative cost: $1,732,246
The remaining 32% of fund were expended on other MCAH Title V Block Grant activities.

In totality, California expended $3,266,807,654. These expenditures include Title V funds, state funds, local MCH funds program income and other federal funds. A comparison of FY 13 expenditures ($2,754,569,205) to FY 14 expenditures ($3,266,807,654) shows an increase over 10%. This is due to:

-
An increase in direct services and case management by the DHCS, SCD
An increase in local MCH funds –LHJs are increasing their local funds to provide MCH services and to increase their match to draw Title XIX

Expenditure by types of service in FY 14 are categorized differently than they were in prior years; hence a comparison by service type will not be presented in this section. The breakdown of FY2014 expenditures by types of services are as follows:

Direct Services: $2,852,495,157

$38,497,559 in preventive and primary care services
$2,813,997,596 in children with special health care needs
Enabling Services: $279,764, 809
Public Health Services and System: $102,366,392

Lastly, Section 4 on Form 3b displays direct service expenditures by service type. Title V Block Grant funds were not used to pay for any of these direct services. State general funds, local funds and program income reimbursed these expenditures.

III.B. Budget

Since the enactment of the Omnibus Budget Reconciliation Act of 89, California has maintained the availability of Title V funds under both the maintenance of effort and the match requirements.

The proposed allocation of the FY 2016 Title V Block Grant for California is $38,984,226. Preventive and primary care services for children (PPCSC) are designated to receive $11,822,478 (30%) and Children with Special Health Care Needs (CSHCN) are designated to receive $12,169,912 (32.%). Title V funded administrative costs are budgeted at $2,205,449 (6%). Administrative costs defined in this application are the amount of funds the state uses for the administration of the Title V allocation through support staff and operating costs associated with the administrative support of MCAH, these support functions include but are not limited to: Contract management, accounting, budgeting, personnel, audits and appeals, maintenance of central contract files, and clerical support for these functions.

The required state general fund match is $29,170,670. California's FY 2016 budget for Title V MCH programs is $3,419,689,140, an increase over FY 2015 by 9.59%. The budgeted amount includes State general funds of 1,546,019,283, which is $1,458,860,533 above the FY 1989 Maintenance of Effort amount of $87,158,570; Program Income of $1,652,875,731; and Local MCH funding of $181,899,900.

CDPH has an ongoing commitment to provide maternal and child health services to women and children within the State of California. This commitment includes continued support to local health jurisdictions, local programs, clinics and Medi-Cal providers for maternal and child health. It is the State's intent to ensure that State General Fund contributions to these local programs ,which are also funded in part by the Federal Title V Block Grant, be administered by CDPH/MCAH and DHCS/Systems of Care Division (SCD).

For FY 2016 CDPH has budgeted a total of $31,543,337 in other federal funds which include awards for Maternal Infant Early Childhood Home Visiting Program, Expectant and Parenting Teens Program, Personal Responsibility Education Program, and Project Launch.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Title V and Title IX Interagency Agreement.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - APPENDICES.pdf

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: California

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION	$ 38,894,226	$ 33,402,919
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)		
A. Preventive and Primary Care for Children	$ 11,822,478	$ 10,837,424
B. Children with Special Health Care Needs	$ 12,169,912	$ 10,421,488
C. Title V Administrative Costs	$ 2,205,449	$ 1,732,248
2. UNOBLIGATED BALANCE	$ 0	$ 0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	$ 1,546,019,283	$ 1,445,314,553
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	$ 181,899,900	$ 151,226,066
(Item 18d of SF-424)		
5. OTHER FUNDS	$ 0	$ 0
(Item 18e of SF-424)		
6. PROGRAM INCOME	$ 1,652,875,731	$ 1,604,682,820
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	$ 3,380,794,914	$ 3,201,223,439
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	$ 87,158,750	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	$ 3,419,689,140	$ 3,234,626,358
(Same as item 18g of SF-424)		
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS	$ 31,543,337	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	$ 3,451,232,477	$ 3,234,626,358
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

	FY14 Annual Report Budgeted
1. FEDERAL ALLOCATION	$ 35,292,014
A. Preventive and Primary Care for Children	$ 11,139,029
B. Children with Special Health Care Needs	$ 10,811,999
C. Title V Administrative Costs	$ 1,820,137
2. UNOBLIGATED BALANCE	$ 0
3. STATE MCH FUNDS	$ 1,402,450,145
4. LOCAL MCH FUNDS	$ 0
5. OTHER FUNDS	$ 0
6. PROGRAM INCOME	$ 1,382,181,012
7. TOTAL STATE MATCH	$ 2,784,631,157

	FY16 Application Budgeted
9. OTHER FEDERAL FUNDS	
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP);	$ 6,371,903
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program;	$ 22,601,834
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration;	$ 140,800
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI);	$ 100,000
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH;	$ 680,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > EDHI;	$ 148,800
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Expectant and Parent;	$ 1,500,000

Form Notes For Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: In the FY 2014 Budget, local MCH funds were included in the state match portion. The difference is due to the local MCH expenditures being reported in local MCH vs. state match portion.	
2.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2014**
	Column Name:	**Annual Report Expended**
	Field Note: Program income variance in expenditures is due to an increase in state case load. the budget was based on an estimate.	

Data Alerts:

None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: California

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF INDIVIDUALS SERVED		
IA. Federal MCH Block Grant		
1. Pregnant Women	$ 8,832,116	$ 8,199,852
2. Infants < 1 year	$ 3,864,270	$ 2,211,910
3. Children 1-22 years	$ 11,822,478	$ 10,837,424
4. CSHCN	$ 12,169,912	$ 10,421,488
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 36,688,776	$ 31,670,674
IB. Non Federal MCH Block Grant		
1. Pregnant Women	$ 64,224,455	$ 36,294,146
2. Infants < 1 year	$ 36,249,690	$ 30,803,852
3. Children 1-22 years	$ 127,546,809	$ 101,368,814
4. CSHCN	$ 3,152,773,961	$ 3,032,756,627
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 3,380,794,915	$ 3,201,223,439
Federal State MCH Block Grant Partnership Total	$ 3,417,483,691	$ 3,232,894,113

Form Notes For Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts:

None

Form 3b
Budget and Expenditure Details by Types of Services

State: California

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	$ 0	$ 0
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 0	$ 0
C. Services for CSHCN	$ 0	$ 0
2. Enabling Services	$ 25,429,663	$ 22,397,276
3. Public Health Services and Systems	$ 13,464,563	$ 11,005,643
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Total		$ 0
Federal Total	$ 38,894,226	$ 33,402,919

IIB. Non-Federal MCH Block Grant

1. Direct Services	$ 2,946,320,141	$ 2,852,495,157
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 40,111,000	$ 38,497,559
C. Services for CSHCN	$ 2,906,209,141	$ 2,813,997,598
2. Enabling Services	$ 319,071,933	$ 257,367,533
3. Public Health Services and Systems	$ 115,402,840	$ 91,360,749
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 435,081,609
Physician/Office Services		$ 600,804,096
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 1,504,504,492
Dental Care (Does Not Include Orthodontic Services)		$ 96,869
Durable Medical Equipment and Supplies		$ 76,829,624
Laboratory Services		$ 12,449,298
Other		
Other		$ 222,729,169
Direct Services Total		$ 2,852,495,157
Non-Federal Total	$ 3,380,794,914	$ 3,201,223,439

Form Notes For Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4

Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: California

Total Births by Occurrence 494,392

1a. Core RUSP Conditions

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Classic phenylketonuria	487,518 (98.6%)	249	27	27 (100.0%)
Primary congenital hypothyroidism	487,518 (98.6%)	411	241	241 (100.0%)
Congenital adrenal hyperplasia	487,518 (98.6%)	858	33	33 (100.0%)
S,S disease (Sickle cell anemia)	487,518 (98.6%)	204	70	70 (100.0%)
Cystic fibrosis	487,518 (98.6%)	169	50	50 (100.0%)
Severe combined immunodeficiences	487,518 (98.6%)	32	13	13 (100.0%)
Classic galactosemia	487,518 (98.6%)	36	6	6 (100.0%)

1b. Secondary RUSP Conditions

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Newborn Hearing	479,492 (97.0%)	909	909	897 (98.7%)

3. Screening Programs for Older Children & Women

	(A) Number Receiving at	(B) Number Presumptive	(C) Number	(D) Number

Program Name	Least One Screen	Positive Screens	Confirmed Cases	Referred for Treatment
Rapid HIV test	6,837	29	20	20
Conventional HIV test	2,682	8	8	8

4. Long-Term Follow-Up

All newborns with a screen-positive test result are referred to the appropriate state-contracted specialty care follow-up center (cystic fibrosis, metabolic, endocrine, or immunology center) depending on the indication for follow-up. All of the state–contracted specialty care centers are CCS (California Children's Services)-approved centers that offer comprehensive medical services including services provided by nutritionists and social workers. Following a referral, all newborns receive a diagnostic evaluation to determine if a disorder is present or if the disorder can be ruled-out. Appropriate treatment is initiated as soon as possible to minimize the impact of the disorder on the newborn. All diagnosed cases continue to receive follow-up services, including treatment and disease management at the specialty care center. The Genetic Disease Screening Program (GDSP) collects follow-up data once a year on all diagnosed cases through the age of five years as part of routine program

Form Notes For Form 4:

Total births is for 2013. Data Source for newborn screening tests: California Department of Public Health, 2013 Newborn Screening Records (retrieved using SQL queries from Screening Information System (SIS Every effort is taken to screen all newborns delivered in California; however, the percent receiving at least one screen for each of the tests do not equal to 100% primarily due to some families opting-out of screening, births at military hospitals that do not participate in California's NBS screening program, very early infant deaths occurring prior to screening or newborns being delivered at home, despite our best effort to work with all birth practitioners in the state including midwives and birth attendants. HIV test results are based on no. of case records and not unduplicated no. of individuals.

Field Level Notes for Form 4:

1.	**Field Name:**	**Classic phenylketonuria - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: For those tested for classic phenylketonuria, the number of presumptive positive screens excludes other screened positive combinations , those who screened positive for PKU plus another disorder.	
2.	**Field Name:**	**S,S disease (Sickle cell anemia) - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Core RUSP Conditions - Newborn**
	Field Note: The number of sickle cell cases reported is restricted to the sickle cell disease cases confirmed for the S/S variant, plus Hb S/+BThalassemia and Hb S/B0Thalassemia.	
3.	**Field Name:**	**Rapid HIV test - Confirmed Cases**
	Fiscal Year:	**2014**
	Column Name:	**Older Children & Women**
	Field Note: Reporting of case events is based on the type of test used for preliminary screening (conventional or rapid). If a case used Rapid testing as the initial test and was presumptive positive or indeterminate, the case may be confirmed using a conventional test and test positive. In such instance, the case is still reported as confirmed positive under Rapid testing even if the confirmatory test was a conventional test (e.g. RNA testing).	
4.	**Field Name:**	**Rapid HIV test - Referred For Treatment**
	Fiscal Year:	**2014**
	Column Name:	**Older Children & Women**
	Field Note: Preliminary HIV-positive test events for which the client was referred to HIV medical care are not included in this column. Guidance from the U.S. Department of Health and Human Services, issued on February 25, 2013, recommends clients receiving a preliminary HIV-positive rapid test be referred and linked to an HIV care provider at that time (http://www.cdc.gov/hiv/pdf/testing_DCL_HRSA_CDC_2013.pdf).	

5.	**Field Name:**	**Conventional HIV test - Positive Screen**
	Fiscal Year:	**2014**
	Column Name:	**Older Children & Women**

Field Note:
Conventional HIV test events were conducted using either blood or oral fluid samples.

Form 5a
Unduplicated Count of Individuals Served under Title V

State: California

Reporting Year 2014

		Primary Source of Coverage				
Types Of Individuals Served	**(A) Title V Total Served**	**(B) Title XIX %**	**(C) Title XXI %**	**(D) Private / Other %**	**(E) None %**	**(F) Unknown %**
1. Pregnant Women	494,392	45.7	0.0	50.8	3.3	0.2
2. Infants < 1 Year of Age	520,510	95.0	1.0	4.0	0.0	0.0
3. Children 1 to 22 Years of Age	7,254,655	74.0	18.0	8.0	0.0	0.0
4. Children with Special Health Care Needs	224,364	74.0	18.0	8.0	0.0	0.0
5. Others	1,000	0.0	0.0	100.0	0.0	0.0
Total	8,494,921					

Form Notes For Form 5a:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2014**
	Field Note: Estimate is based on the 2013 number of live births and include an estimated 2016 clients in the Adolescent Family Life Program, and 1187 clients in the Black Infant Health Program. Source: State of California, Department of Public Health, 2013 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Both expected source of payment for delivery and prenatal care coverage were used to determine "Primary Source of Coverage" for pregnant women. A woman who had Medi-Cal coverage for either prenatal care or delivery was considered covered by Title XIX. Some payment source codes used for (D) might include some for whom health coverage was actually "none" but could not be separated from "covered" persons within the pertinent codes.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2014**
	Field Note: The discrepancy between the number of infants reported in Forms 5 and 6 is likely due in part to some infants enrolled in the CHDP program being identified for services more than once due to having more than one client index number or the infant being identified for services with both the mother's client index number and its own client index number. It can take several months after birth to rectify these client index number issues	

Form 5b
Total Recipient Count of Individuals Served by Title V

State: California

Reporting Year 2014

Types Of Individuals Served	Total Served
1. Pregnant Women	494,392
2. Infants < 1 Year of Age	520,510
3. Children 1 to 22 Years of Age	7,254,655
4. Children with Special Health Care Needs	224,364
5. Others	1,000
Total	8,494,921

Form Notes For Form 5b:

None

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2014**
	Field Note: No. of pregnant women served is for 2013.	

Form 6

Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: California

Reporting Year 2014

I. Unduplicated Count by Race

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	494,392	354,800	26,614	2,491	68,532	2,073	18,529	21,353
Title V Served	494,392	354,800	26,614	2,491	68,532	2,073	18,529	21,353
Eligible for Title XIX	223,529	173,313	15,133	1,465	13,880	1,027	7,656	11,055
2. Total Infants in State	494,392	354,800	26,614	2,491	68,532	2,073	18,529	21,353
Title V Served	494,392	354,800	26,614	2,491	68,532	2,073	18,529	21,353
Eligible for Title XIX	223,529	173,313	15,133	1,465	13,880	1,027	7,656	11,055

II. Unduplicated Count by Ethnicity

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	247,252	238,200	8,940	494,392
Title V Served	247,252	238,200	8,940	494,392
Eligible for Title XIX	66,340	154,943	2,246	223,529
2. Total Infants in State	247,252	238,200	8,940	494,392
Title V Served	247,252	238,200	8,940	494,392
Eligible for Title XIX	66,340	154,943	2,246	223,529

Form Notes For Form 6:

Data is for 2013. Data Source: Birth Statistical Master File, 2013

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2014**
	Column Name:	**Total All Races**

Field Note:
For the number of Total deliveries, Total infants and Title V infants, the number of 2013 live births (by place of residence) was used as an estimate. For the number of "Deliveries Eligible for Title XIX and "Infants Eligible for Title XIX, a subset of 2013 live births was used as an estimate (subset of all live births for which "expected source of payment for delivery"= Medi-Cal by place of residence). Race and Hispanic origin of mother were used for Section I and II respectively. Data Source: State of California, Department of Public Health, Center for Health Statistics, 2013 California Birth Statistical Master File. Data by race/ethnicity were analyzed using mother's multi-race code. “Title V deliveries served" is assumed to include an estimated 2,374 served by the Adolescent Family Life Program and 1,751 served by the Black Infant Health Program.

Form 7

State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: California

	Application Year 2016	Reporting Year 2014
A. State MCH Toll-Free Telephone Lines		
1. State MCH Toll-Free "Hotline" Telephone Number	(866) 241-0395	(866) 241-0395
2. State MCH Toll-Free "Hotline" Name	MCAH Toll Free Information Line	MCAH Toll Free Information Line
3. Name of Contact Person for State MCH "Hotline"	Michele Naves	Michele Naves
4. Contact Person's Telephone Number	(916) 650-0377	(916) 650-0377
5. Number of Calls Received on the State MCH "Hotline"		779
B. Other Appropriate Methods		
1. Other Toll-Free "Hotline" Names	Genetically Handicapped Persons Program(GHPP) Information Line	Genetically Handicapped Persons Program(GHPP) Information Line
2. Number of Calls on Other Toll-Free "Hotlines"		43,920
3. State Title V Program Website Address	http://www.cdph.ca.gov/programs/MCAH/Pages/default.aspx	http://www.cdph.ca.gov/programs/mcah/Pages/MCAH-TitleVBlockGrantProgram.aspx
4. Number of Hits to the State Title V Program Website		3,889
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes For Form 7:

Total number of calls received on the state MCAH hotline: 779 and includes calls to the state MCAH toll-free information line (866-241-0395) from(July 1, 2013) to June 30, 2014. It does not include 66,916 calls received collectively by the 61 MCAH local health jurisdiction toll free lines and 296,591 web hits to the MCAH local health jurisdiction websites.

Form 8
State MCH and CSHCN Directors Contact Information

State: California

Application Year 2016

1. Title V Maternal and Child Health (MCH) Director

Name	Addie Aguirre
Title	Staff Services Manager III, Assistant Division Ch
Address 1	1615 Capitol Avenue, MS 8300
Address 2	
City / State / Zip Code	Sacramento / CA / 95814
Telephone	(916) 650-0311
Email	Addie.Aguirre@cdph.ca.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Louis Rico
Title	Chief, Systems of Care Division
Address 1	1515 K Street, Room 400
Address 2	
City / State / Zip Code	Sacramento / CA / 95814
Telephone	(916) 327-2435
Email	louis.rico@dhcs.ca.gov

3. State Family or Youth Leader (Optional)

Name	
Title	
Address 1	
Address 2	
City / State / Zip Code	
Telephone	
Email	

Form Notes For Form 8:

None

Form 9
List of MCH Priority Needs

State: California

Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Improve preconception health by decreasing risk factors for adverse life course events among women of reproductive age	Continued	
2.	Reduce infant morbidity and mortality	Continued	
3.	Improve the cognitive, physical, and emotional development of all children	Continued	
4.	Provide high quality care to all CYSHCN within an organized care delivery system.	Continued	
5.	Increase access to CCS paneled providers such that each child has timely access to a qualified provider of medically necessary care.	Continued	
6.	Increase conditions in adolescents that lead to improved adolescent health	Continued	
7.	Increase access and utilization of health and social services	Continued	
8.	Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and physically active lifestyle	Continued	

Form Notes For Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: California

Form Notes for Form 10a NPMs and NOMs:

None

NOM-1 Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	82.9 %	0.1 %	401,885	485,098
2012	82.5 %	0.1 %	405,189	491,367
2011	82.2 %	0.1 %	402,692	489,959
2010	82.0 %	0.1 %	406,920	496,183
2009	81.4 %	0.1 %	413,437	507,742

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-1 Notes:

None

Data Alerts:

None

NOM-2 Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

2012	154.5	1.8 %	7,345	475,323
2011	136.3	1.7 %	6,517	478,084
2010	131.3	1.6 %	6,413	488,530
2009	128.8	1.6 %	6,534	507,189
2008	115.8	1.5 %	6,161	532,034

Legends:
Indicator has a numerator ≤10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-2 Notes:

None

Data Alerts:

None

NOM-3 Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2013	5.7	0.5 %	145	2,537,798
2008_2012	8.5	0.6 %	220	2,594,872
2007_2011	8.7	0.6 %	231	2,657,531
2006_2010	9.5	0.6 %	259	2,717,851
2005_2009	10.5	0.6 %	289	2,756,535

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-3 Notes:

None

Data Alerts:

None

NOM-4.1 Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.8 %	0.0 %	33,753	494,587
2012	6.7 %	0.0 %	33,655	503,641
2011	6.8 %	0.0 %	33,946	502,021
2010	6.8 %	0.0 %	34,641	510,087
2009	6.8 %	0.0 %	35,802	526,913

Legends:
🏴 Indicator has a numerator <10 and is not reportable
⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.1 Notes:

None

Data Alerts:

None

NOM-4.2 Percent of very low birth weight deliveries (<1,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.2 %	0.0 %	5,683	494,587
2012	1.1 %	0.0 %	5,612	503,641

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	1.1 %	0.0 %	5,717	502,021
2010	1.1 %	0.0 %	5,791	510,087
2009	1.2 %	0.0 %	6,064	526,913

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.2 Notes:

None

Data Alerts:

None

NOM-4.3 Percent of moderately low birth weight deliveries (1,500-2,499 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.7 %	0.0 %	28,070	494,587
2012	5.6 %	0.0 %	28,043	503,641
2011	5.6 %	0.0 %	28,229	502,021
2010	5.7 %	0.0 %	28,850	510,087
2009	5.6 %	0.0 %	29,738	526,913

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-4.3 Notes:

None

Data Alerts:

None

NOM-5.1 Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	8.4 %	0.0 %	41,589	493,900
2012	8.4 %	0.0 %	42,439	502,704
2011	8.5 %	0.0 %	42,634	501,020
2010	8.6 %	0.0 %	43,579	509,002
2009	8.8 %	0.0 %	46,040	524,937

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.1 Notes:

None

Data Alerts:

None

NOM-5.2 Percent of early preterm births (<34 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	2.3 %	0.0 %	11,557	493,900
2012	2.3 %	0.0 %	11,519	502,704

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	2.3 %	0.0 %	11,648	501,020
2010	2.3 %	0.0 %	11,782	509,002
2009	2.3 %	0.0 %	12,301	524,937

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.2 Notes:

None

Data Alerts:

None

NOM-5.3 Percent of late preterm births (34-36 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	6.1 %	0.0 %	30,032	493,900
2012	6.2 %	0.0 %	30,920	502,704
2011	6.2 %	0.0 %	30,986	501,020
2010	6.3 %	0.0 %	31,797	509,002
2009	6.4 %	0.0 %	33,739	524,937

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-5.3 Notes:

None

Data Alerts:

None

NOM-6 Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	24.4 %	0.1 %	120,643	493,900
2012	25.0 %	0.1 %	125,897	502,704
2011	25.4 %	0.1 %	127,148	501,020
2010	26.5 %	0.1 %	134,867	509,002
2009	27.8 %	0.1 %	146,049	524,937

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM-6 Notes:

None

Data Alerts:

None

NOM-7 Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013/Q2-2014/Q1	5.0 %			

Legends:

Indicator results were based on a shorter time period than required for reporting

NOM-7 Notes:

None

Data Alerts:

None

NOM-8 Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	5.6	0.1 %	2,760	496,101
2012	5.2	0.1 %	2,603	505,085
2011	5.4	0.1 %	2,731	503,491
2010	5.3	0.1 %	2,688	511,514
2009	5.3	0.1 %	2,803	528,392

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-8 Notes:

None

Data Alerts:

None

NOM-9.1 Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.8	0.1 %	2,354	494,705
2012	4.5	0.1 %	2,244	503,755
2011	4.8	0.1 %	2,403	502,120
2010	4.7	0.1 %	2,417	510,198
2009	4.9	0.1 %	2,590	527,020

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.1 Notes:

None

Data Alerts:

None

NOM-9.2 Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	3.3	0.1 %	1,648	494,705
2012	3.1	0.1 %	1,582	503,755
2011	3.4	0.1 %	1,704	502,120
2010	3.3	0.1 %	1,685	510,198
2009	3.3	0.1 %	1,756	527,020

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.2 Notes:

None

Data Alerts:

None

NOM-9.3 Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	1.4	0.1 %	706	494,705
2012	1.3	0.1 %	662	503,755
2011	1.4	0.1 %	699	502,120
2010	1.4	0.1 %	732	510,198
2009	1.6	0.1 %	834	527,020

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.3 Notes:

None

Data Alerts:

None

NOM-9.4 Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	166.8	5.8 %	825	494,705
2012	147.7	5.4 %	744	503,755

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011	164.9	5.7 %	828	502,120
2010	163.1	5.7 %	832	510,198
2009	158.8	5.5 %	837	527,020

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.4 Notes:

None

Data Alerts:

None

NOM-9.5 Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	51.6	3.2 %	255	494,705
2012	50.0	3.2 %	252	503,755
2011	47.8	3.1 %	240	502,120
2010	51.2	3.2 %	261	510,198
2009	48.2	3.0 %	254	527,020

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-9.5 Notes:

None

Data Alerts:

None

NOM-10 The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

FAD Not Available for this measure.

NOM-10 Notes:

None

Data Alerts:

None

NOM-11 The rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations

Data Source: State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	5.6	0.1 %	2,668	475,335
2011	4.6	0.1 %	2,220	478,085
2010	4.6	0.1 %	2,235	488,532
2009	4.1	0.1 %	2,059	507,191
2008	2.9	0.1 %	1,525	532,038

Legends:
🏴 Indicator has a numerator ≤10 and is not reportable
ϟ Indicator has a numerator <20 and should be interpreted with caution

NOM-11 Notes:

None

Data Alerts:

None

NOM-12 Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-12 Notes:

None

Data Alerts:

None

NOM-13 Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM-13 Notes:

None

Data Alerts:

None

NOM-14 Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	22.1 %	1.5 %	1,918,067	8,680,928

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-14 Notes:

None

Data Alerts:

None

NOM-15 Child Mortality rate, ages 1 through 9 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	13.5	0.5 %	618	4,568,839
2012	13.7	0.6 %	628	4,573,601
2011	14.8	0.6 %	675	4,552,448
2010	15.0	0.6 %	680	4,543,114
2009	17.1	0.6 %	771	4,511,167

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-15 Notes:

None

Data Alerts:

None

NOM-16.1 Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	25.2	0.7 %	1,309	5,187,609
2012	24.4	0.7 %	1,281	5,255,464
2011	26.2	0.7 %	1,396	5,325,505
2010	26.8	0.7 %	1,449	5,414,870
2009	29.7	0.7 %	1,615	5,440,872

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.1 Notes:

None

Data Alerts:

None

NOM-16.2 Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	7.7	0.3 %	622	8,124,990
2010_2012	7.1	6.5 %	585	8,289,696
2009_2011	8.0	7.4 %	669	8,412,412
2008_2010	9.1	8.4 %	768	8,481,411
2007_2009	11.6	10.9 %	980	8,451,072

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.2 Notes:

None

Data Alerts:

None

NOM-16.3 Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2013	5.5	5.0 %	445	8,124,990

Year	Annual Indicator	Standard Error	Numerator	Denominator
2010_2012	5.4	4.9 %	446	8,289,696
2009_2011	5.5	5.0 %	462	8,412,412
2008_2010	5.1	4.6 %	433	8,481,411
2007_2009	4.8	4.3 %	404	8,451,072

Legends:
Indicator has a numerator <10 and is not reportable
Indicator has a numerator <20 and should be interpreted with caution

NOM-16.3 Notes:

None

Data Alerts:

None

NOM-17.1 Percent of children with special health care needs

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	15.0 %	1.2 %	1,387,632	9,248,443
2007	14.5 %	1.5 %	1,358,794	9,392,086
2003	13.3 %	0.9 %	1,250,474	9,378,237

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.1 Notes:

None

Data Alerts:

None

NOM-17.2 Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	16.3 %	1.7 %	147,835	908,236

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-17.2 Notes:

None

Data Alerts:

None

NOM-17.3 Percent of children diagnosed with an autism spectrum disorder

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	2.0 %	0.6 %	152,153	7,772,911
2007	0.4 %	0.3 %	32,857	7,829,111

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.3 Notes:

None

Data Alerts:

None

NOM-17.4 Percent of children diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	5.5 %	0.9 %	425,509	7,759,284
2007	4.3 %	1.0 %	337,647	7,792,432

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-17.4 Notes:

None

Data Alerts:

None

NOM-18 Percent of children with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	62.7 %	6.5 %	424,480	677,498
2007	53.8 %	8.5 %	281,217	522,791
2003	54.6 %	5.6 %	274,018	501,615

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-18 Notes:

None

Data Alerts:

None

NOM-19 Percent of children in excellent or very good health

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	77.6 %	1.5 %	7,179,542	9,247,696
2007	77.7 %	2.0 %	7,300,335	9,392,086
2003	77.5 %	1.1 %	7,268,304	9,378,237

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-19 Notes:

None

Data Alerts:

None

NOM-20 Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	30.4 %	2.5 %	1,172,712	3,857,835
2007	30.5 %	3.2 %	1,193,001	3,910,432
2003	30.1 %	1.9 %	1,064,126	3,541,460

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012	34.5 %	0.1 %	214,173	620,378

Legends:
Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Legends:
Indicator has an unweighted denominator <100 and is not reportable
Indicator has a confidence interval width >20% and should be interpreted with caution

NOM-20 Notes:

None

Data Alerts:

None

NOM-21 Percent of children without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	7.4 %	0.2 %	673,848	9,166,036
2012	8.1 %	0.2 %	744,050	9,229,544
2011	8.0 %	0.2 %	740,018	9,263,415
2010	9.1 %	0.2 %	842,611	9,303,929
2009	9.4 %	0.2 %	889,219	9,431,766

Legends:
Indicator has an unweighted denominator <30 and is not reportable
Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

NOM-21 Notes:

None

Data Alerts:

None

NOM-22.1 Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	69.3 %	4.0 %	507,389	731,918
2012	66.8 %	3.8 %	495,075	741,593
2011	70.1 %	2.9 %	537,744	766,808
2010	54.1 %	3.4 %	431,958	798,406
2009	49.9 %	3.2 %	418,633	839,003

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.1 Notes:

None

Data Alerts:

None

NOM-22.2 Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2014	63.0 %	2.1 %	5,411,810	8,583,798
2012_2013	56.9 %	2.0 %	4,914,724	8,644,738
2011_2012	53.4 %	2.3 %	4,669,752	8,738,930
2010_2011	50.7 %	1.7 %	4,383,557	8,646,070
2009_2010	40.2 %	1.7 %	3,350,628	8,334,895

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.2 Notes:

None

Data Alerts:

None

NOM-22.3 Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Female

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	67.6 %	4.8 %	859,363	1,271,898
2012	65.0 %	4.2 %	835,170	1,284,159
2011	65.0 %	3.5 %	846,880	1,302,873
2010	56.1 %	4.6 %	706,463	1,259,365
2009	49.2 %	4.8 %	639,630	1,299,337

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Male

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	50.9 %	4.9 %	679,233	1,334,396
2012	29.4 %	3.8 %	395,293	1,346,253
2011	13.0 %	2.6 %	178,299	1,368,081

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.3 Notes:

None

Data Alerts:

None

NOM-22.4 Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	91.1 %	2.3 %	2,373,154	2,606,294
2012	89.4 %	2.0 %	2,352,300	2,630,411
2011	82.5 %	2.0 %	2,202,745	2,670,954
2010	71.2 %	2.9 %	1,839,853	2,585,060
2009	53.1 %	3.3 %	1,416,155	2,665,818

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.4 Notes:

None

Data Alerts:

None

NOM-22.5 Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	80.9 %	2.9 %	2,107,567	2,606,294
2012	76.0 %	2.8 %	1,997,989	2,630,411
2011	75.4 %	2.2 %	2,013,617	2,670,954
2010	66.7 %	3.0 %	1,723,450	2,585,060
2009	58.4 %	3.2 %	1,557,992	2,665,818

Legends:
Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM-22.5 Notes:

None

Data Alerts:

None

Form 10a
National Performance Measures (NPMs)

State: California

NPM-1 Percent of women with a past year preventive medical visit

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	65.3	65.3	65.3	65.3	65.3

NPM-3 Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	81.4	81.4	81.4	81.4	81.4

NPM-4 A) Percent of infants who are ever breastfed

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	95.2	95.2	95.2	95.2	95.2

NPM-4 B) Percent of infants breastfed exclusively through 6 months

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	28.8	28.8	28.8	28.8	28.8

NPM-6 Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

Annual Objectives					
	2016	2017	2018	2019	2020

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	29.9	29.9	29.9	29.9	29.9

NPM-9 Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	14.0	14.0	14.0	14.0	14.0

NPM-11 Percent of children with and without special health care needs having a medical home

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	37.4	37.4	37.4	37.4	37.4

NPM-12 Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	39.2	39.2	39.2	39.2	39.2

NPM-15 Percent of children ages 0 through 17 who are adequately insured

Annual Objectives					
	2016	2017	2018	2019	2020
Annual Objective	81.9	81.9	81.9	81.9	81.9

Form 10b

State Performance/Outcome Measure Detail Sheet

State: California

States are not required to create SOMs/SPMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10c

Evidence-Based or Informed Strategy Measure Detail Sheet

State: California

States are not required to create ESMs until the FY 2017 Application/FY 2015 Annual Report.

Form 10d
National Performance Measures (NPMs) (Reporting Year 2014 & 2015)

State: California

Form Notes for Form 10d NPMs and SPMs

None

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

	2011	2012	2013	2014	2015
Annual Objective	100.0	100.0	100.0	100.0	100.0
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	663	602	515		
Denominator	663	602	515		
Data Source	Genetic Disease Screening Program	Genetic Disease Screening Program	Genetic Disease Screening Program	Genetic Disease Screening Program	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

   Field Note:
   A provisional indicator is reported for 2014.

2. **Field Name:** **2013**

   Field Note:
   • It is assumed that all confirmed cases need treatment and received treatment.

3. **Field Name:** **2012**

   Field Note:
   NBS includes screening for the following conditions: Phenylketonuria (PKU), congenital hypothyroidism, galactosemia, sickle cell disease (Hb S/S, Hb S/+Thalassemia, and Hb S/B0 Thalassemia only), congenital adrenal hyperplasia, over 40 non-PKU inborn errors of metabolism tested by tandem mass spectrometry, cystic fibrosis, biotidinase deficiency, and severe combined immunodeficiency disorders (SCID).

   The number or affected newborns receiving timely follow-up is the number of cases summed over all screened disorders. It is extremely rare for a newborn to be a case for more than one screened disorder.

4.	**Field Name:**	**2011**

Field Note:
NBS includes screening for the following conditions: Phenylketonuria (PKU), congenital hypothyroidism, galactosemia, sickle cell disease (Hb S/S, Hb S/+Thalassemia, and Hb S/B0 Thalassemia only), congenital adrenal hyperplasia, over 40 non-PKU inborn errors of metabolism tested by tandem mass spectrometry, cystic fibrosis, biotidinase deficiency, , and pilot testing for severe combined immunodeficiency disorders (SCID).

The number or affected newborns receiving timely follow-up is the number of cases summed over all screened disorders. It is extremely rare for a newborn to be a case for more than one screened disorder.

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	48.0	48.0	48.0	48.0	48.0
Annual Indicator	61.8	61.8	61.8	61.8	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey	National Survey	National Survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2009/10. Note: this population, estimated to be 997,157, is not generalizable to CCS because this includes all incomes and persons with non-CCS eligible conditions.

4. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	44.0	44.0	44.0	44.0	44.0

	2011	2012	2013	2014	2015
Annual Indicator	38.3	38.3	38.3	38.3	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws,

respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	61.0	61.0	61.0	61.0	61.0
Annual Indicator	59.1	59.1	59.1	59.1	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2.	**Field Name:**	**2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3.	**Field Name:**	**2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4.	**Field Name:**	**2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 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)

	2011	2012	2013	2014	2015
Annual Objective	87.0	87.0	87.0	87.0	87.0
Annual Indicator	64.8	64.8	64.8	64.8	
Numerator					
Denominator					
Data Source	National Survey of	National Survey of	National Survey of	National Survey of	

	2011	2012	2013	2014	2015
	CSHCN	CSHCN	CSHCN	CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording,

order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 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.

	2011	2012	2013	2014	2015
Annual Objective	39.0	39.0	39.0	39.0	39.0
Annual Indicator	37.4	37.4	37.4	37.4	
Numerator					
Denominator					
Data Source	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	National Survey of CSHCN	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

2. **Field Name:** **2013**

Field Note:
For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs

(CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.
All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

3. **Field Name:** **2012**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

4. **Field Name:** **2011**

Field Note:
For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Data Alerts:

None

NPM 07 - Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

	2011	2012	2013	2014	2015
Annual Objective	82.1	82.1	82.1	82.1	82.1

	2011	2012	2013	2014	2015
Annual Indicator	81.7	73.5	81.9	81.9	
Numerator	404,197	359,215	414,778		
Denominator	494,733	488,728	506,444		
Data Source	National Immunization Survey	National Immunization Survey	National Immunization Survey	National Immunization Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
A manual indicator is reported for 2014 based on 2013.

2. **Field Name:** **2013**

Field Note:
Source of percent immunized: US, National Immunization Survey, Q1/2013-Q4/2013. Denominator: The number of two-year olds in the given year is from the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity and Detailed Age and Gender, 2010–2060. Sacramento, CA, December 2014. Numerators are estimates derived by multiplying the percent of immunized children by the denominator. The 4:3:1:3:3 series coverage is based on the new definition for this series. Coverage estimates are based on 4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Hib vaccine, and 3 or more doses of hepatitis B vaccine.

3. **Field Name:** **2012**

Field Note:
Source of percent immunized: US, National Immunization Survey, Q1/2012-Q4/2012.

Denominator: The number of two-year olds in the given year is from the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age and Gender, 2010–2060. Sacramento, CA, January 2013. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

The 4:3:1:3:3 series coverage is based on the new definition for this series. Coverage estimates are based on 4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Hib vaccine, and 3 or more doses of hepatitis B vaccine. The new definition for Hib takes into consideration the brand type (meaning some children only need 3 doses to be up to date, while others need 4 doses to be up to date), It is not recommended for comparison to data for years prior to 2009 because of changes in the way Hib vaccine is now measured.

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4.	**Field Name:**	**2011**

Field Note:
Source of percent immunized: Estimated Vaccination Coverage with 4:3:1:3:3 Among Children 19-35 Months of Age by Race/Ethnicity‡ and by State and Local Area -- US, National Immunization Survey, Q1/2011-Q4/2011. Data requested from CDC.

Denominator: The number of two-year olds in the given year is from the State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age and Gender, 2010–2060. Sacramento, CA, January 2013. Numerators are estimates derived by multiplying the percent of immunized children by the denominator.

The 4:3:1:3:3 series coverage is based on the original definition for this series. CDC made this series coverage unavailable starting with the 2010 survey results; it is not recommended for comparison to years prior to 2009 because of the changes made in the way the Haemophilus influenzae type b (Hib) vaccine is now measured. Coverage estimates are based on 4 or more doses of DTaP, 3 or more doses of poliovirus vaccine, 1 or more doses of any MMR vaccine, 3 or more doses of Hib vaccine, and 3 or more doses of hepatitis B vaccine.

Data Alerts:

None

NPM 08 - The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

	2011	2012	2013	2014	2015
Annual Objective	17.4	17.4	17.4	17.4	17.4
Annual Indicator	14.8	13.1	11.1	11.1	
Numerator	11,839	10,359	8,525		
Denominator	801,527	788,279	764,915		
Data Source	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
A manual indicator is reported for 2014 based on 2013.

2.	**Field Name:**	**2013**

Field Note:

Data Source for Numerator: State of California, Department of Public Health, Center for Health Statistics, 2013 California Birth Statistical Master File. Data Source for Denominator: State of California, Department of Finance, State and County Population Projections by Race/Ethnicity, Sex, and Age, 2010-2060, Sacramento, California, December 2014. Tabulations were done by the MCAH Program. Rates for 2010-2012 have been revised based on the updated population's projections for 2010-2060. The revised rates are as follows: 2010= 16.5, 2011= 14.9 and 2012 = 13.3

3.	**Field Name:**	**2012**

Field Note:
Numerator: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations were done by the MCAH Program..

Data reported for 2012 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 16.4.

4.	**Field Name:**	**2011**

Field Note:
Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations were done by the MCAH Program.

Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 16.4.

Data Alerts:

None

NPM 09 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

	2011	2012	2013	2014	2015
Annual Objective	29.0	29.0	29.0	26.3	26.3
Annual Indicator	27.6	16.4	10.9	10.9	
Numerator	129,101	146,702	118,217		
Denominator	467,758	893,580	1,085,391		
Data Source	Dental Health Foundation	CMS Form 415	CMS Form 415	CMS Form 415	

	2011	2012	2013	2014	2015
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: A manual indicator is reported for 2014 based on 2013.	
2.	**Field Name:**	**2013**
	Field Note: Data Source: California Department of Healthcare Services. CMS 416 Reporting- Total County by Line. Federal Fiscal Reporting Period: 2012-2013. Available at: http://www.dhcs.ca.gov/services/Documents/cms416_mar28.pdf. Last accessed on March 5, 2015.	
3.	**Field Name:**	**2012**
	Field Note: Data Source: Center for Medicaid and CHIP Services. Early and Periodic Screening, Diagnostic, and Treatment, CMS Form 416, 2012 State Data. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT2012National.zip. Last accessed on March 12, 2014. Unlike in prior years, data for 2012 represents the percentage of Medi-Cal beneficiaries ages 6-9 who are eligible for EPSDT for 90 continuous days for FFY 2012, receiving a sealant on a permanent molar tooth. Thus, data reported for 2012 is not comparable to data reported in prior years.	
4.	**Field Name:**	**2011**
	Field Note: A Data source for percent of third grade children with sealants: Dental Health Foundation, California Smile Survey, "Mommy It Hurts to Chew," February 2006. Accessed 03/20/13. Denominator source: California Department of Education. Accessed 03/20/13 at http://dq.cde.ca.gov/dataquest/Enrollment/GradeEnr.aspx?cChoice=StEnrGrd&cYear=2011-12&cLevel=State&cTopic=Enrollment&myTimeFrame=S&cType=ALL&cGender=B *Based on weighted results from a completed survey of a representative sample of elementary schools in California conducted during 2004-05. Dental sealant information is based on one-minute, non-invasive oral health screening of all third graders in selected schools using protocols from the Association of State and Territorial Dental Directors at http://www.dentalhealthfoundation.org/index.php?option=com_content&task=view&id=43&Itemid=60. Accessed 02/21/12.	

Data Alerts:

None

NPM 10 - The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

	2011	2012	2013	2014	2015
Annual Objective	1.6	1.6	1.6	1.6	1.6
Annual Indicator	1.1	1.4	1.4	1.4	
Numerator	85	105	108		
Denominator	7,568,037	7,554,127	7,539,906		
Data Source	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
A manual indicator is reported for 2014 based on 2013.

2. **Field Name:** **2013**

Field Note:
Source Data for Numerator: State of California, Department of Public Health, Center for Health Statistics, 2013 California Death Statistical Master File [The International Classification of Diseases (ICD)-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83- V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2]. Source Data for Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, December 2014.Tabulations (by place of residence) were done by the MCAH Program. Data for 2013 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (December 2014). The rates for 2010-2012 using these updated population projections were 1.1, 1.1 and 1.4 respectively.

3. **Field Name:** **2012**

Field Note:
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File [The International Classification of Diseases (ICD)-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83- V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations (by place of residence) were done by the MCAH Program.

Data for 2011-2012 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 1.1.

4.	**Field Name:**	**2011**

Field Note:
Source Data: Numerator: State of California, Department of Public Health, Center for Health Statistics, 2011 California Death Statistical Master File [The International Classification of Diseases (ICD)-10 codes for fatal MV traffic injuries are: V30-V79(.4-.9), V81.1, V82.1, V83-V86(.0-.3), V20-V28(.3-.9), V29(.4-.9), V12-V14 (.3-.9), V19(.4-.6), V02-V04 (.1,.9), V09.2, V80(.3-.5), V87(.0-.8), V89.2].

Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.Tabulations (by place of residence) were done by the MCAH Program.

Data for 2011 should not be compared to data reported in previous years due to recent updates in the population projections released by the California Department of Finance (January 2013). The rate for 2010 using these updated population projections was 1.1.

Data Alerts:

None

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

	2011	2012	2013	2014	2015
Annual Objective	64.2	64.2	64.2	64.2	64.2
Annual Indicator	63.7	64.9	65.4	65.4	
Numerator	240,072	245,022	237,654		
Denominator	376,830	377,290	363,342		
Data Source	MIHA	MIHA	MIHA	MIHA	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
A manual indicator is reported for 2014 based on 2013.

2.	**Field Name:**	**2013**

Field Note:
Data Source: 2013 Maternal and Infant Health Assessment Survey (MIHA), MCAH Program, CA Department of Public Health. Numerator Definition: The number of women who delivered a live birth and who reported that they were still breastfeeding their infant at 3 months of age. Denominator Definition: The number of women who delivered a live birth that reported whether or not they were still breastfeeding at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum. Note: Data from 2011 through 2013 cannot be compared to data for prior years due to changes to the wording of the infant feeding questions; 2011 serves as new baseline to track progress.

3. **Field Name:** **2012**

Field Note:
Source: 2012 Maternal and Infant Health Assessment Survey (MIHA), MCAH Program, CA Department of Public Health.

Numerator: The number of women who delivered a live birth and who reported that they were still breastfeeding their infant at 3 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they were still breastfeeding at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum.

2011 and 2012 data cannot be compared to data for prior years due to changes to the wording of the infant feeding questions. 2011 will serve as new baseline to track progress.

4. **Field Name:** **2011**

Field Note:
Numerator: The number of women who delivered a live birth and who reported that they were still breastfeeding their infant at 3 months of age. Denominator: The number of women who delivered a live birth that reported whether or not they were still breastfeeding at 3 months of age. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth that year and exclude mothers who could not answer the question because they responded to the survey before 3 months post-partum.

Note: 2011 data cannot be compared to data for prior years due to changes to the wording of the infant feeding questions. 2011 will serve as new baseline to track progress.

Data Alerts:

None

NPM 12 - Percentage of newborns who have been screened for hearing before hospital discharge.

	2011	2012	2013	2014	2015
Annual Objective	98.0	99.0	99.0	99.0	99.0
Annual Indicator	97.9	95.0	97.0	97.1	
Numerator	492,337	479,430	479,412	480,000	

	2011	2012	2013	2014	2015
Denominator	503,016	504,814	494,392	494,392	
Data Source	Office of Vital Records	Office of Vital Records birth cert data;NHSP data	Office of Vital Records Birth Certificate	Ofice of Vital Records	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2013**
	Field Note: no data available at this time due to change in contractor.	
2.	**Field Name:**	**2012**
	Field Note: Hearing screening data are underreported for 2012 because there was a 4 month period with no Hearing Coordination Center contractor in Northern California. Aggregate and individual data from hospitals were not consistently collected during that time.	
3.	**Field Name:**	**2011**
	Field Note: Measure based on hospitals carrying out universal newborn hearing screening in California. This measure is the percent of newborns who have been screened for hearing before hospital discharge. Source: Numerator and denominator data are from the State of California, Department of Public Health, Office of Vital Records, birth certificate data. Numerator: Number of newborns who have been screened for hearing before discharge for FY 2011. Denominator: Number of live births by occurrence in California in FY 2011.	

Data Alerts:

None

NPM 13 - Percent of children without health insurance.

	2011	2012	2013	2014	2015
Annual Objective	10.0	10.0	10.0	10.0	10.0
Annual Indicator	11.3	10.2	8.1	8.1	
Numerator	1,102,686	993,064	778,519		

	2011	2012	2013	2014	2015
Denominator	9,796,707	9,782,535	9,671,038		
Data Source	Current Population Survey	Current Population Survey	Current Population Survey	Current Population Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

   Field Note:
   A manual indicator is reported for 2014 based on 2013.

2. **Field Name:** **2013**

   Field Note:
   Data Source: U.S. Census Bureau. 2014 Annual Social and Economic Supplement. Current Population Survey Table Creator. Available at: http://www.census.gov/cps/data/cpstablecreator.html. Last accessed on March 5, 2015. The numerator and denominator data were recalculated using the California Department of Finance population projections for 2011 and prior years. The numerator and denominator data reported for 2013 is based on the U.S. Census Bureau projections weighted to the 2010 U.S. Census.

3. **Field Name:** **2012**

   Field Note:
   Source: U.S. Census Bureau. 2013 Annual Social and Economic Supplement. Current Population Survey Table Creator. Available at: http://www.census.gov/cps/data/cpstablecreator.html. Last accessed on December 5, 2013. The numerator and denominator data were recalculated the California Department of Finance population projections for 2011 and prior years. The numerator and denominator data reported for 2012 is based on the U.S. Census Bureau projections weighted to the 2010 U.S. Census.

4. **Field Name:** **2011**

   Field Note:
   Source: Numerator of uninsured children age 0-18 is from the Kaiser Family Foundation analysis of the March 2011 release of the Current Population Survey. Denominator (estimate of the number of children 18 years of age and younger): State of California, Department of Finance,
   Report P-3 Population Projections by Race/Ethnic, Detailed Age, and Gender, 2010-2060, Sacramento, CA, January 2013.

   The percent of uninsured children 0-18 years was calculated by dividing the numerator by the denominator. The percent uninsured is rounded to the fifth decimal point.

Data Alerts:

None

NPM 14 - Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

	2011	2012	2013	2014	2015
Annual Objective	31.4	31.4	31.4	31.4	31.4
Annual Indicator	32.7	32.7	32.7	32.7	
Numerator	85,882				
Denominator	262,637				
Data Source	PedNSS	PedNSS	PedNSS	PedNSS	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: A manual indicator is reported for 2014 based on 2011	
2.	**Field Name:**	**2013**
	Field Note: A manual indicator is reported for 2013 based on 2011	
3.	**Field Name:**	**2012**
	Field Note: A manual indicator is reported for 2012 based on 2011.	
4.	**Field Name:**	**2011**
	Field Note: Data Source: CDC, Pediatric Nutrition Surveillance System (PedNSS) Annual Reports for CY 2011. Table 6D, 2011 Pediatric Nutrition Surveillance, National, Comparison of Growth and Anemia Indicators by Contributor, Children Aged < 5 years..	

Data Alerts:

None

NPM 15 - Percentage of women who smoke in the last three months of pregnancy.

	2011	2012	2013	2014	2015

Annual Objective	2.6	2.6	2.6	2.6	2.6
Annual Indicator	2.9	2.6	2.5	2.5	
Numerator	14,269	12,748	12,057		
Denominator	489,359	491,659	483,469		
Data Source	MIHA	MIHA	MIHA	MIHA	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**
	Field Note: A manual indicator is reported for 2014 based on 2013.	
2.	**Field Name:**	**2013**
	Field Note: Source: 2013MIHA survey, MCAH Program, California Department of Public Health. Numerator Definition: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator Definition: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy. Numerator and denominator are weighted to the number of resident women in the state who delivered a live birth in 2013.	
3.	**Field Name:**	**2012**
	Field Note: Source: 2012 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy. Numerator and denominator are weighted to the number of resident women in the state who delivered a live birth in 2012.	
4.	**Field Name:**	**2011**
	Field Note: Source: 2011 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who delivered a live birth and who reported any smoking in the third trimester of pregnancy. Denominator: The number of women who delivered a live birth and reported whether or not they had smoked during their third trimester of pregnancy. Numerator and denominator are weighted to the number of resident women in the state who delivered a live birth in 2011.	

Data Alerts:

None

NPM 16 - The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

	2011	2012	2013	2014	2015
Annual Objective	4.1	4.1	4.1	4.1	4.1
Annual Indicator	5.8	4.6	5.5	5.5	
Numerator	163	129	149		
Denominator	2,819,402	2,792,808	2,697,644		
Data Source	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	CA Death Statistical Master File	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

Field Note:
A manual indicator is reported for 2014 based on 2013.

2. **Field Name:** **2013**

Field Note:
Source Data for Numerator: State of California, Department of Public Health, Center for Health Statistics, 2013 California Death Statistical Master File (ICD-10 Death Codes X78,X72-X74,X70,X80,X60- X69,X71,X75-X77,X79,X81-X84,U030,U039). Source Data for Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, December 2014. Tabulations (by place of residence) were done by the MCAH Program. Data reported for 2013 should not be compared to data reported in previous years due to updates in the population projections released by the California Department of Finance (December 2014). The rates for 2010-2012 using these updated population projections were 5.3, 5.8 and 4.7 respectively.

3. **Field Name:** **2012**

Field Note:
2012 California Death Statistical Master File (ICD-10 Death Codes X78,X72-X74,X70,X80,X60- X69,X71,X75-X77,X79,X81-X84,U030,U039). Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.. Tabulations (by place of residence) were done by the MCAH Program.

Data reported for 2011-2012 should not be compared to data reported in previous years due to updates in the

population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 5.3.

4.	**Field Name:**	**2011**

Field Note:
2011 California Death Statistical Master File (ICD-10 Death Codes X78,X72-X74,X70,X80,X60-X69,X71,X75-X77,X79,X81-X84,U030,U039). Denominator: State of California, Department of Finance, Report P-3: State and County Population Projections by Race/Ethnicity, Detailed Age, and Gender, 2010-2060. Sacramento, California, January 2013.. Tabulations (by place of residence) were done by the MCAH Program.

Data reported for 2011 should not be compared to data reported in 2010 due to updates in the 2010- 2060 population projections released by the California Department of Finance (January 2013). Rate for 2010 using the updated population estimate = 5.3.

Data Alerts:

None

NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

	2011	2012	2013	2014	2015
Annual Objective	78.6	78.6	78.6	78.6	78.6
Annual Indicator	77.7	77.5	79.8	79.8	
Numerator	4,437	4,350	4,521		
Denominator	5,714	5,615	5,668		
Data Source	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d NPMs:

1.	**Field Name:**	**2014**

Field Note:
A manual indicator is reported for 2014 based on 2013.

2.	**Field Name:**	**2013**

Field Note:
Data Source: State of California, Department of Public Health, Center for Health Statistics, 2013 California Birth Statistical Master File and California Children Services (CCS), Approved Hospitals for NICUs as of December 2013. Tabulations by place of occurrence were done by the MCAH. Data exclude births with unknown birth weight

or births weighing <227g or >8165g. MCAH included births at three birthing hospitals that share a hospital campus or building with a CCS-approved Children's Hospital that has an appropriate level NICU (i.e., the birthing hospital and children's hospital are administratively different hospitals, but are co-located in the same building or campus). Data for 2008-2013 should be not compared to data reported in previous years due to a change in exclusion criteria and methodology.

3. **Field Name:** **2012**

Field Note:
Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File and California Children Services (CCS), Approved Hospitals for NICUs as of December 2012.

Tabulations by place of occurrence were done by the MCAH. Data exclude births with unknown birth weight or births weighing <227g or >8165g. MCAH included births at three birthing hospitals that share a hospital campus or building with a CCS-approved Children's Hospital that has an appropriate level NICU (i.e., the birthing hospital and children's hospital are administratively different hospitals, but are co-located in the same building or campus). Data for 2008-2012 should be not compared to data reported in previous years due to a change in exclusion criteria and methodology.

4. **Field Name:** **2011**

Field Note:
Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File and California Children Services (CCS), Approved Hospitals for NICUs as of December 2011.

Tabulations by place of occurrence were done by the MCAH. Data exclude births with unknown birth weight or births weighing <227g or >8165g. MCAH included births at three birthing hospitals that share a hospital campus or building with a CCS-approved Children's Hospital that has an appropriate level NICU (i.e., the birthing hospital and children's hospital are administratively different hospitals, but are co-located in the same building or campus). Data for 2008-2011 should be not compared to data reported in previous years due to a change in exclusion criteria and methodology.

Data Alerts:

None

NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

	2011	2012	2013	2014	2015
Annual Objective	86.8	86.8	86.8	86.8	86.8
Annual Indicator	83.5	83.8	83.6	83.6	
Numerator	410,213	412,679	406,035		
Denominator	491,034	492,643	485,538		
Data Source	CA Birth Statistical	CA Birth Statistical	CA Birth Statistical	CA Birth Statistical	

	2011	2012	2013	2014	2015
	Master File	Master File	Master File	Master File	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d NPMs:

1. **Field Name:** **2014**

   Field Note:
   A manual indicator is reported for 2014 based on 2013.

2. **Field Name:** **2013**

   Field Note:
   Data Source: State of California, Department of Public Health, Center for Health Statistics, 2013 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

3. **Field Name:** **2012**

   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

   Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

4. **Field Name:** **2011**

   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program.

   Cases in which the time of the first prenatal visit was unknown were excluded from the denominator.

Data Alerts:

None

Form 10d

State Performance Measures (SPMs) (Reporting Year 2014 & 2015)

State: California

SPM 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

	2011	2012	2013	2014	2015
Annual Objective	0.0	30.0	40.0	40.0	40.0
Annual Indicator	0.0	0.0	0.0	2.9	
Numerator	0	0		6,575	
Denominator	1	1		224,210	
Data Source	Pilot Programs Data, CMSNet	Pilot Programs	Pilot Programs	CMS Net/MISDSS	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: TBD	
2.	**Field Name:**	**2012**
	Field Note: This measure is 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. This is a new measure from the 2010 Needs Assessment. The 1115 Federal Waiver CCS Pilot Programs will begin January 2012 so there will be no data for this measure until 2013 for calendar year 2012.	

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2011 SPM# 1. Please review your data to ensure this is correct.

2.	A value of zero has been entered for the numerator for year 2012 SPM# 1. Please review your data to ensure this is correct.

SPM 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.

	2011	2012	2013	2014	2015
Annual Objective	0.0	50.0	50.0	55.0	55.0
Annual Indicator	0.0	0.0	0.0	41.5	
Numerator	0	0		4,065	
Denominator	1	1		9,787	
Data Source	On-line Survey and CCS County programs	On-line Survey	On-line Survey	Statewide CCS survey	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: TBD	
2.	**Field Name:**	**2012**
	Field Note: Survey is currently being developed for children and families in the 1115 waiver by the UCLA Center for Health Policy Research. The CCS Pilot Evaluation Planning Committee, consisting of State and County CCS staff and family representatives, and the CCS Pilot Projects Stakeholder group, provide input into the survey. It is expected that survey will be expanded to representative sample of families with CCS eligible children who do not reside in county participating in 1115 waiver.	

Data Alerts:

1.	A value of zero has been entered for the numerator for year 2011 SPM# 3. Please review your data to ensure this is correct.

2.	A value of zero has been entered for the numerator for year 2012 SPM# 3. Please review your data to ensure this is correct.

SPM 4 - The percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.

	2011	2012	2013	2014	2015
Annual Objective	12.7	12.7	12.7	12.7	12.7
Annual Indicator	13.1	13.9	14.7	14.7	
Numerator	64,188	68,000	70,707		
Denominator	488,606	488,545	480,280		
Data Source	MIHA	MIHA	MIHA	MIHA	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
A manual indicator is reported for 2014 based on 2013.

2. **Field Name:** **2013**

Field Note:
Data Source: 2013 MIHA survey, MCAH Program, California Department of Public Health. Numerator Definition: The number of women who reported that they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant. Denominator Definition: The number of women who reported whether or not they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant plus the number of such women who reported drinking no alcoholic drinks in the past two years. Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in that year.

3. **Field Name:** **2012**

Field Note:
Source: 2012 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who reported that they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant. Denominator: The number of women who reported whether or not they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant plus the number of such women who reported drinking no alcoholic drinks in the past two years.

Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in 2012.

4. **Field Name:** **2011**

Field Note:
Source: 2011 MIHA survey, MCAH Program, California Department of Public Health. Numerator: The number of women who reported that they had four or more drinks in one sitting at least once during the three months before they got pregnant with their most recent live-born infant. Denominator: The number of women who reported whether or not they had four or more drinks in one sitting at least once during the three months before they got

pregnant with their most recent live-born infant plus the number of such women who reported drinking no alcoholic drinks in the past two years.

Numerator and denominator are weighted to the representative number of resident women in the state who delivered a live birth in 2011. In 2011, a new methodology (raking or iterative proportional fitting) was implemented to calculate MIHA survey weights. However, data from prior years are still comparable to 2011.

Data Alerts:

None

SPM 5 - The percent of cesarean births among low-risk women giving birth for the first time.

	2011	2012	2013	2014	2015
Annual Objective	25.1	25.1	25.1	25.1	25.1
Annual Indicator	26.3	26.7	26.5	26.5	
Numerator	40,777	42,429	42,424		
Denominator	155,169	159,030	159,869		
Data Source	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	CA Birth Statistical Master File	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

   Field Note:
   A manual indicator is reported for 2014 based on 2013.

2. **Field Name:** **2013**

   Field Note:
   Data Source: State of California, Department of Public Health, 2013 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Numerator Definition: The number of births delivered by cesarean section to low-risk women giving birth for the first time. Denominator Definition: The number of live births to low-risk women giving birth for the first time. The numerator and denominator represent live births that occurred in California in 2013. Low-risk is defined as full-term (i.e., greater than or equal to 37 weeks gestation), singleton pregnancy, with vertex fetal presentation (head down in the uterus).

3. **Field Name:** **2012**

   Field Note:
   Source: State of California, Department of Public Health, 2012 California Birth Statistical Master File. Tabulations

(by place of residence) were done by the MCAH Program. Numerator: The number of births delivered by cesarean section to low-risk women giving birth for the first time. Denominator: The number of live births to low-risk women giving birth for the first time. The numerator and denominator represent live births that occurred in California in 2012. Starting in 2010, births with gestational age greater than 37 weeks were excluded from the analysis. This new exclusion did not affect rates from prior years (2007-2009).Low-risk is defined as full-term (i.e., greater than or equal to 37 weeks gestation), singleton pregnancy, with vertex fetal presentation (head down in the uterus).

4. **Field Name:** **2011**

Field Note:
Source: 2011 Birth Statistical Master File, MCAH Program, California Department of Public Health. Numerator: The number of births delivered by cesarean section to low-risk women giving birth for the first time. Denominator: The number of live births to low-risk women giving birth for the first time. The numerator and denominator represent live births that occurred in California in 2011. Starting in 2010, births with gestational age greater than 37 weeks were excluded from the analysis. This new exclusion did not affect rates from prior years (2007-2009).
Low-risk is defined as full-term (i.e., greater than or equal to 37 weeks gestation), singleton pregnancy, with vertex fetal presentation (head down in the uterus).

Data Alerts:

None

SPM 6 - The percent of women of reproductive age who are obese.

	2011	2012	2013	2014	2015
Annual Objective	21.7	21.7	21.7	21.7	21.7
Annual Indicator	21.3	21.6	22.0	22.0	
Numerator	1,316,522	1,138,418	1,244,893		
Denominator	6,181,065	5,258,411	5,650,067		
Data Source	Behavioral Risk Factor Survey	Behavioral Risk Factor Survey	CA Behavioral Risk Factor Survey	CA Behavioral Risk Factor Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

Field Note:
A manual indicator is reported for 2014 based on 2013.

2. **Field Name:** **2013**

Field Note:
Data Source: 2013 California Behavioral Risk Factor Survey (BRFS), California Department of Public Health. Numerator Definition: The number of women aged 18-44 years who have a body mass index (BMI) greater than or equal to 30 kilograms body weight / body surface area in square meters (kg/m2). Denominator Definition The number of women aged 18-44 years for whom BMI can be calculated. Results are weighted using 2010 population estimates from the California Department of Finance and exclude women who reported being pregnant at the time of the survey, and women with height < 48 in. or >= 84 in., weight < 75 lbs. or > 399 lbs. or those for whom BMI cannot be calculated (i.e. missing height and/or weight information). Data for 2011 and 2012 should not be compared to data reported in previous years (including 2010) as these data are weighted using 2010 population estimates and previous years are weighted using 2000 population estimates.

3. **Field Name:** **2012**

Field Note:
Source: 2012 California Behavioral Risk Factor Survey (BRFS), California Department of Public Health. Numerator: The number of women aged 18-44 years who have a body mass index (BMI) greater than or equal to 30 kilograms body weight / body surface area in square meters (kg/m2). Denominator: The number of women aged 18-44 years for whom BMI can be calculated. Results are weighted using 2010 population estimates from the California Department of Finance and exclude women who reported being pregnant at the time of the survey, and women with height < 48 in. or = 84 in., weight < 75 lbs. or > 399 lbs. or those for whom BMI cannot be calculated (i.e. missing height and/or weight information). Data for 2010 to 2012 should not be compared to data reported in previous years due to a change in conversion factor for weight in kilograms used to compute BMI. Obesity rates for prior years using the new conversion factor: 2008 =20.9; 2009 =19.7. Data for 2011 and 2012 should not be compared to data reported in previous years (including 2010) as these data are weighted using 2010 population estimates and previous years are weighted using 2000 population estimates.

4. **Field Name:** **2011**

Field Note:
Source: 2011 California Behavioral Risk Factor Survey (BRFS), California Department of Public Health. Numerator: The number of women aged 18-44 years who have a body mass index (BMI) greater than or equal to 30 kilograms body weight / body surface area in square meters (kg/m2). Denominator: The number of women aged 18-44 years for whom BMI can be calculated. Results are weighted using 2010 population estimates from the California Department of Finance and exclude women who reported being pregnant at the time of the survey, and women with height < 48 in. or = 84 in., weight < 75 lbs. or > 399 lbs. or those for whom BMI cannot be calculated (i.e. missing height and/or weight information). Data for 2010 and 2011 should not be compared to data reported in previous years due to a change in conversion factor for weight in kilograms used to compute BMI. Obesity rates for prior years using the new conversion factor: 2008 =20.9; 2009 =19.7. Data for 2011 should not be compared to data reported in previous years (including 2010) as 2011 data are weighted using 2010 population estimates and previous years are weighted using 2000 population estimates.

Data Alerts:

None

SPM 7 - The percent of women whose live birth occurred less than 24 months after a prior birth

	2011	2012	2013	2014	2015
Annual Objective	11.7	11.7	11.7	11.7	11.7

	2011	2012	2013	2014	2015
Annual Indicator	12.3	12.0	11.9	11.9	
Numerator	56,424	59,326	57,830		
Denominator	459,010	495,781	486,250		
Data Source	CA Birth Statiscial Master File	CA Birth Statiscial Master File	CA Birth Statiscial Master File	CA Birth Statiscial Master File	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2014**
	Field Note: A manual indicator is reported for 2014 based on 2013.	
2.	**Field Name:**	**2013**
	Field Note: Data Source: State of California, Department of Public Health, Center for Health Statistics, 2013 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Women with birth intervals less than five months were excluded from the analysis.	
3.	**Field Name:**	**2012**
	Field Note: Source: State of California, Department of Public Health, Center for Health Statistics, 2012 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Women with birth intervals less than five months were excluded from the analysis.	
4.	**Field Name:**	**2011**
	Field Note: Source: State of California, Department of Public Health, Center for Health Statistics, 2011 California Birth Statistical Master File. Tabulations (by place of residence) were done by the MCAH Program. Women with birth intervals less than five months were excluded from the analysis	

Data Alerts:

None

SPM 8 - The percent of public school students in 9th grade reporting a high level of school connectedness.

	2011	2012	2013	2014	2015

	2011	2012	2013	2014	2015
Annual Objective	43.0	43.0	43.0	43.0	43.0
Annual Indicator	44.3	44.8	44.8	44.8	
Numerator	107,535	216,732	216,732		
Denominator	242,857	483,466	483,466		
Data Source	CA Healthy Kids Survey	CA Student Survey	CA Student Survey	CA Student Survey	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

   Field Note:
   A manual indicator is reported for 2014 based on 2013.

2. **Field Name:** **2013**

   Field Note:
   Source: California Student Survey (CSS), 2011-2013. Unpublished data provided by WestEd on June 19, 2014; updated data not available in 2015. CSS data are collected by WestEd on behalf of the California Department of Education using a two year data collection cycle to provide representative data for students enrolled in California public schools. Data from the California Healthy Kids Survey (CHKS) are no longer available; no statewide School Connectedness data are available for the 2010-2012 period. Due to differences in sampling, data from CSS are not comparable to data reported for prior years from CHKS.

3. **Field Name:** **2012**

   Field Note:
   Source: California Student Survey (CSS), 2011-2013. Unpublished data provided by WestEd on June 19, 2014. CSS data are collected by WestEd on behalf of the California Department of Education using a two year data collection cycle to provide representative data for students enrolled in California public schools. Data from the California Healthy Kids Survey (CHKS) are no longer available; no statewide School Connectedness data are available for the 2010-2012 period. Due to differences in sampling, data from CSS are not comparable to data reported for prior years from CHKS.

4. **Field Name:** **2011**

   Field Note:
   Source: California Healthy Kids Survey (CHKS), 2009-11. Unpublished data provided by WestEd on May 16, 2013. CHKS data are collected by WestEd on behalf of the California Department of Education using a two year data collection cycle to provide representative data for students enrolled in California public schools.

Data Alerts:

None

SPM 9 - Low-income infant mortality rate.

	2011	2012	2013	2014	2015
Annual Objective		5.4	5.4	5.4	5.4
Annual Indicator	5.4	5.4	5.4	5.4	
Numerator	1,284				
Denominator	238,562				
Data Source	Birth-Death Cohort file	Birth-Death Cohort file	Birth-Death Cohort file	Birth-Death Cohort file	
Provisional Or Final ?				Provisional	

Field Level Notes for Form 10d SPMs:

1. **Field Name:** **2014**

   Field Note:
   A manual indicator is reported for 2014 based on 2012.

2. **Field Name:** **2013**

   Field Note:
   A manual indicator is reported for 2013 based on 2012.

3. **Field Name:** **2012**

   Field Note:
   A manual indicator is reported for 2012 based on 2011.

4. **Field Name:** **2011**

   Field Note:
   Source: State of California, Department of Public Health, Center for Health Statistics, 2011 Linked Birth – Death Cohort File

   Numerator: Infant deaths where the source of payment for prenatal care or delivery is indicated as Medi-Cal.

   Denominator: Live births to California state residents where the source of payment for prenatal care or delivery is indicated as Medi-Cal.

Data Alerts:

None

SPM 10 - The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home,

	2011	2012	2013	2014	2015
Annual Objective		90.0	90.0	90.0	90.0
Annual Indicator	84.0	62.9	74.6	78.4	
Numerator	206,827	132,974	130,630	175,753	
Denominator	246,301	211,538	174,990	224,210	
Data Source	CMS Net	CMS Net	CMS Net	CMS Net	
Provisional Or Final ?				Final	

Field Level Notes for Form 10d SPMs:

1.	**Field Name:**	**2013**
	Field Note: TBD	
2.	**Field Name:**	**2011**
	Field Note: This new performance measure is the percent of CCS clients with a designated primary care physician or subspecialist physician who provides a medical home. The numerator is the number of CCS clients with a designated medical home, as indicated by the County CCS Office. The denominator is the unduplicated number of CCS clients during state fiscal year 2010-11 who were entered into CMS Net, the CCS reporting system.	

Data Alerts:

None

Form 11

Other State Data

State: California

While the Maternal and Child Health Bureau (MCHB) will populate the data elements on this form for the States, the data are not available for the FY 2016 application and FY 2014 annual report.

State Action Plan Table

State: California

Please click the link below to download a PDF of the State Action Plan Table.
State Action Plan Table