



CALIFORNIA

Maternal and Child Health Services Title V Block Grant

2017-18 Annual Report/2019-20 Application

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A. OVERVIEW OF THE STATE

California is the largest state by population size and the third largest state by land area in the nation.^{1,2} California is bordered by Oregon to the north, Mexico to the south, Nevada and Arizona to the east, and the Pacific Ocean to the west. It is divided into 58 counties ranging in size from under 50 square miles in San Francisco to over 20,000 square miles in San Bernardino.³ These 58 counties and an additional three designated cities, City of Berkeley, City of Long Beach, and City of Pasadena, make up the 61 local health jurisdictions in California.

Population

An estimated 39.6 million people reside in California.⁴ The state's population is projected to increase to 42.3 million by 2025 and 51.0 million by 2060.⁵ By 2025, more than one million residents are projected to live in each of the following 10 counties: Alameda, Contra Costa, Fresno, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, and Santa Clara.⁶

There is no single racial or ethnic group forming a majority of the state's population. The largest racial or ethnic groups are Hispanic (40%), White (37%), and Asian (14%). The

¹ U.S. Bureau of the Census. ACS Demographic and Housing Estimates, 2013-2017 American Community Survey 5-Year Estimates.
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_DP05&src=pt. Accessed January 4, 2019.

² U.S. Bureau of the Census. GCT-PH1. Population Housing Units, Area, and Density: 2010: United States – States: and Puerto Rico 2010 Census Summary File 1.
<https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>. Accessed January 4, 2019.

³ California State Association of Counties. Square Mileage by County. <http://www.counties.org/pod/square-mileage-county>. Accessed January 4, 2019.

⁴ U.S. Bureau of the Census. Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017. 2017 Population Estimates.
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2017_PEPANNRES&src=pt. Published May 2018. Accessed January 3, 2019.

⁵ California Department of Finance. P-1 State Population Projections 2010-2060.
<http://www.dof.ca.gov/Forecasting/Demographics/Projections/>. Published January 2018. Accessed January 3, 2019.

⁶ California Department of Finance. P-2 County Population Projections 2010-2060.
<http://www.dof.ca.gov/Forecasting/Demographics/Projections/>. Published January 2018. Accessed January 3, 2019.

Black population comprises about 6% of the overall population. By 2060, the multiracial population is expected to increase by 71%. The Hispanic population is expected to increase by 43%, while the Asian population is expected to increase by 31%. The Native Hawaiian-Pacific Islander population and the American Indian-Alaska Native population are both expected to increase about 26%. The Black population is expected to increase by 20%.⁷

California's diversity is compounded by multiple subgroups within a single racial or ethnic group. For instance, the state has the largest Asian population in the nation with 5.5 million, followed by New York with 1.7 million.⁸ The Asian population includes, but is not limited to, residents identified as Chinese, Filipino, or Vietnamese. There are more than 20 Asian subgroups, such as Pakistani and Sri Lankan.⁹ The racial or ethnic diversity is further compounded by their concentrations across the state. For instance, the largest number of residents identified as Mexican reside in Los Angeles County, whereas the largest number of residents identified as Salvadoran reside in San Bernardino County.¹⁰

Immigration

California is home to more than 10 million immigrants. The largest numbers of immigrants come from Mexico followed by China, the Philippines, and Vietnam. Foreign-born residents account for over 30% of the population in seven counties, such as Santa Clara and Orange.¹¹ However, in comparison to those who arrived in the previous decades, recent immigrants to California are more likely to have a college

⁷ California Department of Finance. P-2 County Population Projections 2010-2060. <http://www.dof.ca.gov/Forecasting/Demographics/Projections/>. Published January 2018. Accessed January 3, 2019.

⁸ U.S. Bureau of the Census. C02003. Detailed Race, Total Population, 2013-2017 American Community Survey 5-Year Estimates. <https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t>. Accessed January 4, 2019.

⁹ U.S. Bureau of the Census. Asian Alone or in Any Combination by Selected Groups, 2013-2017 American Community Survey 5-Year Estimates. <https://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t>. Accessed January 4, 2019.

¹⁰ Motel, S., & Patten E. The 10 Largest Hispanic Origin Groups: Characteristics, Rankings, Top Counties. Pew Research Center Website. <http://www.pewhispanic.org/2012/06/27/the-10-largest-hispanic-origin-groups-characteristics-rankings-top-counties/>. Published June 2012. Accessed January 4, 2019.

¹¹ Johnson, H., & Hans, J. Immigrants in California. Public Policy Institute of California. Public Policy Institute of California Website. <https://www.ppic.org/wp-content/uploads/jtf-immigrants-in-california.pdf>. Published May 2018. Accessed January 4, 2019.

education. They are also more likely than U.S. born state residents to have a four-year college degree or an advanced degree. This is partly the result of shifting immigration patterns, such as less immigrants arriving from Mexico and more immigrants arriving from China and India.¹²

An estimated 2.4 to 2.6 million undocumented immigrants reside in the state. They make up nearly 25% of all undocumented immigrants in the nation. The size of this population ranges from about 2,000 in Shasta County to 9,000 in San Luis Obispo County and 248,000 in Orange County.¹³

Languages Spoken

Approximately 16.5 million residents aged 5 to 64 years (representing nearly 42% of the total population) speak a language other than English at home.¹⁴ Based on a special tabulation by the U.S. Census, more than 200 languages are spoken at home in California. These languages vary widely from Spanish and Korean to Burmese and Serbian.¹⁵ About 3.5 million – or 21% of all residents speaking a foreign language – do not speak English well or not at all. The levels of English proficiency vary by age. The levels also vary by age and race or ethnic group. For instance, about 4% of children from Spanish-speaking households do not speak English well or not at all compared with 14% of adults in these households. On the other hand, about 6% of children from Asian- and Pacific-Islander-speaking households do not speak English well or not at all compared with 19% of adults in these households.¹⁶

¹² Sanchez, S., & Johnson, H. How Changes in Immigration Affect California's Workforce. Public Policy Institute of California Website. <https://www.ppic.org/blog/how-changes-in-immigration-affect-californias-workforce/>. Published June 2018. Accessed January 4, 2019.

¹³ Hayes, J., & Hill, L. Undocumented Immigrants in California. Public Policy Institute of California Website. https://www.ppic.org/content/pubs/jtf/JTF_UndocumentedImmigrantsJTF.pdf. Published March 2017. Accessed January 4, 2019.

¹⁴ U.S. Bureau of the Census. B16004. Age by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over, 2017 American Community Survey 1-Year Estimates. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_B16004&prodTy pe=table. Accessed January 4, 2019.

¹⁵ U.S. Bureau of the Census. Language Spoken at Home for the Population 5 Years and Over: 2000. Special Tabulation. <https://www.census.gov/data/tables/2000/dec/stp-224.html>. Published April 2004. Accessed January 4, 2019.

¹⁶ U.S. Bureau of the Census. B16004. Age by Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over, 2017 American Community Survey 1-Year Estimates. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_B16004&prodTy pe=table.

Economy

The California economy is the largest in the country accounting for \$2.7 trillion dollars or 14% of the nation's total gross domestic product. The state's economic output in 2016 was the fifth largest in the world after United States, China, Japan, and Germany.¹⁷ It has grown by an average of nearly 3% per year since 2010, based on the value of a dollar in 2009.¹⁸ The finance industry accounts for 22% of the state's economic output. This is followed by the professional and business services industry with 13% and the government industry with 12%. The education industry accounts for 7% of the gross domestic product.¹⁹

Although the state's economy is large, there continues to be great disparities in wealth distribution between households.²⁰

Poverty

An estimated 5.8 million residents in California live below the federal poverty level (FPL). This represents 15% of the state's population. However, several population subgroups experience a higher proportion of poverty. For instance, about 21% of the population living in poverty are children under 18 years of age. A greater proportion of residents identified as Black (23%), American Indian-Alaska Native (22%), or Hispanic (21%) live in poverty than residents identified Asian (11%) or White (14%).²¹ At the county level, the poverty rates are at least five percentage points greater than the state

[pe=table](#). Accessed January 4, 2019.

¹⁷ California Department of Finance. Gross State Product, Comparison to other Major Countries. http://www.dof.ca.gov/Forecasting/Economics/Indicators/Gross_State_Product/. Accessed January 4, 2019.

¹⁸ California Department of Finance. Gross State Product, Gross State Product in California. http://www.dof.ca.gov/Forecasting/Economics/Indicators/Gross_State_Product/. Accessed January 4, 2019.

¹⁹ U.S. Department of Commerce, Bureau of Economic Analysis. California. <https://www.bea.gov/regional/bearfacts/pdf.cfm?fips=06000&areatype=STATE&geotype=3>. Published September 2018. Accessed January 4, 2019.

²⁰ Bohn, S., & Danielson, C. Income inequality and the Safety Net in California. Public Policy Institute of California Website. https://www.ppic.org/content/pubs/report/R_516SBR.pdf. Published May 2016. Accessed January 4, 2019.

²¹ U.S. Bureau of the Census. S1701. Poverty Status in the Past 12 Months. 2013-2017 American Community Survey 5-Year Estimates. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_S1701&prodType=table. Accessed January 4, 2019.

average in 11 counties. These counties include Butte, Del Norte, Fresno, Imperial, Kern, King, Lake, Madera, Merced, Siskiyou, and Tehama.²²

In a joint project between the Public Policy Institute of California and Stanford University, researchers developed an index called the California Poverty Measure, which reportedly improves conventional poverty measures by accounting for a range of costs associated with living expenditures and family resources, such as food stamps.²³

Based on this index, an estimated 7.4 million residents live in poverty and another 2.1 million live in deep poverty. The percent of residents in poverty under this measure has declined from 22% in 2011 to 19% in 2016. The proportion of those living in poverty would be higher without key safety net programs. For instance, the poverty rate would increase to 20% without WIC and 21% without Cal-FRESH. The rate would increase to nearly 32% without all safety net programs.²⁴

Age Distribution

The population of children aged 0 to 19 years in California is projected to remain stable in the 10.4 million range between 2019 and 2025. Over the next four decades, the number of female children is expected to decrease by nearly 2%, while the number of male children is expected to increase by 1%.²⁵

About 8.0 million women of reproductive age (15 to 44 years) reside in California. This number is projected to increase to nearly 8.2 million by 2025 and 8.5 million by 2060, representing an overall increase of 7% over the next four decades. Most of this growth will be among women in the 25-to-37 age group (14%) followed by those in the 40-to-44 age group (7%).²⁶

²² U.S. Bureau of the Census. S1701. Poverty Status in the Past 12 Months. 2013-2017 American Community Survey 5-Year Estimates.
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_S1701&prodType=table. Accessed January 4, 2019.

²³ Stanford Center on Poverty and Inequality. California Poverty Measure.
<https://inequality.stanford.edu/publications/research-reports/california-poverty-measure>. Accessed January 4, 2019.

²⁴ Wimer, C., Mattingly, M., Kimberlin, S., Fisher, J., Danielson, C., Bohn, S. 2.1 Million Californians in Deep Poverty. Stanford University, Stanford Center on Poverty and Inequality, Website.
https://inequality.stanford.edu/sites/default/files/california_poverty_measure_2016.pdf. Published July 2018. Accessed January 4, 2019.

²⁵ California Department of Finance. P-1 State Population Projections 2010-2060.
<http://www.dof.ca.gov/Forecasting/Demographics/Projections/>. Published January 2018. Accessed January 7, 2019.

²⁶ California Department of Finance. P-1 State Population Projections 2010-2060.
<http://www.dof.ca.gov/Forecasting/Demographics/Projections/>. Published January 2018. Accessed January 7, 2019.

Education

There are over 1,000 public school districts located throughout the state serving 6.2 million students. Nearly half (49%) of all students are enrolled in elementary school.²⁷

There are 23 campuses belonging to the California State University system and 10 campuses belonging to the University of California system.^{28,29} There are 115 campuses belonging to the California Community College system. Together, these systems of higher education teach about 2.8 million college-age students each year. This does not include the number of students enrolled in private schools and universities.

California serves the largest number of students under the Individuals with Disabilities Education Act followed by New York and Texas. More than 760,000 students in the state's public schools are identified as needing special education services. This accounts for 11% of all students enrolled in the public school system.³⁰ The number of students with disabilities range from 1,600 with traumatic brain injury to 161,000 with speech or language impairment and 297,000 with a specific learning disability. Another 112,000 are identified as having autism. The students identified under these four disability categories account for about 74% of the entire special education population in the state.³¹

²⁷ California Department of Education. Fingertip Facts on Education in California. <https://www.cde.ca.gov/ds/sd/cb/ceffingertipfacts.asp>. Published July 2018. Accessed January 2, 2019.

²⁸ California State University. Fact Book 2018. <https://www2.calstate.edu/csu-system/about-the-csu/facts-about-the-csu/Documents/facts2018.pdf>. Accessed January 2, 2019.

²⁹ University of California. UC System Overview. <https://www.universityofcalifornia.edu/uc-system>. Accessed January 2, 2019.

³⁰ U.S. Department of Education. Number of Children and Students Served under IDEA, Part B, by Age Group and State, 2017-18. <https://www2.ed.gov/programs/osepidea/618-data/static-tables/index.html>. Published December 2018. Accessed January 2, 2019.

³¹ California Department of Education. Special Education Enrollment by Age and Disability. <https://dq.cde.ca.gov/dataquest/SpecEd/StateRpts/EnrGrdeDis.asp?cChoice=EnrGrdDis1&cLevel=State&cYear=2017-18&ReptCycle=December>. Accessed January 2, 2019.

Housing

California ranks ninth highest in the nation for change in single-family home prices over a five-year period ending in the third quarter of 2018, according to the Federal Housing Finance Agency.³²

The California Department of Housing and Community Development projects that there will continue to be severe housing issues for both rental and homeownership. For instance, from 2015 to 2025, about 1.8 million new housing units will be needed to meet the projected growth in population and household. In other words, the demand for housing will be compounded by both the expected growth in the state population and the expected growth in the size of individual households. Over two-thirds (69%) of all households cannot afford the median price of a house³³

According to November 2018 data from the California Association of Realtors, the median price of a single-family house at the county level ranges from \$184,000 in Lassen to \$1,500,000 in Marin. The median price in at least eight counties are over \$700,000. They include Alameda, San Francisco, San Mateo, Santa Clara, Orange, Santa Cruz, and Mono. Counties with a median price of \$250,000 or less include Glenn, Kern, Kings, Del Norte, Lassen, Siskiyou, and Tehama.³⁴

Associated with the issue of housing is the topic of homelessness, according to a congressional report by the U.S. Department of Housing and Urban Development, an estimated 130,000 persons were homeless in California during a single night in January 2018. This represents a decrease of 1% from 2017, but an increase of 5% since 2010.³⁵

³² Federal Housing Finance Agency. Change in FHFA State House Price Indexes (Seasonally Adjusted, Purchase-Only Index, 2018Q3). [https://www.fhfa.gov/DataTools/Tools/Pages/House-Price-Index-\(HPI\).aspx](https://www.fhfa.gov/DataTools/Tools/Pages/House-Price-Index-(HPI).aspx). Accessed January 2, 2019.

³³ California Department of Housing and Community Development. California's Housing Future: Challenges and Opportunities Final Statewide Housing Assessment 2025. http://www.hcd.ca.gov/policy-research/plans-reports/docs/SHA_Final_Combined.pdf. Published February 2018. Accessed January 7, 2019.

³⁴ California Association of Realtors. California Housing Market Update, Monthly Sales and Price Statistics. <https://www.car.org/en/marketdata/data/countysalesactivity>. Published November 2018. Accessed January 7, 2019.

³⁵ U.S. Department of Housing and Urban Development, Office of Community Planning and Development. The 2018 Annual Homeless Assessment Report to Congress: Part 1: Point-in-Time Estimates of Homelessness. <https://www.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf>. Published December 2018. Accessed January 2, 2019.

About 16% of the total homeless persons in 2018 were families with children. Another 10% were children unaccompanied by a parent or guardian. San Jose and Santa Clara Counties combined had the highest rate in the nation for unaccompanied homeless children living in the streets or other places not designated for a regular sleeping accommodation. Other combined regions in the state with the high rates of unaccompanied homeless children living in the streets included Salinas, Monterey, San Benito Counties (95%), Watsonville and Santa Cruz City and County (93%), and San Luis Obispo County (89%).³⁶

Health Insurance

About 2.8 million residents in California – or 7% of the state population – do not have health insurance coverage.³⁷ This includes about 291,000 children age 0 to 18 years and 753,000 adults with dependent children.^{38, 39} The population groups with the highest rates of uninsured are non-elderly residents at 100 to 199% of the federal poverty level (13%) and residents identified as either American Indian-Alaska Native (12%) or Hispanic (12%).^{40, 41} Based on the most recently computed data from the Maternal and Infant Health Assessment (MIHA) Survey, other population subgroups with high rates of being uninsured include pre-pregnant women (22%) and postpartum women (13%).⁴²

³⁶ U.S. Department of Housing and Urban Development, Office of Community Planning and Development. The 2018 Annual Homeless Assessment Report to Congress: Part 1: Point-in-Time Estimates of Homelessness. <https://www.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf>. Published December 2018. Accessed January 2, 2019.

³⁷ Henry J. Kaiser Family Foundation. Health Insurance Coverage of the Total Population: State Health Facts. <https://www.kff.org/state-category/health-coverage-uninsured/>. Accessed January 3, 2019.

³⁸ Henry J. Kaiser Family Foundation. Health Insurance Coverage of Children 0-18: State Health Facts. <https://www.kff.org/state-category/health-coverage-uninsured/>. Accessed January 3, 2019.

³⁹ Henry J. Kaiser Family Foundation. Health Insurance Coverage of Adults with Dependent Children: State Health Facts. <https://www.kff.org/state-category/health-coverage-uninsured/>. Accessed January 3, 2019.

⁴⁰ Henry J. Kaiser Family Foundation. Uninsured Rates for the Nonelderly by Race/Ethnicity: State Health Facts. <https://www.kff.org/state-category/health-coverage-uninsured/>. Accessed January 3, 2019.

⁴¹ Henry J. Kaiser Family Foundation. Uninsured Rates for the Nonelderly by Federal Poverty Level: State Health Facts. <https://www.kff.org/state-category/health-coverage-uninsured/>. Accessed January 3, 2019.

⁴² California Department of Public Health. Maternal and Infant Health Assessment (MIHA) Survey Data Snapshots, 2013-2015. https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/CDPH%20Document%20Library/2013-2015/Snapshot_ByMaternalAge_2013-2015.pdf. Accessed January 7, 2019.

The rates of insurance coverage vary between counties as well as between population groups within each county. For instance, based on annual estimates for 2017, the lowest rates of uninsured residents were located in El Dorado, Marin, Placer, San Francisco, and Yolo Counties. Each of them had a rate lower than 4%.⁴³

Twelve percent of the state's population aged 26 to 34 years were uninsured compared with 11% of those aged 19 to 25 years and 3% of those aged 6 to 18. The highest rates of uninsured residents aged 26 to 34 were located in Humboldt, Mendocino, Monterey, Nevada, and Ventura Counties. Each had a rate of 16% or more.⁴⁴

The Patient Protection and Affordable Care Act has reduced the number of uninsured residents in California. Overall, there was an 11% point decrease in the rate of uninsured non-elderly persons from 19.4% in 2013 to 8.2% in 2017.⁴⁵

More recent estimates from the Department of Health Care Services (DHCS) show that, accounting for all age groups, there are about 13.1 million Medicaid-certified eligible persons in the state. This includes both dual eligible and non-dual eligible persons. The number of eligible persons has increased nearly 3% since June 2015. Most of the eligible persons (82%) are served under its managed care program.⁴⁶

Government Structure

California's governmental structure is composed of three branches: the legislative, the executive, and the judicial. The executive branch is responsible for administering and

⁴³ U.S. Bureau of the Census. S2701. Select Characteristics of Health Insurance Coverage in the United States, 2017 American Community Survey 1-Year Estimates.
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S2701&prodType=table. Accessed January 7, 2019.

⁴⁴ U.S. Bureau of the Census. S2701. Select Characteristics of Health Insurance Coverage in the United States, 2017 American Community Survey 1-Year Estimates.
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S2701&prodType=table. Accessed January 7, 2019.

⁴⁵ Henry J. Kaiser Family Foundation. Key Facts about the Uninsured Population.
<http://files.kff.org/attachment/fact-sheet-key-facts-about-the-uninsured-population>. Published December 2018. Accessed January 3, 2019.

⁴⁶ California Department of Health Care Services. Medi-Cal Monthly Enrollment Fast Facts: Characteristics of the Medi-Cal population as captured by the Medi-Cal Eligibility Data System.
https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_June2018_ADA.pdf. Published June 2018. Accessed January 3, 2019.

enforcing the laws of California. Led by Gavin Newsom who was sworn in earlier this year as the state's 40th governor, the executive branch houses more than 100 offices, agencies, and departments. One of these agencies is the California Health and Human Services Agency. This agency contains 12 individual departments, including the California Department of Public Health, and others such as the Department of Health Care Services, the Department of Social Services and the Department of Developmental Services.

California's governmental structure is also geographically divided into counties, which are legal subdivisions of the State. For the purposes of administering CDPH/MCAH programs, the California Health and Safety Code goes further to divide the government structure into local health jurisdictions (LHJs), which are defined by the California Health and Safety Code as county health departments or combined health departments.⁴⁷ In California, 61 LHJs directly administer CDPH/MCAH programs within their regions.

Systems of Care

Working with local health jurisdictions, other state departments, and numerous state and local-level governmental and non-governmental organizations, CDPH provides leadership in core public health functions and services. The CDPH/MCAH Division is housed under the Center for Family Health (CFH) and takes the lead in administering state and Federal funds, including, the Title V MCH Block Grant, Title XIX Federal Financial Participation (FFP), the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), the Personal Responsibility Education Program (PREP) and State General Funds targeted to key programs and initiatives that improve the health of moms, babies, children and adolescents in the state. CFH oversees many other programs, such as those providing prenatal and newborn screening and genetic disease detection and monitoring. Other centers within CDPH also provide a range of services important to women and children, such as injury prevention, nutrition and obesity prevention, sexually transmitted disease (STD) education, screening and treatment, surveillance and healthcare facility inspection. CFH collaborates with these other centers on several joint efforts, such as violence prevention, health equity, and the prevention and response to Zika virus disease and opioid addiction.

Twenty-nine counties in the state have a population of 200,000 or less. Seven counties have a population under 20,000. Alpine and Sierra counties each have less than 4,000

⁴⁷ California Health and Safety Code. Division 106. Personal Health Care (Including Maternal, Child, and Adolescent) Part 2. Maternal, Child, and Adolescent Health [123225-124250]. http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=106.&title=&part=2.&chapter=3.&article=6. Accessed January 2, 2019.

residents.⁴⁸ This presents unique challenges to implementing local MCAH programs, particularly among those located in rural areas where they might face an array of region-specific challenges, such as staff recruitment or retention. The California Office of Statewide Health Planning reports that an estimated 17.1 million residents live in locations designated as having a workforce shortage of providers – 8.8 million live in areas with a shortage of primary care providers, 6.4 million live in areas with a shortage of mental health providers, and 1.9 million live in areas with a shortage of dental health providers.⁴⁹

Another set of challenges highlights the issues of labor and workload. For instance, a single staff member might be responsible for administering several programs within a small LHJ, while a team of staff members might be responsible for administering one program within a large LHJ. This has led some jurisdictions to pool their resources with neighboring jurisdictions to improve service provision and program efficiency. All of these factors, coupled with the state's demographic and economic diversity, impact how CDPH allocates Title V funds and how each LHJ organizes its programs.

There are more than 6,000 licensed healthcare facilities in the state, as reported by the California Office of Statewide Health Planning and Development. These facilities include, but are not limited to, 445 general acute care hospitals, 1,407 community clinics, 46 free clinics, 38 acute psychiatric hospitals, 30 psychiatric health facilities, 13 alternative birthing centers, and six chemical dependency recovery centers. The ten largest general acute care hospitals are located in eight counties: Fresno, Los Angeles, Orange, San Diego, San Francisco, Santa Clara, Sonoma, and Tulare. Each facility has a capacity of more than 600 beds.⁵⁰

According to the Children's Hospital Association, there are 23 children's hospitals located throughout California.⁵¹ These hospitals are located within 10 counties across the state, such as Madera, San Bernardino, and Santa Clara. This suggests that nearly

⁴⁸ California Department of Finance. P-1 State Population Projections 2010-2060. <http://www.dof.ca.gov/Forecasting/Demographics/Projections/>. Published January 2018. Accessed January 3, 2019.

⁴⁹ California Office of Statewide Health Planning & Development. Primary Care Health Professional Shortage Area (HPSA) - Census Detail. <https://data.chhs.ca.gov/dataset/primary-care-health-professional-shortage-area-hpsa-census-detail>. Accessed January 2, 2019.

⁵⁰ California Office of Statewide Health Planning & Development. Facility Finder. <https://oshpd.ca.gov/facility-finder>. Accessed January 2, 2019.

⁵¹ Children's Hospital Association. Children's Hospital Directory. <https://www.childrenshospitals.org/Directorries/Hospital-Directory>. Accessed January 2, 2019.

81% of all counties do not have a designated children's hospital to provide pediatric care.

B. NEEDS ASSESSMENT UPDATE

Five-Year Action Plan Review

At the beginning of the Five-Year Action Plan cycle, California's needs assessment process initially focused on assessing health problems across different population domains to help identify and set priorities for the next five years. As a continual process, the goal of the annual needs assessment update is to identify the tools, resources and assistance needed by LHJs in order to address the priorities and objectives included in the Five-Year Action Plan.

The Five-year Action Plan continues to be reassessed by each of the CDPH/MCAH staff members whose duties, responsibilities and areas of expertise are strongly aligned with selected key strategies designed to address the priority needs of each of the population domains. Modifications and refinements to the strategies and activities enable CDPH/MCAH to achieve positive outcomes. CDPH/MCAH is committed to utilizing and enhancing monitoring and evaluation efforts to clearly define measures to track progress.

Year-End Survey

Each year, CDPH/MCAH develops a Year-End Survey (using Survey Monkey) to gather information and data from the LHJs on additional activities conducted to serve CDPH/MCAH populations not reported on in the LHJ Annual Reports. The most recent survey collected responses to questions pertaining to the local activities and agency performance during Fiscal Year (FY) 2016-17. Of the 61 LHJs, CDPH/MCAH received a total of 60 successfully completed surveys. The information provided by the LHJs validated the concerted efforts within the local MCAH programs that support the goals and objectives in the CA Title V Action Plan. Summaries of responses will be described in further detail in the reporting narratives section addressing each population domain and will comprise the following:

- 1) A brief description of the state's ongoing needs assessment activities and the extent to which families, individuals and other stakeholders were engaged in the process;
- 2) Noted changes in the health status and needs of the state's MCAH population, as compared to the identified priority needs for the MCAH Block

- Grant;
- 3) Noted changes in the state's Title V program capacity or its MCH systems of care, particularly for CYSHCN, and the impact of these changes on MCH services delivery;
 - 4) The breadth of the state's Title V partnerships and collaborations with other federal, tribal, state and local entities that serve the MCAH population;
 - 5) Efforts undertaken by the state to operationalize its Five-Year Needs Assessment process and findings; and

Capacity-building Survey

The University of California, San Francisco, Family Health Outcomes Project (FHOP) and the CDPH/MCAH Action Resource Sharing Best Practices Workgroup collaborated to develop and conduct a survey of the LHJs on sharing resources, data use, training, and capacity building needs. The survey was conducted in June 2017 and was completed by 41 respondents. Respondents were asked about their interest for both skill-based and topic-based webinars. Additionally, the survey also inquired about interest in participating in topic-based discussion forums to share strategies, ideas, research and resources with MCAH colleagues working on the same issue. Results from the survey were used to identify priority capacity building trainings for the LHJs and identify topics that need more in-depth assessment and technical assistance.

For example, CDPH/MCAH and FHOP developed a Maternal Mental Health (MMH) Provider Survey to assess how providers screen for Perinatal Mood and Anxiety Disorders (PMADs). The survey was created after interest was expressed on MMH Discussion Forum calls that began as a result of need expressed by CDPH/MCAH and local program staff.

CDPH/MCAH conducted 11 topic and skill-based training webinars, four MMH discussion forums, and three discussion forums on CYSHCN. In addition to these webinar trainings, CDPH/MCAH facilitated 12 monthly technical assistance webinars to assist local MCAH programs in implementing their Title V action plans. Evaluations were collected for all topic and skill-based webinars and most discussion forums.

Transition Planning Survey for CYSHCN

The California Children's Services (CCS) Advisory Group (AG) continues with the DHCS commitment to engage stakeholders in improving the delivery of health care to CCS children and their families. The AG provides important information in guiding DHCS through the preparation and implementation phases of the Whole-Child Model. It

meets quarterly in Sacramento and consists of individuals from the former CCS Redesign Stakeholder Advisory Board, recognizing their expertise in both the CCS program and care for children and youth with special health care needs.

Integrated Systems of Care Division (ISCD) developed a survey on transition services targeting county CCS administrators to further understand local achievements and areas needing improvement. The data gathered from the survey are being used to inform CCS stakeholders, specifically, the CCS Advisory Group, regarding transition practices and service gaps in the counties.

The survey questions were developed based upon information on transition processes shared by counties and input from ISCD and Medi-Cal Managed Care (MCMC) Quality and Monitoring Division. The survey was piloted in three CCS programs in the counties of Alameda, Los Angeles and San Diego. ISCD incorporated these counties' feedback in the development of the final survey questions. By the end of January 2017, the survey was sent to all CCS county administrators. From the survey results, ISCD has established a baseline for ESM 12.1 – Percentage of county CCS programs with family members providing input into transition policies.

Indian Health Needs Assessment

The Primary Rural Indian Health Division (PRIHD) in the Department of Health Care Services (DHCS) released a Request for Application (RFA) in the spring of 2018 pending results from a comprehensive MCH needs assessment conducted by the Indian Health Program (IHP). The needs assessment report will provide context for future funding priorities for the American Indian MCH program by reviewing California American Indian population-based data; current perinatal health status and perinatal delivery systems; the Indian health delivery system in California; expectations and suggestions from community Talking Circles (focus groups); relevant research; as well as a review of best practices.

Upon release, the report will allow an opportunity for feedback from Tribes and community stakeholders on possible approaches for improving the health of American Indian women and their children through MCH targeted interventions. The recommended interventions presented to the stakeholders will be derived as a result of a literature review, a community focus group recommendation process, and a survey of gaps in services for American Indian Women at primary care clinics in California. The RFA will reflect feedback and results from the needs assessment.

Please note that the IHP previously received State General Fund (about \$6.46 million annually) that was utilized to support clinic infrastructure statewide (i.e. doctors, mid-levels, dentists, etc.) through grants with Indian health programs. This funding was

eliminated in 2009.

Oral Health Needs Assessment

The Oral Health Program was established in CDPH in 2016 with the goal of improving oral health in the California Medi-Cal population. The next step in 2017-18 will involve assessing the current oral health status and needs of each LHJ, including their infrastructure, dental professional availability to serve the Denti-Cal population, availability of culturally appropriate resources and materials, and the status of their population's oral health. Efforts will concentrate on building capacity at the local level to improve oral health outcomes. A preliminary capacity assessment of 56 LHJs show that 38 LHJs have an existing oral health program or implement an intervention designed to increase access to dental care. Application of a fluoride varnish was the most common intervention provided (n=25) followed by working collaboratively with WIC or Head Start on providing local oral health services (n= 20). Nineteen LHJs had a school-based oral health program and another 19 LHJs assist clients in establishing a dental home.

To promote oral health messages to consumers, 33 LHJs disseminated information to the target population through printed materials such as posters, flyers, brochures and infographics, and 11 conducted direct or electronic mailings. Eleven LHJs report use of conventional media such as online, radio or TV promotions, and 11 LHJs also promote oral health messages through social media.

Denti-Cal is currently provided as one of the many health benefits under the Medi-Cal program. Several barriers were identified by LHJs in referring Medi-Cal eligible clients to a Denti-Cal provider. Forty-three percent (24/56) find that most dental providers in their LHJ do not accept Medi-Cal patients. Among those who accept Medi-Cal clients, 43% (24/56) of LHJs have wait times of more than a month to get a dental appointment while a third (18/56) of LHJs report that dental providers in their communities limit the number of Medi-Cal patients they are willing to accept. Twenty-eight percent (16/56) of LHJs find providers not acknowledging the recommendation that children should be seen for an oral health exam as early as 1 year of age and 14% (8/56) of LHJs believe that dental providers in their communities do not understand the importance of prenatal dental care.

The Oral Health Program is primarily funded by the State General Fund, the Preventive Health and Health Services Block Grant, and the Health Resources and Services Administration. Funds in the amount of \$18 million are being made available annually to all 61 LHJs to build the capacity, conduct needs assessment and develop a local action plan. At this time, 56 LHJs have submitted grant applications for funding.

Adolescent Health Assessment

Adolescent Health Programs all continuously assess gaps and needs of the programs and target populations. The Adolescent Health Programs have an overarching plan to continuously and seamlessly monitor and evaluate the program efforts and assess needs. This plan includes the following activities:

- 1) Local funded-agency reporting (semi-annually or annually) to identify community needs, program successes, challenges, and other areas for technical assistance and support.
- 2) Annual program staff capacity surveys to identify successes, challenges, training needs, and other areas for additional technical assistance and supports.
- 3) Agency-level site visits and observations of program implementation for continuous quality improvement.
- 4) Training evaluations to assess needs for ongoing program supports.
- 5) Adolescent Health County Profiles and California Sexual Health Needs Index are generated annually and used to identify health-related trends among the adolescent population in California and assess needs by county and sub-county geography.
- 6) CDPH/MCAH Adolescent Health Programs implement a quality improvement process with local-funded agencies, which includes dissemination of data dashboards and engaging in regular conference calls (both individual and all-site calls) to discuss data, identify needs/gaps/challenges/successes/emerging issues, and set improvement goals. The information from this process is compiled at the state level to better understand needs of each program.

Black Infant Health (BIH) Program Assessment

The BIH Program continuously assess gaps and needs of the programs and target populations where MCAH health disparities by race/ethnicity occur. The BIH Program has an overarching plan to continuously monitor and evaluate the program efforts and assess needs. The cornerstone of the BIH Program is the BIH Group Model to improve health outcomes for African-American mothers and babies. This assessment plan includes the following activities:

- 1) Local funded-agency reporting at least quarterly to identify community needs, program successes, challenges, and other areas for technical assistance and support.

- 2) Annual program staff capacity surveys to identify successes, challenges, training needs, and other areas for additional technical assistance and supports.
- 3) Agency-level site visits and observations of program implementation for continuous quality improvement on an as needed basis.
- 4) Training evaluations to assess needs for ongoing program supports.

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C. FINANCIAL NARRATIVE

It is the State's intent to ensure that all Title V Block Grant funds and additional contributions (Title XIX, State General Fund, local agency funds) are administered effectively by CDPH/MCAH and DHCS/Integrated Systems of Care Division (ICSD).

CDPH/MCAH received \$39,113,905 in Title V funding for fiscal year 2017.

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D. FIVE-YEAR STATE ACTION PLAN

California		State Action Plan Table			2019 Application/2017 Annual Report	
Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures	
Women/Maternal Health						
Improve access and utilization to comprehensive, quality health services for women.	Women/Maternal Objective 1.A: By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care, including decreasing the rate of uninsured women and children who are Medi-Cal eligible from 8.3% and 36.5% to 7.9% and	<p>1.A.1. Provide technical assistance to LHJs to ensure all persons in MCAH programs are enrolled in insurance, linked to a provider, and complete an appointment.</p> <p>1.A.2. Develop a competent workforce that meets the health needs of the population by maintaining work competencies and providing learning opportunities for our LHJs.</p> <p>1.A.3. State and Local MCAH to develop and implement protocols to ensure all clients in MCAH programs are enrolled in a health insurance plan, linked to a provider,</p>	NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year	ESM 1.1: Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit	<p>NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>NOM 3: Maternal mortality rate per 100,000 live births</p> <p>NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks)</p> <p>NOM 6: Percent of early term births (37, 38 weeks)</p> <p>NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births</p> <p>NOM 9.3: Post neonatal mortality rate per</p>	

34.7% respectively and postpartum women without health insurance from 16.7% to 16.2% (MIHA).

and complete an annual visit.

1,000 live births

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

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

NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth.

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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
<p>Improve access and utilization to comprehensive, quality health services for women.</p>	<p>Women/Maternal Objective 1B: By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care, including increasing the rate of preventive visits from 61.9% (2013 Behavioral Risk Factor Surveillance System (BRFSS) to 65.3%.</p>	<p>1.B.1. Based on their Local Needs Assessment, all 61 LHJs will implement a local objective(s) to address increasing access to and utilization of preventive health services for reproductive age women.</p>	<p>NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year</p>	<p>ESM 1.1: Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit</p>	<p>NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>NOM 3: Maternal mortality rate per 100,000 live births</p> <p>NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks)</p> <p>NOM 6: Percent of early term births (37, 38 weeks)</p> <p>NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births</p> <p>NOM 9.4: Preterm-related mortality rate per 100,000 live births</p> <p>NOM 10: The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy</p>

					<p>NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births</p> <p>NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females</p> <p>NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth</p>
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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
<p>Improve access and utilization to comprehensive, quality health services for women.</p>	<p>Women/Maternal Objective 1C: By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care, including increase the rate of first trimester prenatal care initiation from 83.6% (2013 BSMF) to 87.9%.</p>	<p>1.C.1 Collaborate with other CDPH programs, DHCS, Medi-Cal Managed Care, and health plans to improve early entry into prenatal care.</p>	<p>NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year</p>	<p>ESM 1.1: Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit.</p>	<p>NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>NOM 3: Maternal mortality rate per 100,000 live births</p> <p>NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks)</p> <p>NOM 6: Percent of early term births (37, 38 weeks)</p> <p>NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births</p> <p>NOM 9.4: Preterm-related mortality rate per 100,000 live births</p> <p>NOM 10: The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy</p>

					<p>NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births</p>
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NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth

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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
<p>Improve access and utilization to comprehensive, quality health services for women.</p>	<p>Women/Maternal Objective 1D: By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care, including increasing the rate of postpartum visits from 88.3% (2012 Maternal and Infant Health Assessment (MIHA)) to 92.9%.</p>	<p>1.D.1. Collaborate with DHCS, Medical Managed Care, and health plans to increase knowledge and referrals to state and local MCAH programs and identify local barriers, emerging issues and intervention opportunities to improve access to the postpartum visit.</p>	<p>NPM 1: Percent of women ages 18 through 44, with a preventive medical visit in the past year</p>	<p>ESM 1.1: Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit</p>	<p>NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>NOM 3: Maternal mortality rate per 100,000 live births</p> <p>NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks)</p> <p>NOM 6: Percent of early term births (37, 38 weeks)</p> <p>NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births</p> <p>NOM 10: The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy</p>

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NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth

Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
<p>Improve access and utilization to comprehensive, quality health services for women.</p>	<p>Women/Maternal Objective 1E: By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care, including increasing access to providers that can provide the appropriate services and level of care for reproductive age and pregnant women.</p>	<p>1.E.1. Increase knowledge of and facilitate collaboration between local CPSP programs and RPPC to improve maternal and perinatal access to systems of care.</p>	<p>NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year</p>	<p>ESM 1.1: Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit</p>	<p>NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>NOM 3: Maternal mortality rate per 100,000 live births</p> <p>NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks)</p> <p>NOM 6: Percent of early term births (37, 38 weeks)</p> <p>NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births</p> <p>NOM 10: The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy</p>

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NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth

Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
<p>Improve access and utilization to comprehensive, quality health services for women.</p>	<p>Women/Maternal Objective 2: 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.</p>	<p>2.1 Increase local MCAH programs awareness of maternal mental health needs, wellness issues that affect MCAH target populations through various educational opportunities with a special emphasis on primary prevention strategies.</p> <p>2.2 Assess and disseminate available resources, tools, and evidence-based maternal mental health and wellness toolkits for local MCAH programs.</p> <p>2.3 Develop new and strengthen existing collaboratives and partnerships with state and local agencies, mental health providers, professional associations, researchers and universities to address maternal mental health and wellness.</p> <p>2.4 Conduct surveillance and evaluation of maternal mortality</p>	<p>NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year</p>	<p>ESM 1.1: Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit</p>	<p>NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>NOM 3: Maternal mortality rate per 100,000 live births</p> <p>NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks)</p> <p>NOM 6: Percent of early term births (37, 38 weeks)</p> <p>NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births</p> <p>NOM 10: The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy</p>

		<p>related to mental health.</p> <p>2.5 Increase local MCAH programs awareness of maternal substance use (opioid, cannabis, and other drugs) needs and educational opportunities with a special emphasis on primary prevention strategies.</p> <p>2.6 Develop new and strengthen partnerships with national, state and local agencies to address maternal substance-use and wellness.</p>			<p>NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births</p> <p>NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females</p> <p>NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth</p>
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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
<p>Improve access and utilization to comprehensive, quality health services for women.</p>	<p>Women/Maternal Objective 3: By June 30, 2020, MCAH will work with partners to reduce prevalence of hypertension, diabetes, cardiovascular disease and mental illness among women at labor and delivery from 8.0%, 10.0%, 0.54% and 4.4% (2013 Office of Statewide Health Planning and Development (OSHPD) Patient</p>	<p>3.1 Partner with disease-specific organizations to target prevention outreach to women of reproductive age for cardiovascular disease, hypertension, diabetes, and mental illness to ensure prevention strategies are culturally, linguistically, and age appropriate and match literacy level .</p> <p>3.2 Partner with Office of Health Equity, HiAP Task Force to help develop policies and initiatives to address community risk factors for chronic cardiovascular diseases (e.g. healthy food availability, built environment for more active transportation, community safety that promotes active transportation), and ensure applicability of HiAP plans to women of reproductive age.</p> <p>3.3 Establish self-identified maternal levels of care for all birthing facilities</p>	<p>NPM 1: Percent of women, ages 18 through 44, with a preventive medical visit in the past year</p>	<p>ESM 1.1: Percent of local health jurisdictions that have adopted a protocol to ensure that all persons in MCAH Programs are referred for enrollment in health insurance and complete a preventive visit</p>	<p>NOM 2: Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>NOM 3: Maternal mortality rate per 100,000 live births</p> <p>NOM 4: Percent of low birth weight deliveries (<2,500 grams) NOM 5: Percent of preterm births (<37 weeks) NOM 6: Percent of early term births (37, 38 weeks)</p> <p>NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births NOM 9.3: Post neonatal mortality rate per 1,000 live births NOM 9.4: Preterm-related mortality rate per 100,000 live births</p> <p>NOM 10: The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy</p>

	<p>Discharge Data (PDD) to 7.4, 9.5%, 0.51% and 3.9% respectively.</p>	<p>to ensure high-risk moms are delivering in the right level of care.</p> <p>3.4 Conduct surveillance and evaluation of maternal mortality and morbidity including measurement of trends and disparities in chronic disease and the quality maternal care related to chronic disease, etc.</p>			<p>NOM 11: The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births</p> <p>NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females</p> <p>NOM 24: Percent of women who experience postpartum depressive symptoms following a recent live birth</p>
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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
<p>Improve access and utilization to comprehensive, quality health services for women.</p>	<p>Women/Maternal Objective 4: By June 30, 2020, California will reduce the prevalence of mistimed or unwanted pregnancy among Black and Latina women with live births from 45.4% and 38.2% to 43.4% and 37.1%.</p>	<p>4.1 Provide local data by age/ethnicity to Local Health Jurisdictions of untimed or unwanted pregnancy.</p> <p>4.2 Conduct/Update an environmental scan of reproductive life planning and preconception health efforts within the state-level MCAH Program, local MCAH programs, and other statewide efforts to identify best practices, areas of need and opportunities.</p> <p>4.3 Assess framing around reproductive life planning and preconception health efforts, in collaborations with members of the target population including youth, to improve relevance and effectiveness of messaging.</p> <p>4.4 Identify National, State, and Local programs/initiative that address reproductive life planning and asses</p>	<p>SPM 2: Percent pregnancies that are mistimed or unwanted among women with a recent live birth</p>		

		<p>available resources, and disseminate culturally and linguistically appropriate tools.</p> <p>4.5 Integrate pregnancy intention into the Title V program (BIH, AFLP, CHVP, CPSP, Adolescent Health, CDAPP) to promote appropriate contraception counseling to match pregnancy desire and timing.</p> <p>4.6 Integrate preconception health into the Well-woman visit.</p>			
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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
<p>Improve access and utilization to comprehensive, quality health services for women.</p>	<p>Women/Maternal Objective 5: Train MCAH LHJ workforce to address IPV at the community level.</p>	<p>5.1 Create or adapt a range of culturally competent, evidence-based, and trauma-informed education materials on IPV for LHJs public health professionals.</p> <p>5.2 Identify training/technical assistance opportunities to support MCAH funded Programs and LHJs in implementing IPV, reproduction and sexual coercion prevention strategies.</p>	<p>SPM 11: Percent of Local Health Jurisdiction (LHJ) with staff who received Intimate Partner Violence (IPV) Prevention training</p>		
<p>Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active life style.</p>	<p>Women/Maternal Objective 6: By June 30, 2020, increase the percent of women with recommended weight gain during pregnancy from 34.3% (2013 BSMF) to 36.1%.</p>	<p>6.1 Conduct surveillance of preconception weight and weight gain during pregnancy, including measurement of trends and disparities.</p> <p>6.2 Improve capacity for nutrition and physical activity for women of reproductive age including optimum preconception weight and prenatal weight gain through collaboration and technical assistance, especially by sharing science-based resources with</p>	<p>SPM 1: Percent of women with the appropriate weight gain during pregnancy</p>		

		key partners such as CPSP, WIC, CMQCC, BIH, AFLP, and CHV.			
Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active life style	Women/Maternal Objective 7: 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%.	7.1 Provide review and technical assistance of all materials in state programs to ensure culturally congruent messaging and education regarding folic acid intake among women of reproductive age.	SPM 1: Percent of women with the appropriate weight gain during pregnancy		

Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Perinatal/Infant Health					
Reduce infant morbidity and mortality.	Perinatal/Infant Objective 1: By June 30, 2020, decrease the percentage of preterm births, less than 37 completed gestational weeks, from 8.4% (2013 BSMF) to 8.3%.	<p>1.1 Develop new and sustain existing partnerships with state and local agencies, community-based organizations, academia, provider networks and hospitals to maximize resource capacity in addressing preterm birth reduction.</p> <p>1.2 Facilitate the coordination of perinatal activities between MCAH LHJs and the RPPC by supporting the local perinatal advisory councils to provide regional planning, coordination and recommendations to ensure appropriate levels of care are available and accessible to high-risk pregnant women and their infants.</p> <p>1.3 Co-lead the Community Birth Plan Task Force and integrate prematurity prevention strategies that are recommended into relevant MCAH program curricula and activities with a</p>	NPM 3: Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)	ESM 3.1: Percent of facilities with a plan for transport out of complicated obstetric/maternal patients.	<p>NOM 8: Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <p>NOM 9.1: Infant mortality rate per 1,000 live births NOM 9.2: Neonatal mortality rate per 1,000 live births</p> <p>NOM 9.4: Preterm-related mortality rate per 100,000 live births</p>

focus on reduction of preterm births in the African-American population.

1.4 Distribute and encourage MCAH programs to integrate evidence based preterm birth prevention activities and resources to educate women and providers about how to prevent preterm births.

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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Reduce infant morbidity and mortality.	Perinatal/Infant Objective 2: By June 30, 2020, increase the percentage of women who report exclusive breastfeeding at 3 months from 26% (2012 MIHA) to 27.2%.	<p>2.1 Conduct surveillance and evaluation of breastfeeding outcomes, including measurement of trends and disparities in breastfeeding initiation, duration and exclusivity, and the quality of maternity care related to breastfeeding.</p> <p>2.2 Promote culturally congruent breastfeeding best practices by providing education, resources and technical assistance to funded MCAH programs and partners for the promotion of environmental change practices and programmatic policies.</p> <p>2.3 Build and sustain partnerships and collaborations with national, state and local partners (such as WIC, NEOPB, the United States Breastfeeding Committee, the California Breastfeeding Coalition, and the California WIC Association) to promote breastfeeding by offering webinars, conferences, developing and</p>	<p>NPM 4:</p> <p>A) Percent of infants who are ever breastfed</p> <p>B) Percent of infants breastfed exclusively through 6 months</p>	ESM 4.1: The proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies.	<p>NOM 9.3: Post neonatal mortality rate per 1,000 live births</p> <p>NOM 9.5: Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>

		disseminating lactation accommodation and hospital breastfeeding best practices.			
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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Reduce infant morbidity and mortality.	Perinatal/Infant Objective 3: By June 30, 2020, reduce the rate of Sudden Unexpected Infant Deaths (SUID) from 54.4 per 100,000 live births (2013 BSMF) to 50.3 per 100,000.	<p>3.1 Provide the latest American Academy of Pediatrics guidelines on infant safe sleep practices/Sudden Infant Death Syndrome risk reduction through two SIDS trainings each year, and the Annual SIDS Conference for SIDS coordinators, public health professionals, and emergency personnel.</p> <p>3.2 Disseminate to LHJs the latest infant safe sleep practices, SIDS risk reduction health education materials, messages to outreach and engage parents of infants regarding safe sleep practices.</p> <p>3.3 Review new literature on SUID/SIDS research, infant safe sleep campaigns, and other promising practices and develop a consensus document on California Safe Sleep Guidance for California communities.</p>	SPM 8: Rate of Sudden Unexpected Infant Death (SUID) per 100,000 live births		

<p>Reduce infant morbidity and mortality.</p>	<p>Perinatal/Infant Objective 4: By June 30, 2020, 100% of parents/caregivers experiencing a sudden and unexpected infant death will be offered grief/bereavement support services.</p>	<p>4.1 Provide training to coroners/medical examiners on the significance of referring to local health department all families who experience the sudden, unexpected death of their baby regardless of circumstances of death.</p> <p>4.2 Make grief/bereavement support materials and peer support organizations available on the California SIDS Program website.</p> <p>4.3 Provide training on grief and bereavement support services to public health professionals and emergency personnel who respond to sudden unexpected infant deaths.</p> <p>4.4 Track if 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.</p>	<p>SPM 9: Percent of parents/caregivers experiencing a sudden unexpected infant death (SUID) who were offered grief/bereavement support services.</p>		
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<p>Reduce infant morbidity and mortality.</p>	<p>Perinatal/Infant Objective 5: By June 2020, sixteen counties will conduct Fetal and Infant Mortality Reviews (FIMR) and implement plans that improved systems of care for women and infants to reduce deaths in these counties.</p>	<p>5.1 Conduct community-based, action-oriented processes that examine fetal and infant deaths, determines preventability, and engages communities to take action.</p>	<p>SPM 10: Number of Local Health Jurisdictions (LHJ) that examine and monitor fetal and infant deaths</p>		
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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Child Health					
<p>Improve the cognitive, physical, and emotional development of all children.</p>	<p>Child Objective 1: By June 30, 2020, increase the rate of children ages 9 months through 35 months screened for being at risk for developmental, behavioral and social delay, using a parent-completed standardized developmental behavioral screening tool during a healthcare visit from 22.4 percent (2016 National Survey of Children’s Health</p>	<p>1.1 Collaborate with relevant partners to strengthen systems to improve rates of behavioral, social, and developmental screening of children ages 9 months through 35months.</p> <p>1.2 Collaborate with relevant partners to strengthen systems to improve referrals and linkage to needed services for all children and youth, especially children birth through five years and at- risk populations.</p> <p>1.3 Provide technical assistance to MCAH programs to implement their SOW, promote the use of Birth to 5: Watch Me Thrive! or other appropriate materials, develop protocols to screen and refer all children in MCAH home visiting or</p>	<p>NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year</p>	<p>ESM 6.1: No. of LHJs that implement at least two core components of the Help Me Grow System that connects at-risk-children for developmental and behavioral problems with services they need.</p>	<p>NOM 13: Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)</p> <p>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health</p>

	<p>(NSCH) to 26.9 percent.</p>	<p>case management programs to early intervention services and develop quality improvement plans to ensure CYSHCN are identified early and connected to needed and ongoing services.</p>			
		<p>1.4 Assist MCAH LHJs to implement developmental screening, referral and appropriate linkages for all children using a parent-completed validated screening tool; provide technical assistance to improve provider, family and community outreach, and develop centralized telephone access and data collection processes.</p>			

Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
<p>Increase access and utilization of health and social services.</p>	<p>Child Objective 2: By June 30, 2020, increase the rate of children ages 1-17 years who received a dental visit in the last year from 75.3 % (2011/12 NSCH) to 79.1%.</p>	<p>2.1 Under the guidance of the CDPH State Dental Director, MCAH and the Oral Health Program (OHP) will collaborate to implement the State's Oral Health Plan to identify priorities, goals, objectives and key strategies.</p> <p>2.2 LHJ staff informs all eligible and enrolled clients of currently available dental benefits offered by Medi-Cal promote the dental home and Medi-Cal warm transfer service through 1-800 customer service phone number or other referral services.</p> <p>2.3 Under the guidance of the CDPH State Dental Director, MCAH and OHP will collaborate to implement the newly funded Local Oral Health Programs and pursue a coordinated system involving various State Programs that serve children's dental needs.</p>	<p>SPM 6: Percent of children ages 1-17 years who received a dental visit in the past year.</p>		

<p>Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active lifestyle.</p>	<p>Perinatal/Infant Objective 3: By June 30, 2020, reduce the proportion of WIC children aged 2- 4 years who are overweight or obese from 34.5% (WIC PC 2012) to 33.5%.</p>	<p>3.1 Improve capacity for nutrition and physical activity for children through collaboration and technical assistance, especially by sharing science-based resources such as new nationally recognized guidelines and initiatives as well as trainings and funding opportunities with LHJ MCAH directors and MCAH funded program contacts.</p>	<p>SPM 12: Percentage of children, ages 2 to 4 years, receiving WIC services who are considered overweight or obese.</p>		
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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Adolescent Health					
<p>Promote and enhance adolescent strengths, skills, and supports to improve adolescent health.</p>	<p>Adolescent Objective 1: From July 1, 2015 to June 30, 2020, racial and ethnic disparities in adolescent birth rates (ages 15-19) in California will decrease by 10%.</p>	<p>1.1 Target all MCAH adolescent sexual health programs (ASH) to high need and/or historically underserved populations.</p> <p>1.2 Fund, administer and provide technical assistance to local agencies to implement evidence-based, community-informed adolescent education approaches on pregnancy and sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV).</p> <p>1.3 Ensure local funded agencies educate adolescents regarding the use of long-acting reversible contraceptives (LARCs), condoms and other birth control methods.</p> <p>1.4 Identify and address gaps in the availability of youth-friendly reproductive health services.</p>	<p>SPM 7: Hispanic :White birth rate ratio among adolescents, ages 15-19 years</p>		

1.5 Develop and implement strategies to empower parents and caregivers with skills and knowledge to strengthen effective communication with adolescents regarding sexual health.

1.6 Lead and coordinate the Statewide Adolescent Sexual Health Work Group (ASHWG) to advance the sexual health and wellness of youth in California.

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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
<p>Promote and enhance adolescent strengths, skills, and supports to improve adolescent health.</p>	<p>Adolescent Objective 2: By June 30, 2020, increase the percent of adolescents 12-17 with a preventive medical visit from 76.2% (NSCH 2016-17) to 80%.</p>	<p>2.1 Ensure effective MCAH program policies and procedures to support local funded agencies with linking youth in MCAH program to preventive and reproductive health services that are affordable, accessible, confidential, and youth-friendly.</p> <p>2.2 Participate as a core member of the CDHP Adolescent Preventive Health Initiative (APHI) to develop and implement a statewide framework to increase access to and quality of preventive services for adolescents.</p> <p>2.3 Raise awareness among local health agencies and MCAH funded programs about the prevention, screening and other new Bright Futures recommendations.</p> <p>2.4 Participate in and disseminate</p>	<p>NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.</p>	<p>ESM 10.1: Percentage of adolescents 12-17 served in AFLP with a referral to preventive services.</p>	<p>NOM 16.1: Adolescent mortality rate ages 10 through 19, per 100,000</p> <p>NOM 16.2: Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000</p> <p>NOM 16.3: Adolescent suicide rate, ages 15 through 19, per 100,000</p> <p>NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling</p> <p>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health</p> <p>NOM 20: Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)</p> <p>NOM 22.2: Percent of children, ages 6 months through 17 years, who are</p>

		resources from the CDPH school-based health center initiative.			<p>vaccinated annually against seasonal influenza</p> <p>NOM 22.3: Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</p> <p>NOM 22.4: Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</p> <p>NOM 22.5: Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</p> <p>NOM 23: Teen birth rate, ages 15 through 19, per 1,000 females</p>
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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Promote and enhance adolescent strengths, skills, and supports to improve adolescent health.	Adolescent Objective 3: By June 30, 2020, all Title V programs serving adolescents will incorporate the Positive Youth Development (PYD)/Resiliency framework.	<p>3.1 Develop tools and standards to incorporate PYD principles, resiliency framework and training on healthy coping skills in program implementation and materials.</p> <p>3.2 Train state and local staff on the principles of Positive Youth Development, resiliency and healthy coping skills for adolescents.</p> <p>3.3 Develop program evaluation tools to measure resiliency in adolescents.</p> <p>3.4 Streamline and expand PYD messaging across state and local partners.</p> <p>3.5 Increase ongoing youth engagement in state level MCAH efforts.</p>	SPM 5: Percent of youth ages 12 through 17, who have an adult in their lives with whom they can talk about serious problems.		
Children with Special Health Care Needs					
Provide high quality	CYSHCN Objective 1: By	1.1 Identify priorities and strategies for filling gaps and	SPM 4: Percent of Children with		

<p>care to all CYSHCN within an organized care delivery system.</p>	<p>June 2020, develop a detailed plan for the California MCAH program with strategies and activities to strengthen systems that support CYSHCN in California by assessing current data, engaging broad stakeholders, and identifying priority needs and best practices.</p>	<p>addressing unmet needs in the state to improve systems of care for CYSHCN, with a specific focus on medical homes and transition to adult care.</p>	<p>Special Health Care Needs (CSHCN) with select conditions who have special care center (SCC) team report documenting visit to subspecialist within 90 days of California Children's Service (CCS) eligibility determination.</p>		
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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
<p>Provide high quality care to all CYSHCN within an organized care delivery system</p>	<p>CYSHCN Objective 2: By June 30, 2020, increase child and youth enrollment in the CCS program.</p>	<p>2.1 Refine the selected whole child approach to optimize access to qualified providers.</p> <p>2.2 Conduct and analyze surveys of CCS families and providers to assess satisfaction with organized care delivery system.</p>	<p>NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home</p>	<p><i>Inactive - ESM 11.1: Number of county CCS programs with family members providing input into CCS medical home policies.</i></p> <p>ESM 11.2: Number of completed informational trainings to increase awareness and participation in activities that engage families into partnership</p>	<p>NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system</p> <p>NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling</p> <p>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health</p> <p>NOM 25: Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year</p>

				with systems and services	
Provide high quality care to all CYSHCN within an organized care delivery system.	CYSHCN Objective 3: By June 30, 2020, increase the number of CCS clients who receive care within a medical home.	3.1 Increase the number of counties with a family advisory council, parent health liaison, family-centered care workgroup, or other role supporting CYSHCN.	NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	<p><i>Inactive - ESM 11.1: Number of county CCS programs with family members providing input into CCS medical home policies.</i></p> <p>ESM 11.2: Number of completed informational trainings to increase awareness and participation in</p>	<p>NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system</p> <p>NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling</p> <p>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health</p> <p>NOM 25: Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year</p>

				activities that engage families into partnership with systems and services	
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Priority Needs	Objectives	Strategies	National and State Performance Measures	Evidence-Based or –Informed Strategy Measures	National and State Outcome Measures
Provide high quality care to all CYSHCN within an organized care delivery system.	CYSHCN Objective 4: By June 30, 2020, increase the number of CCS clients with a documented	<p>4.1 Identify CCS county and WCM managed care plans’ transition strategies and best practices.</p> <p>4.2 Increase the number of family members providing input into the development of transition practices and guidelines.</p>	NPM 12: Percent of adolescents with and without special health care needs, ages 12 through 17, who	ESM 12.1: Number of county CCS programs with family members providing input into transition policies.	NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

	transition plan.	4.3 Identify processes to track CCS clients completed a visit with a managed care adult physician.	received services necessary to make transitions to adult health care		
Increase access to CCS paneled providers such that each child has timely access to a qualified provider of medically necessary care.	CYSHCN Objective 5: By June 30, 2020, ensure CCS clients receive appropriate care from a subspecialist in a timely manner.	5.1 Identify barriers to access to CCS-paneled providers. 5.2 Define and identify issues associated with access to durable medical equipment, pharmacy, home health and behavioral health providers.	SPM 4: Percent of Children with Special Health Care Needs (CSHCN) with select conditions who have special care center (SCC) team report documenting visit to subspecialist within 90 days of California Children's Service (CCS) eligibility determination		

<p>Increase access to CCS paneled providers such that each child has timely access to a qualified provider of medically necessary care.</p>	<p>CYSHCN Objective 6: By June 30, 2020, CCS county programs will demonstrate increased knowledge on billing processes for telehealth services.</p>	<p>6.1 Update existing telehealth codes in the Medi-Cal billing systems database.</p> <p>6.2 Distribute the updated CCS Numbered Letter (Policy letter) on billing guidelines for telehealth services.</p> <p>6.3 Develop and implement trainings for providers on the billing guidelines for telehealth services.</p> <p>6.4 As part of telehealth billing services trainings, conduct pre- and post-test evaluations.</p> <p>6.5 Post updated resources and FAQs on the DHCS Medi-Cal and Telehealth webpage.</p>	<p>NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home</p>	<p><i>Inactive - ESM 11.1: Number of county CCS programs with family members providing input into CCS medical home policies.</i></p> <p>ESM 11.2: Number of completed informational trainings to increase awareness and participation in activities that engage families into partnership with systems and services</p>	<p>NOM 17.2: Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system</p> <p>NOM 18: Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling</p> <p>NOM 19: Percent of children, ages 0 through 17, in excellent or very good health</p> <p>NOM 25: Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year</p>
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E. STATE ACTION PLAN NARRATIVE BY DOMAIN

Women/Maternal Health – Annual Report Narrative (FY 2017-18)

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

Objective 1:

By June 30, 2020, increase the rate of women with appropriate preventive care, including:

- a) increase the rate of preventive visits among reproductive age women (18-44) from 61.9% (2013 Behavioral Risk Factor Surveillance System (BRFSS)) to 65.3%;**
- b) increase the rate of first trimester prenatal care initiation among women with a recent live birth from 83.6% (2013 BSMF) to 87.9%; and**
- c) increase the rate of postpartum visits among women with a recent live birth from 88.3% (2012 Maternal and Infant Health Assessment (MIHA)) to 92.9%.**

This objective aimed to promote healthy pregnancies and births by fostering strategies and activities to increase preventive and postpartum care. One of the best ways to promote a healthy birth is by having a healthy pregnancy. Getting early and regular prenatal care improves the chances of a healthy pregnancy. Preconception care can help to reduce health risks prior to pregnancy and prenatal care can help prevent complications and informs women about important steps they can take to protect their baby and ensure a healthy pregnancy. Babies of mothers who do not get prenatal care are more likely to have a low birth weight and more likely to die than those born to mothers who do get care. Likewise, postpartum care is an important determinant of quality health care outcomes for women giving birth. Since medical complications can occur after a woman has given birth, postpartum visits can address any adverse effects that giving birth had on a woman's body and provides an opportunity for inter-conception care, pregnancy planning, and prolongation of the inter-pregnancy interval.

In the five-year period from 2012 to 2016, the national Behavioral Risk Factor Surveillance data show that for Objective 1a, the percent of women age 18 through 44 with a preventive medical visit in the past year fluctuated by 6.2 percentage points. In 2016, the percent of women with a preventive medical visit was 65.4 percent, which is higher than the 61.7 percent estimate for 2015.

Using data reported in the California birth certificates, Objective 1b or the percent of

pregnant women receiving first-trimester prenatal care remained stable from 82.9% in 2014 to 83.6% in 2016. Women identified as Whites, Asians, or Multiple Race were among those most likely to receive early prenatal care. The proportion of women in each of these race-ethnic groups was 80% or more. Women identified as American Indians had the lowest three-year average (68.5%) In contrast, using the Centers for Disease Control (CDC) data from the Behavioral Risk Factor Surveillance Survey, the percent of women receiving first-trimester prenatal care steadily increased from 82.5 percent from 2012 to 85.0 percent in 2016. White and Asian women (88.9 percent and 87.2 percent, respectively) were more likely to receive early prenatal care followed by Multiple Race and Hispanic women (85.0 percent and 82.9 percent, respectively).

Using data from the Maternal and Infant Health Assessment survey, Objective 1c or the percent of women reporting a postpartum visit remained stable at 88% between 2012 and 2014.

Objective 1: Strategy 1:

Provide technical assistance to LHJs to develop and implement a protocol to ensure all persons in MCAH programs are enrolled in insurance, linked to a provider, and complete an appointment.

CDPH/MCAH continued to provide Title V funding to Local Health Jurisdictions (LHJs) MCAH activities. LHJ developed a scope of work based on local needs, contributed local funds and drew down Title XIX, when appropriate. For this strategy: All LHJ MCAH Programs are expected to develop and adopt local protocols to ensure that all clients in MCAH Programs have health insurance, are linked to a provider and access a preventive visit. In collaboration with the LHJs, CDPH/MCAH has developed *Guidelines for Protocols to link MCAH clients to Health Insurance and Preventive Visit(s)* to assist each LHJ to develop and adopt their own locally specific protocols. The guidelines include a requirement for LHJs to develop processes to verify health insurance status, assist clients to enroll in health insurance, link clients to a health care provider for a preventive visit, and to develop a tracking mechanism to verify that the client enrolled in health insurance and completed a preventive visit. Additionally, LHJs were required to conduct quality assurance activities to ensure protocols are implemented as intended and revised as needed.

Through the CDPH/MCAH Program Year-End survey, 51 LHJs reported adoption of one or more protocols or policies that pertain to linking clients to health insurance for preventive visits. Of these, 49 adopted a policy to assist clients to enroll in health insurance; 46 LHJs adopted a policy to link clients to a healthcare provider for a preventive visit and 22 developed tracking mechanisms to verify that clients enrolled

in health insurance completed a preventive visit. (Source: 2017-18 Year End Survey)

LHJs include activities to improve insurance enrollment and to increase access and utilization of health and social services in their MCAH Scope of Works. A few examples from the 2017-18 MCAH Annual Reports of LHJ activities:

- Alameda County - Applied for and was awarded funding for supportive services for Pacific Islander residents, to improve reproductive health outcomes and family members' enrollment in health insurance, a priority health issue for Alameda County. Local Tax Measure A funds, \$250,000 for 2 years, starting January 2018.
- Butte County - Butte County Public Health continues to collaborate with the Department of Social Services to expedite Medi-Cal applications. The program stamps or earmarks every pregnant client's application and routes them to two eligibility workers for processing. When the project began, approximately 30% of the applications were still pending after 45 days. At last count, only 5% of the applications were still pending after 45 days.
- San Mateo County - Family Health Services (FHS) provides home visiting staff with updated health insurance information and resources via monthly all-staff meetings and quarterly Public Health Nurse (PHN) Resource meetings. FHS has collaborated with Health Coverage Unit (HCU) to disseminate health coverage information to their clients and refer clients to HCU's services when appropriate. Through FHS' collaboration with HCU and Human Services Agency, FHS staff are able to assist clients with their health insurance issues more quickly and easily.

California Home Visiting Program (CHVP): CHVP is funded through the Health Resources and Services Administration (HRSA) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program and administered and led by the CDPH/MCAH Division. CHVP collaborates with Title V funded programs and initiatives where there are common objectives and opportunities. CHVP funds agencies to implement evidence-based home visiting models, including Nurse-Family Partners (NFP) and Healthy Families America (HFA). The primary goal of the CHVP is to help ensure a healthy pregnancy and a healthy baby. One of the ways this is accomplished is by linking all families to a medical provider. Whenever the mother does not have health insurance, the home visitor helps the mother obtain health insurance. The home visitor also helps the mother schedule a doctor's appointment with her provider and encourages the mother to attend regular prenatal appointments and to comply with her health care provider's instructions. The home visitors' follow-up with the mother about her prenatal care during each home visits. Home visitors provide information to the mother about the importance of attending regular prenatal appointments and provide educational materials and resources for a healthy pregnancy. During 2017-18, 92% of

CHVP participants reported having insurance coverage, 4.7% did not have insurance, and 3.3% had an unknown insurance status. (Source: CHVP) At the local level, CHVP sites developed and maintained ongoing strategic partnerships with local service providers, including clinics and hospitals, to deliver services.

American Indian Infant Health Initiative (AIIHI): The AIIHI is funded using Title V funds for home visitation program for American Indian women that are pregnant or parenting to receive health education and psychosocial support services beginning with pregnancy until the infant reaches age three. The counties participating in this Title V home visitation funding included: Humboldt, Riverside, San Bernardino, Sacramento, and San Diego.

AIIHI clinics received funding to support provider salaries to increase access to preventive services for American Indian women. AIIHI clinics provided over 5,147 preventive care services to women seen at the American Indian clinics during FY 2017-18.

One of the objectives of the AIIHI program is to increase access to preventive health services for American Indian women. Clinic staff refer all American Indian women with a positive pregnancy test to the AIIHI home visitation program. AIIHI staff provided targeted outreach to identified high-risk American Indian women that were pregnant or parenting to provide prompt diagnosis, education, and support during the pre and postnatal period. In addition, the Indian Health Program (IHP) expanded program availability by adopting an evidenced-base home visitation program called Family Spirit, which provides home visitation for all women pregnant with an American Indian baby and does not restrict the curriculum to only high-risk mothers. Home visitors support mothers by assisting with scheduling visits to see their OB providers, including postpartum care and well child checks. AIIHI clinic staff also offer transportation to increase likelihood of mothers receiving timely prenatal and postnatal care.

During this funding period, preventive services were offered to 122 women enrolled in the AIIHI program. Two of the AIIHI grantees provide OB services on site. Because of infrastructure funding, these two clinics reported 414 postpartum visits. Of the 122 families who received AIIHI services, 13 reported pregnancies and 12 expectant mothers received first trimester prenatal care in FY 2017-18.

Black Infant Health (BIH): The CDPH/MCAH uses Title V funds to lead the implementation of BIH in 15 LHJs. These LHJs also receive California State General Fund, contribute local agency funds, and drawdown Title XIX to support their efforts when appropriate. Local BIH programs conduct group sessions with complementary

case management that provide social support while helping women develop skills to reduce stress, enhance emotional well-being and develop life skills in a culturally affirming environment that honors the history of Black women. The BIH Program Policies and Procedures required that all local BIH Programs complete an intake assessment with all BIH Participants upon enrollment. Assessment questions included if the participant had medical insurance, had a medical/prenatal provider and if she had completed any appointments. Participants, who stated that any of these services had not been met, were provided assistance with follow-up. The BIH Efforts to Outcomes (ETO) data system was utilized to track the number of BIH Participants who enrolled in health insurance.

Adolescent Family Life Program (AFLP): AFLP is also a Title V-funded program that CDPH/MCAH leads. Currently 19 local health agencies and community-based organizations receive funds to implement the program. Many also contribute local agency funds and draw down Title XIX, when appropriate. Similar to CHVP and BIH, AFLP case managers, who work with expectant and parenting youth, support and promote access to health insurance and preventive health services. The case managers assess need regularly, support youth in building knowledge and skills, provide referrals and support for accessing services, and regularly follow-up. For more information about AFLP, see the Adolescent Health Section.

Evidence-based and evidence-informed practices utilized for this strategy

Evidence-based and evidence-informed practices utilized for this strategy included the following:

- CDPH/MCAH provided workforce development with instructional webinars and monthly technical assistance conference calls to LHJs
- LHJs provided outreach to underserved populations to increase access and utilization of care
- CDPH/MCAH facilitated systems change by including a requirement to develop protocols or policies to ensure that all clients in MCAH programs are linked to insurance and see a provider for preventive visit(s)
- All MCAH enabling services employ evidence-based or evidence-informed program models, including, Family Spirit, Nurse-Family Partnership, Healthy Families America, BIH, and the AFLP Positive Youth Development Model. Health.

Challenges for this strategy

Challenges and opportunities for improvement from the LHJs include:

- Napa County - 2017-18 was an extremely difficult year for multiple counties due to the widespread fires with significant damage and long-term effects. For example, the Napa County Fire Complex began on October 8, 2017. This group included public health staff including the local MCAH Director, MCAH Coordinator and MCAH staff were involved in continuity of operations including locating and checking on vulnerable MCAH clients. Loss of revenue for the County Departments has had serious long-term consequences including budget cuts, program closure and loss of staffing which may not be resolved for many years to come. Many of the ongoing activities of public health and MCAH were postponed or delayed this year due to the demands created by the fire and the subsequent priority needs in the community. In addition, the MCAH Director, MCAH Coordinator and MCAH staff were involved in a pertussis outbreak that required prophylaxis of 150 MCAH clients in the community, and this became a priority work assignment for over 2 months from July to September 2017.
- Timely postpartum care remains an ongoing challenge at AllHI funded clinics. There are four AllHI clinics providing services in five counties. Only two clinics provide OB services on site. Lack of OB services on site at all Indian clinics contributes to the lack of postnatal follow-up in the community. Additional challenges faced by American Indian mothers include difficulty accessing care and coordinating childcare when there are other children in the home and mom and infant must travel a distance to be evaluated by the OB provider. Other challenges include difficulty locating some mothers who do not have stable housing, or may have substance use or mental health issues.

Objective 1: Strategy 2:

Collaborate with DHCS, Medi-Cal Managed Care, and health plans to increase knowledge and referrals to state and local MCAH programs and identify local barriers, emerging issues and intervention opportunities.

Health insurance is the gateway to receiving health care services. Women without health insurance often have inadequate access to care, get a lower standard of care when they receive health care and have poorer health outcomes. Women without health insurance are also less likely to receive adequate preconception, prenatal and post-natal care that are important determinants of maternal and fetal health.

The percent of uninsured women age 18 to 44 who are Medi-Cal eligible increased from 7% in 2014 to 9.2% in 2015 and 9.1% in 2016.

Data from the California Health Interview Survey (CHIS) shows that the percent of

uninsured children age 1 to 17 years who are Medi-Cal eligible increased from 32.7% in 2014 to 42.9% in 2015 before decreasing to 34.3% in 2016.

In 2015, 83.3% of women had health insurance before pregnancy. A greater proportion of Asian/Pacific Islander women (92.8%) had pre-pregnancy health insurance followed by Black women (91.5%), White women (90.9%), and Hispanic women (75.1%). Women identified as other race/ethnicity were the least likely to have pre-pregnancy insurance (62.6%).

The percent of postpartum women without health insurance dropped to 12.1% in 2014. The three-year average over the previous three years was about 17.4%. Since 2011, postpartum Hispanics were most likely to be uninsured (15.2%). Blacks were least likely to be uninsured (2.7%).

Data from the American Community Survey show that the percent of children age 0 through 17 without health insurance steadily decreased from about 8.1% in 2012 to 3.0% in 2016. In 2016, the concentration of children without health insurance was highest among those identified as American Indian-Alaska Native (9.2%), Native Hawaiian-Other Pacific Islander (5.1%), and Hispanic (3.8%). Data from the 2016 National Survey for Children's Health show that 72.7% of all children age 0 to 17 years had adequate health insurance for their health care needs.

Local Health Jurisdictions (LHJs): CDPH/MCAH funded and required that all 61 LHJs conduct activities that promoted access to and quality of perinatal care. Many activities focused on collaborating with providers to increase utilization of these services. Other activities ranged from building workforce capacity to ensuring program fidelity.

In their 2017-18 Annual Reports, all 61 LHJs reported activities to increase access and utilization of perinatal care for pregnant women. Examples include:

- Kern County – Comprehensive Perinatal Health Worker staff informed all patients that transportation is available through Medi-Cal and hence Managed Care. Collaborations with Managed Care in Kern Community collaboratives, as well as Quarterly MOU meetings, has aided in the dialogue and dissemination about the needs of patients and delivery of services. Incentives for early access to care, incentives for completion of program and incentives for simply attending meetings, have been made available by Managed Care to patients. These incentives appear to be generating more compliance in early entry into care and

completion of programs offered. CPSP has been one such program to benefit from these Managed Care incentives.

- Modoc County - Clients enrolled in the Perinatal Outreach and Education (POE) program who have Medi-Cal were able to receive gas vouchers through the MCAH program to their out of county prenatal/postpartum and dental appointments in order to assist with access to care. Nineteen Medi-Cal eligible POE clients utilized transportation assistance. A total of 77 gas vouchers were provided. The percentage of appointments kept was 95% (73 appointments were kept and 77 were intended).
- San Francisco County - Develop/implement plan to prioritize enrollment of low-income pregnant women: A newly created video highlighting our work will help re-enforce this work <https://vimeo.com/279131910/a15951b440>. New brochures and other outreach materials are currently in production.

Comprehensive Perinatal Services Program (CPSP): CPSP is a Title V funded program that CDPH/MCAH leads in collaboration with the LHJs. The program delivered services that provided a wide range of culturally competent services to Medi-Cal eligible, low-income pregnant and postpartum women. In addition to standard obstetric services, women received enhanced services in the areas of nutrition, psychosocial and health education. Qualified CPSP providers receive an enhanced Medi-Cal fee for delivery of CPSP services to pregnant and postpartum women in addition to the usual standards of obstetric care as an incentive. These enhanced services are also negotiated within Medi-Cal Managed Care (MCMC) contracts.

Each of the 61 LHJs has at least one designated Perinatal Services Coordinator (PSC) to oversee the fee-for-service and Federally Qualified Health Center (FQHC) CPSP providers' implementation of the program in their local offices or clinics. PSCs provided training, consultation, and technical assistance to CPSP providers on program implementation; assisted providers to develop or revise protocols and train staff, and monitored the local CPSP program by conducting CPSP quality improvement/quality assurance (QI/QA) activities. Some local PSCs also conducted roundtables for community partners. CPSP roundtables are educational and networking opportunities for perinatal care providers and their staff with an interest in community resources for perinatal care and newborn care topics.

Examples from the LHJs of CPSP activities include:

- Sutter County – Harmony Health became a new CPSP provider. The perinatal provider network has improved greatly over the last year with the addition of Harmony Health along with Rideout Health gaining three new

- providers. California Health and Wellness has improved access to care by executing a contract with Rideout Health.
- Yolo County - The CPSP program hosts two roundtables a year that focus on current issues effecting Medi-Cal eligible women's access to prenatal care. We invite the local CPSP providers and staff, and other community partners that provide CPSP-like services to this vulnerable population. Activities have included CPSP Roundtables on increased STD rates in California, and Maternal Mental Health resources in Yolo County.

CDPH/MCAH received an additional 52 CPSP provider enrollment applications and approved enrollment for six physician providers (solo), six physician groups, a certified nurse midwife provider (solo), an alternate birthing center, eight community clinics, and a community outpatient hospital.

The CPSP Executive Committee (made up of representatives from the four CPSP regions, partners and state staff) worked on projects to improve access to and quality of CPSP services. For example, they continued to update the CPSP provider application forms and instructions, developed a quality improvement/quality assurance (QA/QI) tool to improve the ability to describe the impact of CPSP, and planned meetings and trainings. The Executive Committee also brought forth concerns from their regions about access to perinatal care, Medi-Cal CPSP provider billing issues.

Department of Health Care Services/Medi-Cal Benefits/Policy and Medi-Cal Managed Care (DHCS/MCMC): CDPH/MCAH collaborated with the DHCS/ Medi-Cal staff to increase knowledge of one another's priorities and to improve communication and relationships. CDPH/MCAH participated on the weekly DHCS Maternal Care and CPSP Code Conversion Team Status Meeting with stakeholders to represent CPSP in the Medi-Cal code conversion project. CDPH/MCAH communicated regularly with Medi-Cal Medical Policy Section and fiscal intermediary. CDPH/MCAH, the CPSP Executive Committee and DHCS worked on developing the necessary data indicators for a data report on provider reimbursement of CPSP services using aggregate CPSP service codes. PSCs will use this information to monitor CPSP service delivery in provider offices and clinics and provide technical assistance as needed to improve the quality of CPSP services.

Black Infant Health (BIH): Local BIH Programs conducted presentations with Kaiser and Anthem Blue Cross for the purpose of enhancing collaborative efforts, creating referral partnerships and promoting awareness of BIH Program goals and services. Attendees expressed appreciation as well as increased knowledge about the BIH Program and stated they would be more cognizant of recognizing and referring

eligible women to BIH.

In BIH, women were encouraged to maintain preventive health care visits with their primary care provider. Participants were also provided with educational materials and resources to ensure that they were well informed when speaking with health care providers regarding their preventive health care needs. Additionally, the BIH program continuously promoted coverage and access to preventative and health care services during their program outreach with all their BIH sites.

Local BIH staff members provided follow-up telephone calls and home visits with participants within one week after delivery to encourage women to keep postpartum and other preventive health visits. BIH continues to collaborate with MCMC and CPSP providers to improve and increase the rates of postpartum visits for African-American moms. The BIH SOW also includes a process outcome measure for the purposes of tracking participant postpartum checkups in order to provide assistance and ensure that participants attend postpartum checkups to moms in this area.

Adolescent Family Life Program (AFLP): AFLP supports adolescent parents with accessing needed perinatal services and coordinates with CPSP and local health providers. For more information about AFLP, refer to Adolescent Health Domain Section.

Department of Healthcare Services/Indian Health Program (DHCS/IHP): Through collaboration with DHCS/IHP, clinic staff referred all American-Indian women with a positive pregnancy test to the American-Indian Infant Health Initiative (AIIHI) program. Staff provided targeted outreach to identified high-risk American-Indian women who were pregnant or parenting to provide prompt diagnosis, education, and support during the perinatal period.

Challenges for this strategy

Challenges and opportunities for improvement from the LHJs include:

- Calaveras County - Calaveras continues not having a birthing hospital or center, obstetricians, or FPACT providers, requiring women to leave the county for services. However, MCMC plans are aware of the challenges and continue to work with local network providers to improve access.
- Placer County - There is only one CPSP provider enrolled in Placer County, which limits availability of quality prenatal care. Because there are very few OB providers in Placer County accepting Medi-Cal, most women travel long

distances in order to access prenatal care services. In addition, no OB providers in Placer County accept Presumptive Eligibility Medi-Cal, further deterring early access to quality comprehensive prenatal care. Case managers work with clients to help them navigate the confusing process of choosing a Medi-Cal Managed Care Plan and obtaining OB services. Placer County MCAH staff also communicates with both Medi-Cal Managed Care plans in an attempt to increase the number of available OB providers. Chapa de Indian Health Service recently began offering prenatal care services to pregnant women up to 34 weeks gestation, after which time patients are transferred for the remainder of their pregnancy to a CPSP provider in Sacramento. While this has offered the opportunity for residents to receive most of their prenatal care within Placer County, patients are still forced to transfer care and travel to Sacramento for delivery.

- Shasta County - Often women are not able to schedule appointments early in their pregnancy for prenatal care because the prenatal care providers who accept Medi-Cal are already booked with appointments. There are also barriers to care such as transportation. Moreover, it is difficult if not impossible for pregnant women on Medi-Cal to receive dental care during pregnancy.

Objective 1: Strategy 3:

Collaborate with Text 4 Baby to deliver messages to pregnant women and hospital partners about the importance of the postpartum visit during prenatal care and/or during hospitalization after labor/delivery.

Challenges for this strategy

CDPH/MCAH has worked in partnership with Text4baby to share essential health information, tips and reminders with expectant women and new mothers, and their partners or loved ones. However, CDPH/MCAH has revised this activity and is no longer contracting with Text4Baby. CDPH/MCAH is working with the Division's newly formed MCAH Communication Unit to utilize CDPH and other social media platforms (Facebook, Twitter, Instagram) to develop and post messages and identify opportunities for education and outreach to pregnant mothers and hospital partners to have a broader reach and promote multiple resources through multiple platforms.

Objective 2:

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

Objective 2: Strategy 1:

Provide technical assistance for local MCAH programs to improve access to needed health care services for postpartum women.

The percent of postpartum women without health insurance dropped to 12.1% in 2014. The average from 2011 to 2013 was 17.4%. Postpartum Hispanic women were most likely to be uninsured (15.2%), whereas postpartum Black women were least likely to be uninsured (2.7%).

Local Health Jurisdictions (LHJs): CDPH/MCAH supports LHJs by providing technical to help them develop and adopt protocols within their local MCAH programs to improve access to care for postpartum women. Below are a few examples in the local MCAH Annual Reports of LHJ activities to improve access to and utilization of the postpartum visit:

- Amador County - The Perinatal Office continues to screen for Perinatal Mood and Anxiety Disorder for all pregnant and postpartum women within their practice. They use the community-wide Edinburgh Maternal Depression scale at set intervals as part of their intake and standard of care policies. They refer to community counseling services as indicated. The clinic hosted two Grandmother Teas providing birth and postpartum education to pregnant women and their mother/mother-in-laws.
- Santa Barbara County - MCAH field nursing served 1455 unique individual families. Of the 1455 families, 54% (790) were postpartum mothers, referred by the Health Care Center OB departments, which had a home visit for case management services.

Adolescent Family Life Program (AFLP): AFLP case managers support pregnant and parenting youth with accessing health insurance and needed services, including postpartum care. For more details about AFLP, refer to Adolescent Health Section.

California Home Visiting Program (CHVP): The NFP model requires mothers be enrolled before 29 weeks gestation and HFA requires mothers be enrolled 3 months postpartum. Home visits begin upon enrollment and continue until the child is two for NFP and up to the age of five for HFA. If the mother is without health insurance, she will be linked with appropriate services.

Comprehensive Perinatal Services Program (CPSP): PSCs provided technical assistance to CPSP providers to implement the program according to Title 22 by conducting 768 quality assurance/quality improvement (QA/QI) activities. PSCs provided 768 QA/QI site visits to CPSP provider offices to monitor implementation of

CPSP. The QA/QI visit included an evaluation of the delivery of the required CPSP postpartum assessment, needed follow-up care and individualized care plan revisions. If the PSC noted a trend where clients were not returning to the provider office for their postpartum assessment, they assist the provider and provider staff to develop a plan to ensure that postpartum women complete their OB and CPSP postpartum visits.

CDPH/MCAH and the Title V-funded technical assistance provide at the University of California San Francisco, Family Health Outcomes Project (FHOP), developed a QA/QI pilot project to identify common challenges and areas of improvement for CPSP services by developing a chart review tool. Six LHJs participated in the pilot project and sent their completed chart reviews and chart review tools to FHOP. FHOP reviewed each tool, created an Excel data entry template for data collection, and shared the data entry template with the pilot LHJs for review and input. CDPH/MCAH and FHOP are continuing to develop recommendations for improvement of QA/QI tools, CPSP data collection processes, and addressing common challenges of CPSP implementation in provider offices and clinics.

CDPH/MCAH, the CPSP Executive Committee and DHCS worked on developing the necessary data indicators for a data report on provider reimbursement of CPSP services using aggregate CPSP service codes. PSCs will use this information to monitor CPSP service delivery in provider offices and clinics (QA/QI), and provide technical assistance as needed to improve the quality of CPSP services.

Evidence-based and evidence-informed practices utilized for this strategy

The following evidence-based or evidence-informed practices were utilized for this strategy:

- Implementation of CPSP as an evidence-informed model for comprehensive prenatal/postpartum care.
- The models used for case management (AFLP and BIH) and home visiting programs to support postpartum care are evidence-based or evidence-informed. One of the MIECHV Performance Measures highlights the importance of timely postpartum care and tracks the number of mothers enrolled in home visiting prenatally or within 30 days of delivery that receive a postpartum visit with a healthcare provider within eight weeks (56 days) of delivery.

Challenges for this strategy

Challenges and opportunities for improvement from the LHJs include:

- Marin County – Gaps for services continue to be the lack of access to mental health for clients who have only pregnancy-related Medi-Cal. When their CPSP provider is discontinued, there is difficulty accessing postpartum services, especially in mental health. The new Maternal Mental Health Collaborative in Marin is addressing these barriers.
- Trinity County – There are limited providers for postpartum visits in the county.

Objective 2: Strategy 2:

Increase knowledge of and facilitate collaboration between local MCAH programs and Regional Perinatal Programs to improve maternal and perinatal systems of care, including coordinated postpartum referral systems for high-risk mothers and infants upon hospital discharge.

Regional Perinatal Programs of California (RPPC) is also a Title V-funded program that CDPH/MCAH leads in collaboration with RPPC Directors. The goals of the program are to ensure pregnant women and their babies have access to the correct level of care and to implement quality improvement activities to reduce adverse maternal and neonatal outcomes. RPPC develops and maintains a network of providers and facilities within nine specific geographic areas and match the needs of high-risk perinatal patients with the appropriate type and level of care. RPPC is the only linkage between CDPH/MCAH and birthing hospitals advocating for improved care through an integrated regional perinatal system.

CDPH/MCAH includes guidance in the Local MCAH Policies and Procedures Manual to work with the perinatal community, including providers, RPPC Directors, managed care plans and other health and human service providers to reduce barriers to care, avoid duplication of services and improve quality of perinatal care. CDPH/MCAH also added information about how to increase collaboration with RPPC to coordinate continuity of care for high-risk pregnant women.

During this reporting period, CDPH/MCAH led the launch of the Maternal Levels of Care Steering Committee to establish hospital-level criteria for ensuring high risk moms are delivering babies at the appropriate hospital according to their need. The Maternal Risk-Appropriate Care and Transport Stakeholder meeting took place on May 10, 2018. At this meeting neonatal and maternal care providers, health plan

representatives and researchers came together to address the need for a more comprehensive maternity care system in California. A CDC representative presented data as a starting point to the conversation on what work needs to happen in California to establish maternal levels of care as defined by ACOG/SMFM. An outcome of this meeting was the establishment of four workgroups to continue the conversation:

- 1) Realignment of existing funds to support transfer/transport of pregnant women
- 2) Cross collaboration between different level facilities and systems
- 3) Identify data necessary to support maternal levels of care
- 4) Verification of maternal levels of care

CDPH/MCAH continued discussions with the local MCAH Directors, PSCs and RPPC Directors to identify activities to strengthen state and local ties and provide continuity of care for at-risk pregnant women during pregnancy and upon hospital discharge after birth. In addition, CDPH/MCAH designated an RPPC liaison to participate on the CPSP Executive Committee monthly calls.

Many LHJs collaborated with RPPC to improve maternal and perinatal systems of care. Examples from the LHJ Annual Reports include:

- Fresno County – The MCAH Director collaborated with the RPPC to build out objectives for the Baby Friendly Hospital project, sat on the planning committee for the Central Valley Regional Perinatal Symposium which focused on Congenital Syphilis and Thromboprophylaxis in pregnancy, and was active in the RPPC leadership meetings along with the PSC.
- Mendocino County – The Regional PSC representative and the Local RPPC Director met with two providers (birthing hospitals) in the county to review quality assurance data: California Maternal Quality Care Collaboration toolkits, breastfeeding, transport incidence, neonatal abstinence syndrome policy, immunizations, Zika virus, Safe Sleep, birth certificate data, maternal mental health, and hospital disaster evacuation policies.
- Santa Clara County - Participation in local RPPC site visits to local delivery hospitals and the PSC has provided information on local perinatal initiatives and resources including Universal Prenatal Screening, Maternal Mental Health, and Breastfeeding as well as other perinatal resources for pregnant clients receiving Medi-Cal.

Objective 3:

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.

The rate of mental illness hospitalizations among individuals age 15 to 24 steadily

increased from 1,469 per 100,000 in 2013 to 1,533 per 100,000 in 2015. The three-year average rates were highest among Blacks followed by those identified as White (2,920 and 2,182 per 100,000, respectively). The average rate was lowest among Asian/Pacific Islanders (562 per 100,000).

Objective 3: Strategy 1:

Increase local MCAH programs awareness of Maternal Mental Health (MMH) needs and wellness issues that impact MCAH target populations through various educational opportunities.

CDPH/MCAH conducts an annual survey of women who recently gave birth in order to learn more about their needs and barriers to health. The Maternal and Infant Health Assessment (MIHA), is an annual, statewide-representative survey of women with a recent live birth in California. MIHA collects self-reported information about maternal and infant experiences and about maternal attitudes and behaviors before, during and shortly after pregnancy. The survey is one of the best in the country with a 60% response rate as such, it is a reliable resource to guide family health programs and policies.

CDPH/MCAH has developed strategies to improve maternal mental health by raising awareness, developing resources, implementing screening and referral processes and enhancing collaboration. Over two thirds of Local MCAH Programs have prioritized action to improve maternal mental health systems of care.

Examples in the LHJ MCAH Annual Reports to address maternal mental health are:

- Santa Barbara County – the MCAH program created the 211 “Maternal Emotional Wellness Resource Guide,” which may be accessed in English and Spanish at the following web link: <http://www.211santabarbaracounty.org/for-agencies/directories/>. In addition, the PSC worked on a subcommittee of the Dignity Health Maternal Mood Disorders Project to create a “PMAD Screening and Care Pathway Guide” for local providers to use, which included suggested screening intervals, care pathway depending on the score of the EPDS or PHQ-9, and local resources.
- Tuolumne County – To increase access to care, the rural health collaborative added Tuolumne Me-Wuk Indian Health Center Substance abuse counselors who work with perinatal women. Two additional social workers from Child Protective Services also work with perinatal women and were concerned about getting them into treatment. A brochure was updated and disseminated to Child Protective Services on “Marijuana Use Is Not Safe While Pregnant” with

Tuolumne County Resources listed on the back of the brochure. Collaboration with providers for Substance Use resulted in an agreement for an immediate appointment for perinatal women who are using/abusing opioids.

- Ventura County - 430 or 38.3% of the 1,123 screens administered using the Edinburgh Postnatal Depression Scale and Postpartum Depression Screening Scale, identified scores of women with possible maternal depression or who have significant symptoms of postpartum depression. A total of 607 women were screened, some screened multiple times. 200 women screened positive for possible maternal depression or had significant symptoms of postpartum depression. 100% (200) of the women at risk or with significant symptoms of postpartum depression were referred for services. 75 of the 200 (37.5%) women that were referred for maternal or postpartum depression services accessed at least one of the services.
- Yolo County – the MCAH program formed a new project called “Roadmaps for Healthy Moms”. This project seeks to utilize the MMH Safety Bundle as a framework to integrate behavioral health into obstetrical settings across in and outpatient settings.

California Home Visiting Program (CHVP): Services that directly address emotional well-being include modules, support groups, socialization groups and mental health consultation. Home visitors tailor their efforts to each family’s needs, addressing a range of issues, including financial struggles, familial relationships, domestic violence, housing instability and navigating the health care system. With the support of subject matter experts, CHVP developed nine social media posts on mental health, developed three mental health-related hashtags throughout the year and produced one Home Story (YouTube video); titled *Faraha’s Story Giving Back to Her Community* which explores her journey with depression triggered by her pregnancy.

American Indian Infant Health Initiative (AIIHI): During this funding cycle, 122 families participated in the AIIHI home visitation program. Staff at these clinics provided 1,626 home visits and conducted 42 screenings using the PHQ-9 assessment tool to screen for maternal depression. Home visitors utilize the evidence-based Family Spirit curriculum, which integrates education regarding mental health and well-being. On September 14, 2017, home visitors received training on conducting assessment screens for mental health concerns.

Adolescent Family Life Program (AFLP): The AFLP program model integrates mental health questions into all assessments used with all youth enrolled in the program. Case managers also link youth to resources and care, when needed. At

each assessment point, it is recommended that additional depression screening is completed using one of the following: Patient Health Questionnaire-9 (PHQ-9), the PHQ-9 Modified for Teens, and the Edinburgh Postnatal Depression Scale (EPDS). In addition, there are key program activities related to building skills around emotion regulation and expanding coping strategies and support systems to navigate difficult life situation. The program incorporate other reflection and prevention activities to help the young moms learn not only about how to take care of their child but also take care of their own physical, emotional and mental health. For more information about AFLP, see the Adolescent Health section.

Black Infant Health (BIH): BIH addresses the chronic stress of historical and current experiences of discrimination – one leading theory than links stress to chronic inflammation that may be underlying preterm birth and higher rates of preeclampsia. BIH has a master’s prepared mental health professional (MHP) at each site. The primary responsibilities of the MHP are: conduct initial assessments which include mental health questions, conduct case conferences for all participants at enrollment and follow-up, act as a liaison to their local mental health services, provide mental health consultation to staff about participants of concern, provide Solution-Focused Brief Therapy on a limited basis, participate in group sessions with a strong mental health component or may be triggering. All women receive the EPDS postpartum which is conducted by public health nurse if there’s one at their sites or other staff. If a women is positive for depression, she is referred to local mental health services.

Maternal Mental Health (MMH) Provider Survey: MCAH and FHOP developed an electronic MMH Provider Survey on how providers screen for Perinatal Mood and Anxiety Disorders (PMADs). This survey was designed by FHOP and CDPH to assess what activities concerning MMH and wellness had been implemented within each LHJ. More specifically, what resources, connections, and partnerships have been developed and what resources are still needed. The purpose of this survey had determined wellness as the primary prevention, in addition to screening and referral, was necessary to address MMH in California.

Comprehensive Perinatal Services Program (CPSP): The CPSP is a Medi-Cal program that provides psychosocial, nutrition and health education services, in addition to obstetric care. CPSP providers screen for depressive symptoms throughout pregnancy and the postpartum period using validated tools or assessments and provide enhanced support to ensure that women in need of additional services are linked to a provider.

Evidence-based and evidence-informed practices utilized for this strategy

The PHQ-9, the PHQ-9 Modified for Teens, and the EPDS are all validated assessment tools to screen for depression and utilized through a variety of CDPH/MCAH programs. Case management and home visiting are strategies that support prevention, screening and connecting new moms with needed services to address any mental health concerns. Social media is also an effective strategy for raising awareness about important maternal mental health issues

Challenges for this strategy

Challenges and opportunities for improvement from the LHJs include:

- City of Berkeley – There is a limited list of mental health providers that accept Medi-Cal in Berkeley, in addition to the stigma around mental health issues and accessing services.
- Modoc County - Screening using the PHQ-9 and GAD-7 during pregnancy testing has been challenging. The nurses have encountered several clients who were not willing to fill out the forms and a few who were not capable of filling out the form. In those cases, the PHNs verbally asked about their mental health concerns. Nurses have stated that several clients did not appear to have any depression/anxiety but ended up having elevated scores.

Objective 3: Strategy 2:

Develop and distribute an evidence-based Maternal Mental Health and Wellness Toolkit for local MCAH programs.

Comprehensive Perinatal Service Program (CPSP): CDPH/MCAH has enrolled approximately 1600 CPSP providers throughout California. The CPSP *Steps to Take Manual* provides CPSP providers with the information to effectively assess situations, provide interventions and refer appropriately. The psychosocial section of the manual was reviewed and updated by CDPH/MCAH’s Public Health Medical Officer to provide the most current evidence-based/informed practice and resources.

CDPH/MCAH and FHOP have been collecting evidence-based tools and are in the process of developing a repository for dissemination to local MCAH programs. The sources of the tools include federal and state programs, community-based organizations, professional associations and universities. Some examples include:

- SAMHSA’s *Depression in Mothers: More Than the Blues, A Toolkit for Family Service Providers*
- Mental Health America and SAMSHA’s *Maternal Depression, Making a Difference Through Community Action: A Planning Guide*
- U.S. Preventive Services Task Force’s *Final Research Plan for*

Perinatal Depression

- Every Child Succeed' s *Moving Beyond Depression*
- Massachusetts *Child Psychiatry Access Project*
- Postpartum Support International's *Feelings in Motherhood*

Challenges for this strategy

There are numerous resources related to this topic and CDPH/MCAH has been working to identify, review and match the resources to the needs of the local MCAH programs. Therefore, CDPH/MCAH has not invested in a stand alone toolkit, but rather focused on existing resources that meet the needs of the population in CA.

Objective 3: Strategy 3:

Develop culturally and linguistically appropriate policies and protocols for LHJs and MCAH Programs to reduce discrimination, disparities, and stigmatization related to maternal mental health and wellness issues.

MCAH Programs Focus on Maternal Mental Health: Currently, four CDPH/MCAH programs provide maternal mental health screening services. The BIH Program has masters-prepared mental health professionals at each site. Their key responsibilities include conducting the initial assessments, convening case conferences where mental health concerns are discussed, providing brief counseling as needed, providing referrals for mental health and wellness services, and acting as a liaison to their local mental health community. Recognizing the value of primary prevention in buffering mental health issues, BIH conducts group sessions that help participants manage stress, decrease isolation and empowers participants to make healthier choices. During BIH postpartum visits, BIH participants are screened for depression using the EPDS and referred to mental health services for women who screen positive or present with depressive symptoms.

Local MCAH, through the CPSP, utilizes PSCs in most local health jurisdiction to assist CPSP providers with the implementation of their enhanced services. CPSP providers utilize the CPSP manual, *Steps to Take*, as their guide in assessing, implementing, and/or referring women to services. The Manual includes mental health screening and treatment guidelines and aligns with a recent new policy requiring health care providers and hospitals to screen for depression.

CHVP screens for maternal depression utilizing the EPDS or the PHQ-9, and provides referrals to mental health services for women who screen positive or present with depressive symptoms. Within CHVP, 81.5% of participants were screened for depression within three months of enrollment in 2017-18. About half of the participants

who screen positive for depression receive the recommended services.

AFLP screens for maternal depression utilizing validated tools, and provides referrals for women who identify as having depressive symptoms. Case managers in AFLP also work with participants to build coping and emotional regulations skills.

MIHA Data Brief: MCAH is developing a Data Brief on “*Depressive symptoms during and after pregnancy*”. The Data Brief is based on MIHA data on perinatal depressive symptoms. It contains trend data, statewide disparities and county-level prenatal and postpartum depressive symptoms data among California women with a recent live birth. A brief narrative is included on key social determinants of health (race/ethnicity, income, insurance, stressors during pregnancy, and childhood hardships). Lastly, this data brief is intended to describe the scope of the MMH burden in the state and support local and state efforts to improve maternal mental health.

Evidence-based and evidence-informed practices utilized for this strategy

Utilization of validated screening tools, coupled with tailored support from case managers, home visitors, public health nurses, peer groups and others support prevention, screening and connecting new moms with needed services to address any mental health concerns and reduce stigma.

Challenges for this strategy

Mental health is a critical issue for MCAH populations, however is not the primary focus of activities. The focus is on referring and connecting patients to appropriate services as feasible and raising awareness. To be effective, CDPH/MCAH will continue to strengthen partnerships with agencies providing mental health services at the state and local levels.

Another challenge is a lack of trained staff to screen clients for maternal mental health conditions, and when there is a positive screen for a mental health issue, there are often not enough local mental health service providers available. Lastly, in communities of color, mental health disparities are greater and the stigma about the disease is greater, therefore preventing many people from accessing needed mental health services.

Objective 3: Strategy 4:

Develop and implement evidenced based screening and brief intervention policies that require all Title V funded programs and initiatives to screen participating women and adolescents to determine if they are at risk for mental health and substance use disorders and refer, link, and provide a brief intervention to those who screen positive.

A list of the national clinical recommendations for maternal depression screening guidelines were distributed to local MCAH programs. These include:

- U.S. Preventive Services Task Force
- American Congress of Obstetricians and Gynecologists, Committee on Obstetric Practice
- Council on Patient Safety in Women's Health Care
- American Academy of Pediatrics, Bright Futures and Mental Health Task Force
- AAP/ACOG Guidelines for Perinatal Care
- Centers for Medicaid and Medicare Services

During the 2017-18 report period, various guidelines and proposed legislation were distributed to local MCAH; the distribution of the screening recommendations does not translate to implementation. The following legislation, signed by the Governor Brown, will implement July 20, 2018, July 1, 2019, and January 1, 2020 respectively and will have an impact on California families.

- Assembly Bill (AB) 1893: Requires the California Department of Public Health to investigate and apply for federal opportunities regarding maternal mental health.
- AB 2193: Requires obstetric providers to confirm screening for maternal depression has occurred or to screen directly, at least once during pregnancy or postpartum period. It requires private and public health plans and insurers to create maternal mental health
- AB 3032: Require hospitals to provide maternal mental health training to clinical staff who work with pregnant and postpartum women, and to educate women and families about the signs and symptoms of maternal mental health disorders as well as any local treatment options.

Objective 4:

By June 30, 2020, 100% of parents/caregivers experiencing a sudden and unexpected infant death will be offered grief/bereavement support services.

For FY 2017-18, 174 out of 208 (84%) of families who experienced a sudden unexpected infant death were offered grief/bereavement support services.

Objective 4: Strategy 1:

Contact each local coroner office to review current practices and increase referral of parents of all babies who die suddenly and unexpectedly regardless of circumstances of

death.

CDPH/MCAH funds through Title V and partners with the 61 LHJs to increase communication with their local coroner office. Activities focused on the LHJ reaching out to their coroner and/or working with their local coroner office to remind and encourage referral of parents of all babies who die suddenly and unexpectedly, regardless of circumstances at the time of death. Collaboration between the coroner, medical examiner and the LHJ is essential when an infant dies suddenly and unexpectedly in order for families to be offered grief/bereavement support services.

Through reporting forms from the public health professional, CDPH/MCAH was able to track how the public health professional was notified of an infant death (i.e. coroner, child death review team, hospital, etc.). CDPH/MCAH also tracks receipt of notification to the State of infant deaths by the coroners and communicates with the SIDS Coordinators/public health professionals to be sure they are aware of the deaths. This activity provides an understanding of how public health professionals are informed of infant deaths.

Examples of LHJ efforts include:

- Del Norte - Experienced a delay in notification regarding infant deaths and identified that none of the cases were reported by the Coroner's Office to the LHJ. Local MCAH has met and are working with Sheriff and Coroner's Office to increase communication regarding infant deaths and discuss an official referral process.
- Shasta - The local MCAH programs provided SIDS training to partners and met with the Coroner's Office during Coroner/Vital Records Meeting to clarify roles, responsibilities and contact methods for reporting activities.

Challenges for this strategy

Challenges with this strategy include high turnover at coroner's offices, along with turnover of SIDS Coordinators/public health professionals. To help resolve these challenges, training for new SIDS Coordinators/public health professionals and education on how to work with the local coroner's office is provided by CDPH/MCAH, State SIDS Advisory Council members, other public health professionals, and the California SIDS Program. In addition, quarterly reports are sent by the MCAH Research Scientist to the 61 SIDS Coordinators/public health professionals as a 'check and balance' system. The SIDS Coordinators/public health professionals can learn of deaths they were not notified of and inform MCAH of deaths in which the State was not notified.

Objective 4: Strategy 2:

Make grief/bereavement support materials and peer support organizations available on the California SIDS Program website.

CDPH/MCAH provided grief and bereavement support materials, peer support organization information, and infant safe sleep resources on the California SIDS Program website for anyone experiencing the sudden unexpected loss of an infant. Additional resources such as information targeted to specific populations like grandparents are provided as needed and requested.

Challenges for this strategy

CDPH/MCAH is working to make all approved grief/bereavement support and peer support organizations materials ADA compliant and accessible on the new SIDS Program website.

Objective 4: Strategy 3:

Provide training on grief and bereavement support services to public health professionals and emergency personnel who respond to sudden unexpected infant deaths.

CDPH/MCAH SIDS Program funds and leads, in collaboration with the California SIDS Advisory Council, an annual spring trainings on grief and bereavement support services to public health professionals and emergency personnel who respond to sudden unexpected infant deaths. The trainings are designed for public health nurses, registered nurses, social workers and emergency personnel and provides participants with information, resources and expertise from the CDPH/MCAH, program partners, and community experts on SIDS and sudden unexpected infant death. Topics included current research; risk reduction updates; role of the first responder, coroner, and medical examiner and investigative procedures, and exchange of knowledge and experience from public health professionals including support services. Trainings were developed by California SIDS program in consultation with experts in the field of SIDS. Trainings included information on the community resources available to assist families who have lost an infant suddenly and unexpectedly.

Two trainings were conducted in this reporting period, one in March and one in April 2018. For these trainings a deputy coroner from the north and one from the south presented on the role of the first responder, coroner, and medical examiner and provided progress updates and new strategies about how to improve effective collaboration between coroners and the LHJs. Additional training included the parent

perspective on grief/bereavement support, the role of the SIDS Coordinator/public health professional and vicarious trauma.

Challenges for this strategy

One of the major challenges is increasing attendance to SIDS training of emergency personnel and other professionals who are involved when an infant dies suddenly and unexpectedly. The staff are often the first person on the scene following a lifeless infant. While working to revive the infant, they are faced with consoling the parent or caregiver, as well as assessing and recording information about the death scene. Therefore continued education for emergency personnel plays a vital role in responding to a sudden infant death. Another challenge is the frequent turnover of SIDS Coordinators/public health professionals, which results in the need for training on a regular basis. CDPH/MCAH is currently working on providing web-based trainings in addition to the two annual trainings. Web-based trainings would allow for anyone not in attendance at the annual trainings to participate in the web-based trainings and receive the needed information.

Objective 4: Strategy 4:

Track if 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.

CDPH/MCAH tracked notifications of sudden unexplained infant deaths through receipt of a Coroner Notification Card from the coroner and/or receipt of a Public Health Services Report from the SIDS Coordinator/public health professional. The Coroner Notification Card provides basic demographic information on the infant and the Public Health Services Report provides demographic information, history (prenatal, infant, circumstances of death), assessment of family (coping status, environment), intervention, and plan (referrals) for support. In addition, CDPH/MCAH collected information about when grief/bereavement services were offered, if the family declined, if a home visit was done, if grief/bereavement materials were mailed to the family and any follow-up contact.

Tracking of sudden unexplained infant deaths and corresponding with the SIDS Coordinators/public health professionals has helped to identify deaths that were not known to the jurisdictions and also not known to the State. Through quarterly correspondence, infant deaths that were not referred are identified and immediate contact with the family is made by the SIDS Coordinator/public health professional.

Challenges for this strategy

Not having access to timely death data is a challenge and prohibits CDPH/MCAH from identifying more immediate deaths when no notification has been received. Without immediate identification of deaths, the missed opportunity for a family to receive grief and bereavement support is a lost opportunity.

Objective 5:

By June 30, 2020, MCAH will work with partners to reduce prevalence of hypertension, diabetes, cardiovascular disease and mental illness among women at labor and delivery from 8.0%, 10.0%, 0.54% and 4.4% (2013 Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data (PDD)) to 7.4, 9.5%, 0.51% and 3.9% respectively.

Data from the national Healthcare Cost and Utilization Project reveal that rates of severe maternal morbidity increased from 127.5 per 10,000 delivery hospitalizations in 2012 to 147.4 per 10,000 delivery hospitalizations in 2014.

In 2015, data from the hospital discharge data show that 8.9 percent of women at labor and delivery had a diagnosis of hypertension. This represented less than a percent increase from 2014. A greater proportion of Black women (14.9 percent) and American Indian/Alaskan Native women (11.0 percent) had hypertension than Asian/Pacific Islander women (6.8 percent) or Hispanic women (8.7 percent).

In 2015, data from the hospital discharge data show that 10.6% of women at labor and delivery had a diagnosis of diabetes. The percent of women with diabetes remained relatively unchanged from 2014. A greater proportion of Asian/Pacific Islander women (15.6%) and American Indian/Alaskan Native women had diabetes than White (7.6%) or Black (8.8%) women. One out of nine Hispanic women at labor and delivery had diabetes.

The percent of women at labor and delivery with a diagnosis of heart disease remained stable at 0.6% for both 2014 and 2015 using hospital discharge data. The percent with heart disease by race- ethnicity ranged from 0.4% among Hispanic women to 0.8% among both White and Black women.

The percent of women at labor and delivery with a diagnosis of mental disorder increased from 4.5% in 2014 to 5.4% in 2015. Increases were evident among all women except those identified as American Indian/Alaskan Native. This group experienced a percentage point decrease from 10.6% to 9.6% in 2015.

Objective 5: Strategy 1:

Partner with disease-specific organizations to target prevention outreach to women of reproductive age for cardiovascular disease, hypertension, diabetes, and mental illness to ensure prevention strategies are culturally, linguistically, and age appropriate and match literacy level.

California Pregnancy-Associated Mortality Review (CA-PAMR): is a comprehensive statewide maternal mortality examination that aims to identify pregnancy-related deaths during pregnancy or within 1 year of the end of pregnancy, their causes, factors that contributed to the death, and improvement opportunities in maternity care and support, with the ultimate goal to reduce preventable deaths and associated health disparities. CA-PAMR is a collaborative effort between the CDPH/MCAH and its partners, Stanford University's California Maternal Quality of Care Collaborative (CMQCC) and the Public Health Institute (PHI).

The CDPH/MCAH is a national leader in identifying areas of maternal mortality, and the development and implementation of state and local strategies to reduce the number of maternal deaths. The public health investigation method has informed efforts all across the country and our strategies for taking data to action have been similarly replicated. CA-PAMR recently completed in-depth case reviews of pregnancy-associated suicide in an effort to apply the same methodology to collect data, engage expert review and identify opportunities for improvement. In addition, CA-PAMR is also examining deaths up to one year post pregnancy because although early deaths have decreased, later deaths (up to one year) have risen. CA-PAMR hypothesizes that chronic health conditions may be contributing as the average age of first pregnancy is rising; or improved rescue care may be delaying deaths; or perhaps access to care after routine postpartum care ends at 6 weeks may be a factor.

Major activities include the release of CA-PAMR's report in April 2018 on obstetric-related deaths. This report is a culmination of work that spanned several years and informed the *California Toolkits to Transform Maternity Care* series which include the webinars on Improving Health Care Response to Cardiovascular Disease in Pregnancy and Postpartum and Maternal Venous Thromboembolism. The report was shared via CDPH/MCAH's email marketing tool Constant Contact to a list of 1,512 email subscribers. Of that number, 570 subscribers opened the report. The report was viewed on the CDPH/MCAH website 239 times in the first week of the report's release and viewed 427 times by the end of the first month. The press release generated 13 media inquiries and at least three national news stories. Two social media posts promoting the report release were shared on the CDPH/MCAH Facebook Page, reaching 1,818

Facebook users who performed 72 post clicks. Four posts were tweeted out, reaching 6,510 Twitter users and 17 retweets.

Lastly, CA-PAMR's efforts were also focused on the investigation of suicide among pregnant and postpartum women. These in-depth case reviews of deaths by suicide were completed in 2018, and a report is underway.

CDPH/MCAH supported multiple states with technical assistance on how to set up and conduct maternal mortality reviews.

Regional Perinatal Programs of California (RPPC): RPPC coordinated the planning, collaboration and promotion of an integrated regionalized perinatal health system of high quality, risk appropriate care for pregnant women and their infants. RPPC Regional Directors are highly skilled medical personnel contracted by CDPH/MCAH to develop a provider network within nine specific geographic areas that match the needs of high-risk perinatal patients with the appropriate type and level of care.

The following toolkits were used by the RPPC Directors to assist providers assess and implement clinical best practices and quality improvement strategies to support the reduction in maternal morbidity:

- Improving Health Care Response Cardiovascular Disease (CVD) in Pregnancy and Postpartum
- Improving Health Care Response to Venous Thromboembolism (VTE) in Pregnancy and Postpartum
- Improving Health Care Response to Obstetric Hemorrhage
- Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age
- Improving Health Care Response to Preeclampsia
- CAN Neonatal Disaster Preparedness
- Care and Management of the Late Preterm Infant
- Delivery Room Management for the Very Low Birth Weight (VLBW)
- Infant Early Screening and Identification of Candidates for Neonatal Therapeutic Hypothermia
- Preterm Labor Assessment Toolkit

State and Local MCAH Efforts:

- The RPPC Director from the Southern Inland Region convened a Maternal

- Mental Health Roundtable and invited, hospital leadership, CPSP providers, Maternal Mental Health Coalitions, Mom2020, physicians, representatives from Behavioral Health, local programs and therapists. The Roundtable included formal presentations and opportunities for sharing and collaboration.
- The RPPC Director from the Southern Inland County was invited to participate on the advisory Board of Choose Health LA, a local initiative of the Los Angeles County Department of Public Health to prevent and control chronic disease in Los Angeles County.
 - Santa Barbara County RPPC Director took the lead on gathering various stakeholders from Santa Barbara and Ventura Counties to form a regional collaborative focused on Perinatal Mood and Anxiety Disorders.
 - MCAH collaborated with the Center for Healthy Communities and the Chronic Disease Branch within the CDPH to review the CPSP Steps to Take Manual section on Cardiovascular Disease and they offered to fund the development of a factsheet, “Are you at Risk for Heart Disease Following your Pregnancy” for three target populations: White, Latino and African American Communities. The Chronic Disease Branch contracted with a professor on Cardiovascular Medicine from UC Davis to develop the factsheet content and to conduct a webinar for stakeholders on the importance of good cardiovascular health in pregnancy and the risk for complication with heart disease during and after a pregnancy.

The California Diabetes and Pregnancy Program (CDAPP) Sweet Success:

The California Diabetes and Pregnancy Program (CDAPP) Sweet Success provides technical support and education to medical personnel and community liaisons to assist in promoting improved pregnancy outcomes for high-risk pregnant women with pre-existing diabetes and women who develop diabetes while pregnant, gestational diabetes mellitus (GDM). Providers who complete a CDAPP Sweet Success application, undergo standardized CDAPP Sweet Success training to become a CDAPP Sweet Success Affiliate and provide direct patient care to women with diabetes while pregnant.

CDPH/MCAH contracts the CDAPP Sweet Success Resource Center to develop and record training and education to medical personnel to assist in promoting improved pregnancy outcomes for high-risk pregnant women with preexisting and gestational diabetes. The Resource and Training Center trained about 2000 individual providers working in affiliate organizations in 2017-18 through online trainings that covered a range of subjects, such as gestational diabetes, postpartum care, preconception care and Interconception care. As a provision of being a CDAPP Sweet Success Affiliate, each affiliate is required to complete a specific number of webinar trainings a year. Each training webinar is an hour in length and conducted by state and national experts. In

addition to training, the CDAPP Sweet Success Resource Center also provides educational resources for both providers and pregnant women with diabetes.

The Resource Center has modernized and revamped the CDAPP Sweet Success website to ensure each resource is easy to download and that the site is user-friendly. The resource center re-organized all resources and useful links. CDAPP began review and revision of the Food Guide and Eating out Wisely.

CDPH/MCAH continued to monitor the percent of women hospitalized at time of delivery with Diabetes using Office of Statewide Health Planning and Development (OSHPD) patient discharge data.

A CDAPP Sweet Success Stakeholder Group was implemented by the Resource Center under direction of the MCAH Division in November 2017. This Committee includes four working groups: 1) Medical Management: They review, and make recommendations for updates to CDAPP SS Guidelines for Care or recommend other resources for diabetes management. 2) Technology: They research and make recommendations for innovative technology to support diabetes management. 3) Evaluation and Monitoring: They collaborate with MCAH to design and recommend program evaluation and monitoring to support the success of the CDAPP Sweet Success Program. 4) Resources & Materials: They identify and provide recommendations on revising or developing new CDAPP Sweet Success materials. All Stakeholder Group members provide input to the Web-Based Educational Trainings.

The CDAPP Sweet Success Evaluation Plan working group focused on evaluating postpartum follow up rates and preconception tying in the topic of weight before and after pregnancy. CDPH/MCAH promoted the California My Plate document for pregnant and parenting women and adolescents, as well as women with diabetes in pregnancy through the CDPH/MCAH website, the CPSP Steps to Take Manual, the AFLP nutrition guidelines, the CDAPP Sweet Success guidelines, and related program trainings.

A Technology Tips Factsheet for providers & clients was drafted to provide types of technological devices and services available, acquisition of technology/devices and available funding/reimbursement sources, and assistance with implementing technologies into their practice.

Evidence-based/Evidence Informed Practices utilized for this strategy

The following key literature and published guidelines were utilized to support this strategy:

- Shields, L and Tsay, GS. Editors, California Diabetes and Pregnancy Program Sweet Success Guidelines for Care. Developed with CDPH; Maternal Child and Adolescent Health Division; revised edition, updated September 2015.
- U.S. Department of Health and Human Services and U.S. Department of Agriculture. 2015–2020 Dietary Guidelines for Americans. 8th Edition. 2015. Available at <http://health.gov/dietaryguidelines/2015/guidelines/>
- Institute of Medicine and National Research Council of the National Academies. Weight Gain During Pregnancy Reexamining the Guidelines. 2009. Available at: <http://nationalacademies.org/hmd/reports/2009/weight-gain-during-pregnancy-reexamining-theguidelines.aspx>

Challenges for this strategy

Due to limited funding and minimal Affiliate requirements, the CDAPP Sweet Success Resource Center has barriers in terms of being able to collect more data and analyze it to prove improved client outcomes. With that lens, the CDAPP Sweet Success Stakeholder, Evaluation Plan Working Group considered focusing on postpartum care and follow up rates for our Affiliate sites.

Another challenge faced was the inability to have CDAPP Sweet Success resources and materials translated into other languages by the State. CDAPP Sweet Success Affiliates have diverse client populations and the CDAPP Sweet Success and Resource Center is not able to meet that need.

Objective 5: Strategy 2:

Partner with Office of Health Equity, Health in All Policies (HiAP) Task Force to help develop policies and initiatives to address community risk factors for chronic cardiovascular diseases (e.g. healthy food availability, built environment for more active transportation, community safety that promotes active transportation), and ensure applicability of HiAP plans to women of reproductive age.

CDPH/MCAH continued to promote systems and environmental changes for breastfeeding, nutrition and physical activity by updating the systems and environmental changes toolkit:

<https://www.cdph.ca.gov/Programs/CFH/DMCAH/NUPA/Pages/Systems-and-Environmental-Change.aspx> .

CDPH/MCAH continued to participate in the HiAP task force, which brings State level stakeholders together to address issues that impact our population domains to address social determinants of health inequities.

Local health jurisdiction activities include:

- Imperial LHJ observed childcare providers and found that many childcare sites have taken advantage of the provision of the stenciling on their sidewalks and/or cemented areas, all sites are providing water that is available and accessible to children playing both inside and outside, many sites have a garden on site.
- San Francisco developed the Healthy Apple Program. In this program, childcare programs who participated, created program nutrition and physical activity policies and implemented these policies. The program had 18/23 overall sites achieve Healthy Apple Award levels this year.

Challenges for this strategy

The challenge has been identifying the CDPH/MCAH role within the HiAP group and the best ways to maximize the impact to support MCAH populations.

Objective 5: Strategy 3:

Disseminate the National Preconception Curriculum & Resources Guide for Clinicians training module 5 and the Interconception Care Project of California materials to health care providers to help ensure women with risk factors receive appropriate interconception and follow-up care.

Challenges for this strategy

State MCAH did not implement the dissemination of the training module to health care providers. Rather, State MCAH redirected its efforts towards leading a three-year HRSA Preconception Collaborative Improvement & Innovation Network (COIIN) project focused on the development of a preconception health risk screening tool and clinic implementation process using a human-centered design and approach. As CDPH/MCAH moves forward, the team will examine the capacity for broad rollout of the preconception strategy inclusive of protocols, tools, workforce development, resources and an evaluation or quality assurance/improvement plan in collaboration with local MCAH Directors.

Objective 6:

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

The percent of women reporting mistimed or unwanted pregnancy steadily

decreased from 31.9% in 2013 to 29.1% in 2015.

The percent of mistimed or unwanted pregnancy among Black women of reproductive age increased from 39.7% in 2013 to 40.9% in 2014 before decreasing to 39.7% in 2015.

The percent of mistimed or unwanted pregnancy among Hispanic women of reproductive age decreased 1.4 points from 39.1% in 2013 to 37.7% in 2014 before dropping another 3.4 points to 34.3% in 2015.

Hispanic women (57.7%) and White women (23.9%) were most likely to report unwanted pregnancies, whereas Asian/Pacific Islander women (9.9%) and Black women (7.5%) were among those least likely to report unwanted pregnancies.

Objective 6: Strategy 1:

Broadly disseminate the concept of a Reproductive Life Plan by developing or disseminating culturally and linguistically appropriate tools for integration into existing MCAH programs and public health departments.

CDPH/MCAH has been able to support LHM implementation of these activities by providing technical assistance and dissemination of resources and materials, including data as needed. Many LHJs utilize reproductive life planning in their local programs.

A few examples of LHM activities related to reproductive planning are:

- Sacramento County - A Roundtable Training on Preconception and Inter-conception care titled "Misconceptions; Teaching Preconception Care in a Digital World" was conducted by Jaqueline Sawyer from CSUS school of Nursing. Printed handouts on Reproductive life planning, pregnancy spacing, and healthy weight before and after pregnancy, nutrition (Folic Acid), managing chronic medical conditions and Healthy relationships were provided to the Audience.
- Shasta County – 97 clients have received education on reproductive life planning and where to get these services within the community. The reproductive life planning services information on the womensconnectshasta.com program website is accessible to 100% of the clients that visit the website 24 hours per day, 365 days per year.
- San Diego County - Focus groups were conducted with various segments of the target population to obtain input on the developed inter-conception health education tool. The inter-conception tool is in the form of a booklet

and includes a planner. The tool provides culturally and linguistically appropriate health education messages, interactive self-reflection activities, resources, and supports users to track health status and share information with their healthcare provider. The tool is currently being finalized and will be routed for approval FY 18-19. For the tool to be successful, an integration of authentic relatable images mixed in with health content is necessary components to capture the interest of the target population.

California Home Visiting Program (CHVP): Some home visitors/nurses provide culturally sensitive services to participants. Home visitors/nurses provide information about family planning choices and birth control options during their home visits. They talk with mothers about their plans for another baby and discuss baby spacing benefits. Resources and educational materials are disseminated in a variety of languages consistent with surrounding area population. Services are provided in the family's preferred language when possible.

Black Infant Health (BIH): The BIH Program team continues to ensure that resources, tools and materials are culturally appropriate for the BIH target population. This is evident in the group curriculum as well as in the various trainings conducted each year. BIH Family Health Advocates and Group Facilitators report that participants enjoy utilizing the "About Me" workbook to assist them in setting short and long-term goals as they relate to reproductive life planning and other goals under consideration. Many BIH Participants set long-term educational and career goals as part of overall Life Planning. Having a Reproductive Life Plan permits them to factor in when the ideal time might be to consider expanding their family. Local staff also report that this opens up lines of communication with their partner in order to have viewpoints discussed freely.

The BIH Program introduced various resources and tools from the World Health Organization and other MCAH Programs such as Every Woman California in order to provide BIH Participants with options they can personalize as they formalized Reproductive Life Plans. These tools were instrumental in assisting BIH Family Health Advocates and Group Facilitators with guidance as they provided technical assistance to participants developing Reproductive Life Plans.

Adolescent Family Life Program (AFLP): AFLP integrates the program's *My Life Plan* and *My Goal Sheet* tools to support youth to set goals around reproductive life planning. For more information about AFLP, refer to the Adolescent Health Section.

Challenges for this strategy

The challenges faced for this strategy included: 1) State MCAH lacked personnel capacity to roll out the Reproductive Life Plan in our LHJs. State management will decide if this remains our strategy moving forward and if so, allocate necessary resources; and 2) ensuring that the BIH Program utilized materials and tools that were culturally appropriate and relevant for the BIH population. The BIH team worked diligently to locate resources and materials that included photos of African American women and men to share with participants. The BIH Program also ensured that the group curriculum included culturally appropriate photos.

Objective 6: Strategy 2:

Integrate One Key Question (OKQ) into Title V programs and partner programs to promote appropriate contraception counseling to match pregnancy desire and timing.

MCAH supports LHJ implementation of these activities by providing technical assistance and dissemination of resources and materials, including data as needed.

Fifteen out of the 60 LHJs (25%) state that they have been trained on One Key Question to promote appropriate contraception counseling.

MCAH continues to work with the local PSCs in the promotion of and education to provider on promoting pregnancy spacing. Additionally, MCAH is supporting the Every Woman California, Preconception Health Council of California website. The site includes FAMILIA, a text-messaging program, developed to provide tips on family planning, contraception options and other health topics. Each message links to the FAMILIA website form more information, apps, blogs, and videos related to that topic. A person will receive three healthy living texts each week for three months promoting preconception health.

Objective 6: Strategy 3:

Standardize the content of the postpartum visit by collaborating with existing partners such as Medi-Cal Managed Care Plans and each LHJ's Perinatal Service Coordinator to use the National Preconception Curriculum & Resources Guide for Clinicians training module 4 "In Between Time: Interconception Health Care Part 1: Routine Postpartum Care for Every Woman."

Comprehensive Perinatal Services Program (CPSP): CDPH/MCAH staff updated the CPSP Steps to Take (STT) Manual that provides information on prenatal and postpartum care, nutrition, health education and psychosocial issues that provider staff can use with their CPSP clients. STT also contains patient handouts in English

and Spanish on important and common health issues. There are many handouts, but a few examples that related to preterm birth are; If Your Labor Starts too Early; Did You Have Complications During Pregnancy; Signs and Symptoms of Heart Disease; Diabetes While You are Pregnant; Welcome to Pregnancy Care, and Drugs and Alcohol When You Want to STOP.

CPSP providers are required to implement CPSP according to the American Congress of Obstetricians and Gynecologists guidelines. CPSP providers are also Medi-Cal providers and must fulfill Medic-Cal requirements and guidelines.

Black Infant Health (BIH): The BIH Program continues to collaborate with the MCMC Plans and CPSP Providers to ensure that BIH Participants are keeping postpartum visits. BIH Family Health Advocates and PHNs are instrumental in conducting home visits and/or making phone calls with participants within one week of delivery to reinforce the importance of making and keeping their six-week postpartum appointment. The BIH Program continues to utilize the joint BIH/MCMC and BIH/CPSP letters with state and local partners in order to reinforce programmatic best practices for participants receiving services from BIH, MCMC Plans and CPSP Providers. Local BIH Program staff have collaborated with MCMC Plans and CPSP Providers to conduct an overview of BIH Program services, including shared visions of our respective programs regarding the importance of postpartum visits.

During the 2017-18 report period, highlights include the following: statewide, local BIH program staff conducted approximately 70 presentations with staff from various MCMC Plans and CPSP Providers providing an overview of BIH program services. BIH staff report that the presentations were well received and resulted in referrals of plan members eligible for the BIH Program. Local BIH Program staff also provided referral outcomes to MCMC Plan and CPSP Providers in order to further enhance and maintain collaborative partnerships.

Statewide ETO data during this reporting period reflected approximately 182 referrals to the BIH program from MCMC Plans and CPSP providers resulting from the presentations conducted by BIH local staff. The BIH Program will continue to devote efforts to this strategy to highlight the importance of programmatic collaborative practices as they relate to postpartum visits.

Objective 7:

- a) **By June 30, 2020, at least 30 out of 61 LHJs (2013-14 MCAH Annual Reports) will adopt elements of the MCAH's Intimate Partner Violence (IPV) Toolkit.**
- b) **By June 30, 2020 all MCAH programs (i.e., AFLP, BIH, CHVP, I&E, PREP) will adopt elements of MCAH's IPV Toolkit.**

- c) **By June 30, 2020, all funded Title V Indian Health sites will adopt elements of MCAH's IPV Toolkit.**

Objective 7: Strategy 1:

Develop, implement, and evaluate MCAH's IPV Toolkit with tools and resources for all Title V funded programs (i.e., AFLP, BIH and LHJs MCAH Programs). 2. Identify, develop and implement culturally congruent trainings, technical assistance and education for the sustainability of MCAH's IPV Toolkit.

The Intimate Partner Violence (IPV) efforts continue to be developed as part of California's Title V efforts to address multifactorial components including behavioral, social, cultural, and environmental factors and the complexity of the interaction of these factors. National Screening tools and training including local training efforts will be identified, disseminated, and promoted to assist local MCAH program efforts.

Black Infant Health (BIH): The BIH Program features a curriculum focused on Empowerment and Social Support inclusive of 10 Prenatal and 10 Postpartum sessions each. Session 9 of the Prenatal Sessions promotes healthy relationships and Session 17 of the Postnatal Sessions promotes effective communication to promote healthy relationships. Program participants are encouraged to discuss any issues or concerns they have or are experiencing at any time throughout their program participation. Additionally, the BIH Program provides an overview of IPV and Reproductive Coercion strategies that participants can utilize to assist them with having healthy relationships. The BIH Program has collaborated with partner agencies to provide IPV trainings to local BIH Mental Health Professionals and Public Health Nurses for providing additional supportive services when IPV issues are revealed by participants.

The BIH Program collaborated with a local partner agency to provide a training related to IPV and healthy relationships to approximately 30 BIH MHPs and PHNs. The training provided an overview of healthy relationships, intervention protocols, referral processes and safety planning. The training also provided strategies that staff could utilize in the areas of vicarious trauma and self-care to decrease stress and burn-out.

The BIH Program utilized resources and tools from partners such as *Futures Without Violence* in order to provide additional assistance and support to BIH Participants experiencing IPV. The tools were used by local BIH staff as guidance to promote discussions and implement strategies for participants experiencing IPV, reproductive coercion and birth control sabotage.

Adolescent Family Life Program (AFLP): The AFLP model includes key

assessment questions around IPV, with support for linking to support when needed. The model also incorporates standardized activities around healthy relationships and all local agencies distribute and discuss *Futures Without Violence* resources with all youth in the program. For additional details about AFLP refer to *Adolescent Health Domain*

Challenges for this strategy

Many IPV resources were not written in a culturally sensitive manner. The BIH Program reviewed resources and materials to find culturally and linguistically appropriate materials.

Objective 7: Strategy 2:

Identify, develop and implement culturally congruent trainings, technical assistance and education for the sustainability of MCAH's IPV Toolkit.

Black Infant Health (BIH): Local BIH Programs are charged with ensuring that participants understand the characteristics of healthy relationships and provide resources that can help participants deal with abuse, reproductive coercion or birth control sabotage and also provide referrals and promote linkages to family planning providers including Family Planning, Access, Care, and Treatment (Family PACT).

BIH Program materials and curriculum include an overview of IPV and Reproductive Coercion strategies that participants can utilize to assist them with having healthy relationships. The BIH Program has collaborated with partner agencies to provide IPV trainings to local BIH Mental Health Professionals and Public Health Nurses for the purpose of providing additional supportive services when IPV issues are revealed by participants.

A highlight of implementing this strategy is that the BIH Program collaborated with a local partner agency to provide a training related to IPV and healthy relationships to approximately 30 BIH MHPs and PHNs. The training provided an overview of healthy relationships, intervention protocols, referral processes and safety planning. The training also provided strategies that staff could utilize in the areas of vicarious trauma and self-care to decrease stress and burn-out.

Objective 7: Strategy 3:

Develop and implement an IPV Initiative Performance and Quality Improvement (PQI) tool to evaluate the effectiveness of the elements within MCAH's IPV Toolkit.

CDPH/MCAH recognizes that there are other experts working in this area with established toolkits and resources. Therefore, activities have been redirected and

this strategy is revised in the next fiscal year plan.

Objective 7: Strategy 4:

Build and sustain internal and external collaborations to share practices and support MCAH's IPV efforts.

CDPH/MCAH is supportive of reproductive and sexual coercion guidelines as safeguards to prevent IPV. CDPH/MCAH is committed to identifying, disseminating and promoting resources for effective assessments and responses by advocates and health care providers. Such guidelines will support the expansion of routine screening for IPV to include assessment for reproductive and sexual coercion.

Local Health Jurisdictions (LHJs): For FY 2017-18, Implementation of which activities LHJs chose to work on varied widely due to the diversity in resources and challenges unique to each LHJ across the state. Because of this great diversity, implementation of these activities were specific to the needs of the population of each LHJ and identified during their 5-year needs assessment.

A few examples of LHJ activities to address IPV are:

- Glenn County - MCAH Director met with Glenn Medical Center (GMC) Nurse Director to discuss IPV policies. GMC and other entities are aware of referring to Westside Domestic Violence Shelter or Catalyst in Butte Co. GMC as a whole are trained on domestic violence and child abuse reporting to the Sheriff Office and county CPS department.
- Merced County - The Commercially Sexually Exploited Children (CSEC) tool was developed in partnership with the Merced County Human Services Agency. Utilizing the developed tool, 85% or more of all clients in the MCAH programs are assessed for the presence and extent of human trafficking. The CSEC tool is used by AFLP/Young Parents Programs staff when there is a suspicion. In addition, both AFLP and HFA, and field nursing home visiting programs assess for Intimate Partner Violence. One hundred percent (100%) of MCAH clients are assessed for IPV.
- Santa Clara County - Public Health Employees received education and training on domestic violence/intimate partner violence, healthy relationships, its impact on health, and vicarious trauma including current resources and tools. Employee evaluations and pre and post surveys were completed. The pre-post surveys completed after the IPV training showed increased comfort with PHD staff talking with clients about healthy and unhealthy relationships. The pre-post survey results also showcased staff's increased confidence in

knowing local and national resources that are available to assist clients if they have experienced IPV.

Black Infant Health (BIH): The BIH Program collaborated with local partners such as Futures Without Violence and “WEAVE”, a Sacramento non-profit agency that provides support and crisis intervention services to families experiencing Domestic Violence and other adverse circumstances.

BIH Mental Health Professionals (MHPs) were able to assist BIH Participants by using techniques such as Motivational Interviewing in order to provide enhanced individualized support and guidance. BIH Coordinators and Program Managers provide opportunities to discuss concerns related to IPV during reflective and clinical supervision with direct line staff.

The BIH Program adapted segments of the Reproductive and Sexual Coercion Guidelines for the Empowerment and Social Support curriculum utilized with participants. Adapted segments are included in Session 10 of the Prenatal Sessions focused on Raising Awareness for making informed decisions, Common Language in order to define affected populations, and Cultural and Linguistic Competency in order to identify appropriate resources.

Local BIH agencies also provide services in culturally affirming environments and have staff that reflect the target population. The BIH Program also used resources and tools from “WEAVE” to enhance support services that local BIH Program staff provides to BIH Participants.

Challenges for this strategy

Due to changing priorities, CDPH/MCAH has not had dedicated personnel assigned to IPV activities.

Women/Maternal Health – Application Narrative (FY 2019-20)

Priority 1: Improve access and utilization to comprehensive, quality health services for women.

Surveillance: MCAH will review the national performance and national outcome data included in the Federally Available Data report prepared by MCHB and made available to states by May 2019. MCAH will monitor select quantifiable characteristics to track the health of California women and mothers as part of its routine health surveillance efforts. The following select indicators and measures, listed in the table below, will be continuously and systematically collected, analyzed and interpreted to guide program planning, implementation and evaluation of interventions. The State will continue to analyze these indicators at the State and sub-state levels to identify specific improvement opportunities.

Select Women's/ Maternal Health Indicators and Measures	Data Source
Preventive care visits	2017 Behavioral Risk Factor Survey
First trimester prenatal care initiation	2017 CA Birth Statistical Master file
Postpartum care visit (2016 only)	2015-16 Maternal and Infant Health Assessment Survey
Health Insurance Coverage	2015-16 Maternal and Infant Health Assessment Survey
Nutrition and Weight	2015-16 Maternal and Infant Health Assessment Survey
Physical or psychological intimate partner violence during pregnancy	2015-16 Maternal and Infant Health Assessment Survey
Substance Use	2015-16 Maternal and Infant Health Assessment Survey
Pregnancy Intention and Family Planning <ul style="list-style-type: none"> • Mistimed or unwanted pregnancy • Unsure of pregnancy intentions • Postpartum birth control use 	2015-16 Maternal and Infant Health Assessment Survey
Maternal mortality ratio	2015 CA Birth Death file
Severe maternal morbidity	2016 CA Patient Discharge data
Morbidities at labor and delivery <ul style="list-style-type: none"> • Hypertension • Diabetes • Cardiovascular disease • Mental illness 	2016 CA Patient Discharge data

The select indicators and measures above serve as an early warning system to identify emerging issues, target program interventions or track progress toward specified objectives in the Action Plan, allow priorities to be re-evaluated and inform public health policy and strategies. MCAH utilizes Information gleaned from health surveillance data to mobilize partners and stakeholders, at the local and state level, to galvanize improvement efforts that lead to desired outcomes.

To provide a greater depth in understanding the health status of women and mothers and to uncover health disparities, analysis of these key indicators and measures will include stratification by key demographic factors such as race/ethnicity, county or by hospital as appropriate given the specific measure and the data constraints.

Objective 1a:

By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care, including decreasing the rate of uninsured women and children who are Medi-Cal eligible from 8.3% and 36.5% to 7.9% and 34.7% respectively and postpartum women without health insurance from 16.7% to 16.2% (MIHA).

Objective 1a: Strategy 1:

Provide technical assistance to LHJs to ensure all persons in MCAH programs are enrolled in insurance, linked to a provider, and complete an appointment.

- CDPH/MCAH will utilize data and reports to monitor Medi-Cal enrollment by county and by a key set of specific perinatal outcomes, and provide technical assistance to the LHJs as appropriate.
- State and Local MCAH will continue to work with stakeholders to develop policies and plans that support individual and community health efforts to enroll people in health insurance and needed health services.
- CDPH/MCAH and FHOP will continue to conduct technical assistance calls with the LHJs and other MCAH programs to identify best practices, address entry into healthcare systems, and assess availability of needed services and providers.
- CDPH/MCAH will continue to provide technical assistance to LHJs for the purpose of implementing the community perinatal program and encouraging provider enrollment into CPSP. Technical assistance includes, but is not limited to, CPSP provider enrollment, CPSP training, provision of services, and quality of care.

- CDPH/MCAH will continue to fund local MCAH programs at the LHJs with Title V. Each LHJ develops a scope of work based on local needs, contributes local funds and draws down Title XIX, when appropriate. Examples of planned activities for this strategy to increase enrollment in insurance and linkages to providers are:
 - San Francisco County: MCAH will collaborate with Human Services Agency to develop an improvement plan to streamline the Medi-Cal application process for women who are applying for Medi-Cal due to pregnancy and determine a baseline.
 - Siskiyou County: 100% of women enrolled in MCAH's Prenatal Care Guidance (PCG) Program will be screened for health insurance coverage and a primary care provider.
 - Riverside County: 75% of CPSP providers will have working knowledge of the new comprehensive resource and referral guide and use it to increase referrals to meet the specific needs of their clients.
- CDPH/MCAH will continue to fund the BIH Program to ensure that participants are enrolled in prenatal care and are receiving risk-appropriate perinatal care during their time in BIH and upon completion for preventive health care.
- MCAH will continue to utilize various data sources (BRFSS, CHIS and MIHA) to monitor insurance coverage for women and children in California.
- MCAH will continue to support the Department's Office of Oral Health (OOH) efforts by being an active member on the State's Oral Health Advisory Committee, and ensures the California Oral Health Plan is implemented to address determinants of health and promote local preventive interventions.

Objective 1a: Strategy 2:

Develop a competent workforce that meets the health needs of the population by maintaining work competencies and providing learning opportunities for our LHJs.

- To improve access to quality health care and services, MCAH will provide educational opportunities and resources for the LHJs that address:
 - Enrollment in and utilization of health insurance through Medi-Cal and Covered California (California's Health Insurance Marketplace)
 - Culturally and linguistically appropriate information to aid them in helping underserved populations to better understand how to utilize health care coverage, understand benefits, and connect to primary care and preventative services.
 - Lessons learned from other LHJs and MCAH Programs on health care coverage outreach, education, and enrollment activities.
 - Social determinants of health that impact individuals and families' ability

- to access health and social services such as institutionalized racism, lack of housing and transportation, food insecurity, lack of educational attainment.
- Health care services such as mental health, STDs/STIs and substance use.
 - Provide training to state and local staff on quality assurance/improvement using evidence-based frameworks such as Plan, Do, Study, Act or Results Based Accountability.
 - MCAH will continue to host five in-person CPSP provider orientation trainings and online orientation trainings for new CPSP providers, their staff and PSCs.
 - MCAH will continue to promote and provide the current CPSP Provider Online Training.
 - MCAH will promote evidence-based research and practice to CPSP Providers to improve pregnancy outcomes. These include promotion of the following:
 - 17 alpha-hydroxyprogesterone (17-P)
 - Long-Acting Reversible Contraceptives (LARCs)
 - Low-Dose Aspirin
 - Birth Spacing
 - MCAH, in collaboration with LHJs, will continue to address identified gaps, challenges, and emerging needs by providing resources, educational webinars, trainings and opportunities that expand competencies of State and Local workforce.
 - MCAH, in collaboration with PSCs, will continue to update assessment tools and resources such as the Provider Handbook and Steps to Take Manual for PSCs and CPSP providers to ensure providers, provider staff and PSCs will have up-to-date, culturally congruent, and relevant resources for client education and program implementation and evaluation.
 - BIH will continue to stress the importance of hiring and maintaining culturally competent/relevant personnel to implement a BIH Program that is relevant to the cultural heritage of African-American women and the community.
 - BIH will also continue to promote the importance of utilizing the HRSA MCH Leadership competencies during BIH trainings in order to enhance the knowledge, skills and professional development of BIH staff. BIH Coordinators are also encouraged to allow each staff person to work on integrating a specific competency each year that will assist with enhancing their professional development.

Objective 1a: Strategy 3:

State and Local MCAH to develop and implement protocols to ensure all clients in MCAH programs are enrolled in a health insurance plan, linked to a provider, and

complete an annual visit.

- MCAH will continue to host webinars to assist LHJs to implement required local protocols and guidelines to assist clients with health coverage enrollment and referrals.
- All 61 LHJs will provide a toll-free telephone information service to facilitate linkage of MCAH population to health care services.
- State BIH program staff will continue to promote health insurance coverage and access to prenatal and preventative services for all participants during program outreach and trainings with all local BIH sites.
- BIH will continue to provide participants with health education materials and messages emphasizing the importance of attending prenatal and postpartum visits. BIH will also strive to increase knowledge of and facilitate collaboration with local MCAH programs to improve perinatal and postpartum referral systems for high-risk participants.
- CHVP home visitors and patient advocates will continue to link participants with resources to subsidized health insurance.
- CHVP home visitors will continue to help participants enroll in a health insurance program by providing a referral, making the call with them during the home visit, and helping fill out the paperwork with the family when necessary.

Objective 1b:

By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care, including increasing the rate of preventive visits from 61.9% (2013 Behavioral Risk Factor Surveillance System (BRFSS)) to 65.3%.

Objective 1b: Strategy 1:

Based on their Local Needs Assessment, all 61 LHJs will implement a local objective(s) to address increasing access to and utilization of preventive health services for reproductive age women.

- To identify and address barriers to accessing health services and providers, State and LHJs will continue to partner with existing stakeholders to assist with referrals and increase access to and utilization of needed services.
- To investigate and identify the evidence-based or informed interventions or best practices proven to increase utilization of preventative health services and well-woman visits.
- State MCAH staff will continue to meet monthly with the CPSP Executive

Committee to improve implementation of CPSP in Medi-Cal Fee for Service provider offices, FQHCs, MCMC and other health plans.

- AFLP case managers will continue to support expectant and parenting youth with identifying need, and accessing and utilizing needed services and resources, including health insurance, prenatal, postpartum and preventive care.
- BIH Programs will continue to implement the participant triage algorithm as potential participants are referred to BIH.
- BIH staff will continue to stress the importance of participants keeping preventive health care visits with their primary care provider upon intake, during individual Life Planning/Case Management meetings, and upon completion of BIH Program services.
- BIH will also continue to provide participants with transportation assistance as necessary in order to attend prenatal, postpartum and preventive health care visits. Currently, BIH Programs utilize ride sharing, taxicab and/or bus vouchers/tokens, and county fleet vehicles as necessary when participants express a need for transportation assistance for health care visits and BIH services.
- Examples of planned activities from LHJs to increase access and utilization of preventive health services and well-woman visits are:
 - Alameda County: Perinatal Services staff will improve access to health care, dental, and mental health services by sharing at least 75 local resource announcements with at least 700 health and human services staff for their use in providing services to clients in need.
 - Contra Costa County: Participants in MCAH home visiting services who are currently incarcerated will understand the laws and codes that impact perinatal incarcerated persons and their families, including information about accessing health and social services while incarcerated.
 - Lassen County: The MCAH program will offer assistance to 80% of their clients to schedule a well-woman appointment and arrange transportation as needed.

Continue to utilize various data sources (BRFSS, CHIS and MIHA) to monitor insurance coverage for women and children in California.

Objective 1c:

By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care, including increasing the rate of first trimester prenatal care initiation from 83.6% (2013 BSMF) to 87.9%.

Objective 1c: Strategy 1:

Collaborate with other CDPH programs, DHCS, Medi-Cal Managed Care, and health plans to improve early entry into prenatal care.

- MCAH will work with LHJs to identify barriers preventing women from early entry into prenatal care and the best practices that improve early entry into prenatal care rates. Findings from the investigation will be shared with all LHJs.
- MCAH will work with providers, Medi-Cal, Medi-Cal Managed Care, and LHJ staff, including PSCs, to share best practice strategies to increase rates of early entry into prenatal care and utilization of Presumptive Eligibility. This will be accomplished during the local needs assessment process, stakeholder meetings, provider roundtables, etc. Best practice strategies will be shared via conference calls, statewide meetings, and focused trainings.
- MCAH will continue to administer the State CPSP evidence informed model that provides comprehensive perinatal services including nutrition, health education, and psycho-social services to eligible women to ensure healthy outcomes for mother and babies. This includes the following:
 - Outreach and enrollment of new CPSP providers in underserved areas-of-need to facilitate eliminating barriers to access to care and to improve early entry into prenatal care.
 - PSCs will continue to collaborate with MMC plans, hospitals, and other health and social services agencies to address gaps in early entry to prenatal care, capitalize on existing opportunities to promote early prenatal care and support professional knowledge and practice to improve early entry into prenatal care visits.
 - MCAH will continue to work with local PSCs to promote prenatal immunizations, i.e., Tdap.
 - State MCAH and LHJs will continue to collaborate on efforts with CDPH STD Control Program in the early identification of pregnant females in counties with high syphilis rates to seek early prenatal care, and offer syphilis testing and treatment in the prevention of congenital syphilis.
- For women who enroll in the BIH Program, local staff will continue to assess whether or not they have a prenatal care provider, inform women about the importance of early entry into prenatal care, and assist participants who do not have an established health care provider in connecting with a provider.
- State BIH staff will continue to share and disseminate resource materials with MCAH LHJ staff to facilitate continued promotion and awareness of the role of the BIH Program and emphasize the strength of the program in serving and supporting pregnant and parenting African-American women. Resource sharing

reminds LHJs to refer to the BIH Program for case management and support throughout the woman's pregnancy experience.

- The BIH Program will also continue to promote collaborative efforts between MCMC Plan liaisons, CPSP provider networks, Family PACT and LHJ BIH staff to serve as awareness reminders of the important role of the BIH Program in serving as social support and empowerment navigators for pregnant and parenting African-American women.
- MCAH will continue to use MIHA data to monitor the rate of postpartum visits among women with a recent live birth in California.
- The DHCS-Indian Health Program provide funding to Indian health programs to strengthen the American Indian perinatal health system in Tribal and Urban Indian communities. The case management program will seek to strengthen the local perinatal system by ensuring continuity of services for pregnant American Indian women and their infants, and improve information flow between community providers and Indian health clinics through case management. Clinic staff will provide direct case management services and care coordination to assist a woman pregnant with an American Indian baby to receive health care monitoring, education, emotional support, and referrals to social services during pregnancy and six weeks post-delivery.
- Through local community developed projects, Indian health programs will conduct a needs assessment to identify gaps in services for American Indian women and infants. Grantees will solicit technical assistance from community partners or consultants to develop and implement interventions that address identified needs of American Indian women and infants.

Objective 1d:

By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care, including increasing the rate of postpartum visits from 88.3% (2012 Maternal and Infant Health Assessment (MIHA)) to 92.9%.

Objective 1d: Strategy 1:

Collaborate with DHCS, Medi-Cal Managed Care, and health plans to increase knowledge and referrals to state and local MCAH programs and identify local barriers, emerging issues and intervention opportunities to improve access to the postpartum visit.

- MCAH Directors and staff will continue to conduct facility site visits in 2019–20 to gain knowledge about other facilities' policies and procedures around referrals and health education practices for both mothers and infants. Information collected will inform what other questions or approaches will be

used to better understand hospital discharge practices for high-risk mothers and their babies to ensure appropriate continuity of care after hospital discharge and to improve care and follow-up upon discharge for high-risk women at postpartum discharge.

- BIH Family Health Advocates and PHNs will continue to provide follow-up telephone calls and home visits with participants within one week after delivery to encourage women to keep postpartum and other preventive health visits.
- BIH will continue its efforts to collaborate with MCMC and CPSP providers to identify strategies and activities, provide technical assistance to improve access to health care services, and increase utilization of postpartum visits for African-American moms.
- The BIH will continue to include a process outcome measure for the purposes of tracking participant postpartum checkups to provide assistance and ensure that participants understand the importance of keeping all appointments to address overall health care needs.

Objective 1e:

By June 30, 2020, increase the rate of women of reproductive age with appropriate preventive care, including increasing access to providers that can provide the appropriate services and level of care for reproductive age and pregnant women.

Objective 1e: Strategy 1:

Increase knowledge of and facilitate collaboration between local CPSP programs and RPPC to improve maternal and perinatal access to systems of care.

- MCAH will facilitate coordination between the CPSP and RPPC programs to build relationships and improve connections between CPSP providers and birth facilities in their respective region. The local CPSP program will be required to meet and/or attend meetings with Regional Directors to assist and facilitate coordination of activities to improve care including referrals for high-risk mothers and infants upon hospital discharge.
- MCAH will continue to process, review and evaluate provider applications for CPSP to increase the number of providers and locations for CPSP services.
- MCAH will continue to foster a stronger relationship between RPPC Directors and local PSCs to improve maternal and perinatal systems of care, including coordinated postpartum referral systems for high-risk mothers and infants upon hospital discharge. PSCs and RPPC Directors will be encouraged to attend program meetings together when possible, identify common activities

and work together to leverage these resources and improve the capacity for systems changes.

- PSCs and RPPC Coordinators will continue to identify new and existing opportunities to work together to address locally identified issues affecting pregnant women and their infants.

Objective 2:

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.

Objective 2: Strategy 1:

Increase local MCAH programs awareness of maternal mental health needs, wellness issues that affect MCAH target populations through various educational opportunities with a special emphasis on primary prevention strategies.

- MCAH will continue to disseminate information and educational opportunities from a variety of sources on maternal mental health such as the CPSP assessment forms that include screening for maternal mental health issues and linking to services as needed.
- To ensure that women of reproductive age will have access to mental health and wellness needed services, each LHJ will be required to develop, implement protocols to ensure access to needed services and to develop a comprehensive resource and referral guide of available health and social services.
- The CPSP *Steps to Take* manual will be updated and expanded to include more information and client friendly education on maternal mental health.
- MCAH and FHOP will continue to offer technical assistance calls with the LHJs addressing the major health issues identified in the state and local needs assessment, including mental health, substance use, violence and unintentional injury and other SDOH contributing issues.
- State MCAH will continue to produce educational videos that address maternal mental health and wellness. This includes pointing viewers toward the website and resources and materials for prevention and treatment.
- State MCAH will continue to develop social media campaigns that address the issue and aim to reduce the stigma and build awareness of Maternal Mental Health issue signs, symptoms, prevention and treatment.
- MCAH and FHOP will use the results of the Maternal Mental Health Provider Survey on how providers screen for Perinatal Mood and Anxiety Disorders (PMADs) to identify gaps, challenges and opportunities for success.

- MCAH will continue to collaborate with state agencies to maximize efforts in increasing educational opportunities, in addition to utilizing materials developed by established organizations to improve maternal mental health.

Objective 2: Strategy 2:

Assess and disseminate available resources, tools, and evidence-based maternal mental health and wellness toolkits for local MCAH programs.

- MCAH will continue to develop an inventory of evidence-based maternal mental health and wellness assessments and toolkits and will develop a repository for dissemination to LHJ programs. MCAH will focus on toolkits that are available that can be customized to meet local needs.
- MCAH will continue to promote the use of evidence-based screening tools to ensure all women in MCAH programs are screened, referred and linked to appropriate services. These resources are made available through the CDPH/MCAH website. As new recommendations become available, MCAH will distribute them to LHJs.
- MCAH will continue to provide training and technical assistance to LHJs to implement evidence-based or evidence-informed screening, referral and linkages to LHJ staff.
- MCAH will continue hosting a Maternal Mental Health Resources webpage that makes resources and tools available in one aggregated place.
- MCAH Communications and Outreach Unit will produce and disseminate a maternal mental health education campaign that includes fact sheets, discussion points, social media posts, an informational video and public service announcement about the signs of perinatal mood and anxiety disorders and where to seek help. MCAH will widely promote and distribute to partners a social media campaign in May in honor of maternal mental health month.

Objective 2: Strategy 3:

Develop new and strengthen existing collaboratives and partnerships with state and local agencies, mental health providers, professional associations, researchers and universities to address maternal mental health and wellness.

- MCAH will continue to lead a Maternal Mental Health Think Tank workgroup to address maternal mental health and wellness issues.
- The workgroup developed and conducted an LHJ survey and distributed recommendations from *A Report from the California Task Force on the Status of Maternal Mental Health Care*.
- MCAH will continue to expand its network to include mental health

associations who will focus on evidence-based recommendations from the analysis of the survey and the report.

- The BIH Program will collaborate with local staff to support participants to:
 - Understand how mental health contributes to overall health and wellness,
 - Recognize the connection between stress and mental health and practice stress reduction techniques,
 - Help participants understand the connection between physical activity and mental health,
 - Understand the symptoms of postpartum depression.
- Local staff will administer the EPDS to every participant 6-8 weeks after she gives birth
- Provide referrals and follow-up to mental health services when appropriate.

Objective 2: Strategy 4:

Conduct surveillance and evaluation of maternal mortality related to mental health.

- The CDPH/MCAH will continue to lead the CA-PAMR project, which recently concluded a review of 99 pregnancy-associated suicide cases and will release a report in 2019-20. This report will be released in collaboration with partners at CMQCC and PHI.
- The MIHA team will continue to collect and use MIHA data to monitor symptoms of depression during and after pregnancy and gather and analyze new data on perceived need for and barriers to receipt of mental health care services among females with a recent live birth.
- A statewide report and other targeted communications will be developed to describe prevention themes for women who die from suicide while pregnant or within one year postpartum.

Objective 2: Strategy 5:

Increase local MCAH programs awareness of maternal substance use (opioid, cannabis, and other drugs) needs and educational opportunities with a special emphasis on primary prevention strategies.

- MCAH will continue to disseminate information and resources from a variety of sources on maternal substance use that include screening for maternal substance use and linking to services as needed.
- To ensure that women of reproductive age will have access to substance use facilities, LHJ will be required to develop, implement protocols to ensure access to needed services and to develop a comprehensive resource and referral

guide of available health and social services.

- The CPSP *Steps to Take* manual will be updated and expanded to include more information and client friendly education on maternal substance use.
- MCAH and UCSF/FHOP will continue to offer technical assistance calls with the LHJs addressing substance use.
- MCAH Communications and Outreach will develop and/or share maternal substance use educational materials focused on primary prevention strategies. Education tools will be shared with MCAH programs as well as disseminated via social media.
- Continue to use MIHA data to monitor use of alcohol, tobacco, and marijuana during the perinatal period among women with a recent live birth by maternal characteristics at the state and local level.
- CDPH/MCAH will continue the implementation of the ASTHO partnership grant to educate clinical providers and the public health workforce about perinatal opioid issues and resources to address the growing epidemic.

Objective 2: Strategy 6:

Develop new and strengthen partnerships with national, state and local agencies to address maternal substance-use and wellness.

- CDPH/MCAH will continue to collaborate with the Chronic Disease Prevention Branch to identify the best education and support models to provide services to opioid addicted women.
- CDPH/MCAH is working with the Department of Social Services and the role of health care providers and hospitals in reporting to child welfare with maternal substance use during pregnancy in light of recent federal Child Abuse Prevention and Treatment Act/Comprehensive Addiction and Recovery Act law changes and current state law.
- The CDPH Fusion Center has convened the Maternal/Neonatal Opioid Task Force team on interdisciplinary work in addressing opioid use in all populations. CDPH/MCAH will continue to participate and work on addressing perinatal issues.
- CDPH/MCAH will continue to partner on the California Health Care Foundation's survey of California hospitals (conducted by the Urban Institute) on identifying current practices on assessment, treatment, and follow-up for mothers and newborns on maternal opioid use and neonatal abstinence.
- CDPH/MCAH will continue to work with the CMQCC and ACOG on implementation and dissemination of the AIM Opioid safety bundle at targeted hospitals.

- CDPH/MCAH will continue discussion implications and findings of a survey regarding neonatal care with CPQCC and assist in developing outreach efforts to those hospitals in most need of improving care.
- In partnership with ACOG and the American Academy of Pediatrics, CDPH/MCAH will participate in discussions on potential collaboration to facilitate a warm handoff to pediatric primary care providers after hospital discharge.

Objective 3:

By June 30, 2020, MCAH will work with partners to reduce prevalence of hypertension, diabetes, cardiovascular disease and mental illness among women at labor and delivery from 8.0%, 10.0%, 0.54% and 4.4% (2013 Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data (PDD)) to 7.4, 9.5%, 0.51% and 3.9% respectively.

Objective 3: Strategy 1:

Partner with disease-specific organizations to target prevention outreach to women of reproductive age for cardiovascular disease, hypertension, diabetes, and mental illness to ensure prevention strategies are culturally, linguistically, and age appropriate and match literacy level.

- MCAH will continue to collaborate with disease specific organizations, the Office Health Equity HiAP task force, and others to promote activities such as reducing smoking and increasing activity levels that reduce the prevalence of hypertension, diabetes, cardiovascular disease and mental illness among women.
- MCAH will continue to partner within the Department's Chronic Disease Control Branch, Nutrition, Obesity, Education and Prevention Branch to identify opportunities to support and collaborate with MCAH's CDAPP Sweet Success Resource and Training Center, which provide diabetes education materials and resources to providers through web-based trainings. MCAH will continue to utilize a stakeholder group to assist in assessing resources, materials and trainings, investigate current diabetes management technology to identify innovative ways to support gestational and Type I & II diabetic pregnant women and the evidence based strategies and activities conducted by other states to support these diabetes patients.
- The Resource Center will expand the work groups to include addressing perinatal weight. MCAH will expand collaboration with MCAH, CDPH and DHCS diabetes programs to serve the medical needs of pregnant patient with diabetes. MCAH will investigate producing an outreach campaign for care of women with GDM. Materials and guidelines regarding perinatal weight will be developed,

CDAPP Sweet Success materials will be reviewed and translated into Chinese and Spanish, as resources allow.

- MCAH staff will continue to collaborate with LHJs to share newly developed training and resource materials to support the prevention and/or management of the diabetic pregnant patient.
- MCAH will continue to disseminate and promote maternal quality improvement toolkits on the CDPH website and in CA birthing hospitals.

These toolkits include:

- Venous Thromboembolism
- Cardiovascular Disease
- OB Hemorrhage
- Preeclampsia
- MCAH will be adapting the newly created *Are You at Risk for Disease – Following your Pregnancy* fact sheet to be culturally appropriate and relevant to address heart disease among the African-American pregnant females.
- The BIH Program will continue to partner with the Chronic Disease Control Branch to identify resource materials to share with local BIH program staff to prevent and/or manage chronic health conditions including but not limited to diabetes, heart disease, cancer.
- MCAH will produce an outreach campaign, including educational videos and social media, on cardiovascular disease, preeclampsia and diabetes. A promotional toolkit will be disseminated to local programs and will provide a video link, story handout, social media, newsletter blurb and images and/or infographics on each chronic disease.
- MCAH will work with disease-specific organizations to produce and disseminate storytelling campaigns, including video, social media, story handout and promotional materials to increase statewide and local awareness of maternal health and prevention of cardiovascular disease, hypertension (preeclampsia), diabetes and mental illness.

Objective 3: Strategy 2:

Partner with Office of Health Equity, Health in All Policies (HiAP) Task Force to help develop policies and initiatives to address community risk factors for chronic cardiovascular diseases (e.g. healthy food availability, built environment for more active transportation, community safety that promotes active transportation), and ensure applicability of HiAP plans to women of reproductive age.

- MCAH will meet to strengthen collaboration with Office of Health Equity to:
 - Identify common areas for collaboration to address health inequities for the MCAH population

- Assess new and emerging opportunities to further advance health equity within the local MCAH population
 - Identify new data, best practices foster organizational cultural humility to promote positive health outcomes
 - Continue to partner with the LHJs to further support their work on HiAP
- MCAH is receiving technical assistance (TA) from UCLA with funds from MCH Bureau via the Association of State Public Health Nutritionists (ASPHN). The TA is to develop an improved policy, systems, and environmental change web resource and related training for LHJs.

Objective 3: Strategy 3:

Establish self-identified maternal levels of care for all birthing facilities to ensure high - risk moms are delivering in the right level of care.

- During the annual site visits with birthing hospitals, RPPC Directors will re-assess facility's maternal levels of care using the CDC LOCATe tool as needed, and offer professional development on ACOG/SMFM defined Maternal Levels of care for facility staff and leadership.
- MCAH will continue the Maternal Risk-Appropriate Care and Transport stakeholder engagement efforts to inform and support the implementation of the plan to establish maternal levels of care in California.
- RPPC will continue additional activities to improve and establish maternal risk-appropriate care. These activities include:
 - Working with hospitals to review maternal data center and neonatal transport data to identify quality improvement opportunities to ensure timely and appropriate care for all mothers and infants.
 - Review facility's policies for patient transfer, transport agreement and their Regional Cooperative Agreement (RCA) and provide technical assistance to those facilities that identify a need to improve the functionality of their RCA or who do not have and existing RCA and or transfer and transport agreement in place.
 - Link higher-level hospitals in the region with lower-level hospitals to encourage communication and collaboration to improve timely and safe transports of high-risk patients.
 - Strengthen regional, cross-regional and/or statewide communication and collaboration to support maternal and perinatal services through collaboration with local and state organizations, MCAH local health jurisdictions, and other State Programs.

- In the next contract period (2019 – 2022) administer the Maternal Levels of Care Module from CDC LOCATe tool to reassess facilities levels of care to support and inform the maternal-risk appropriate care efforts.

Objective 3: Strategy 4:

Conduct surveillance and evaluation of maternal mortality and morbidity including measurement of trends and disparities in chronic disease and the quality maternal care related to chronic disease, etc.

Maternal Morbidities

- MCAH will continue to fund and work with the University of California, Los Angeles (UCLA) Department of Obstetrics on a Maternal Quality Indicator Project whose focus is to conduct complex population-based data analyses to inform decision-making for implementation of a system of maternal levels of care. UCLA will develop a risk profile of women in order to understand the distribution of medically complex pregnancies throughout the state and identify where they give birth.
- MCAH will monitor the percent of women hospitalized at time of delivery, hospitalizations with hypertension, diabetes, cardiovascular disease and mental illness using Office of Statewide Health Planning and Development (OSHPD) patient discharge data.
- MCAH will monitor the rate of severe maternal morbidity at the time of hospitalization and delivery.
- In collaboration with the Maternal Quality Indicators (MQI) workgroup, based out of the UCLA Department of Obstetrics, MCAH will develop a risk profile of women to look at the distribution of medically complex pregnancies throughout the state and identify where they give birth. This project will inform decision-making for implementation of a system of maternal levels of care and quality of care improvement opportunities.
- MCAH will monitor trends and disparities in the percent of women with chronic health conditions at time of delivery hospitalization, including hypertension, diabetes and asthma, using Office of Statewide Health Planning and Development (OSHPD) patient discharge data.
- MCAH will monitor trends and disparities in the rate of severe maternal morbidity at time of delivery hospitalization. (Title V)
- In collaboration with the Maternal Quality Indicators (MQI) workgroup, based out of the UCLA Department of Obstetrics, MCAH will develop a risk profile of

women to look at the distribution of medically complex pregnancies throughout the state and identify where they give birth. This project will inform decision-making for implementation of a system of maternal levels of care.

Maternal Mortalities

- In collaboration with the California Maternal Quality Care Collaborative (CMQCC) and the Public Health Institute (PHI), MCAH implemented a new process to track the rates of pregnancy-related deaths and their causes, called the California Pregnancy Mortality Surveillance System (CA-PMSS). Briefly, this enhanced surveillance is a hybrid modeled after CDC's PMSS that includes a rapid cycle review of cases by an expert committee to establish cause and mechanism of death, timing, and pregnancy-relatedness. The sources of data for these reviews include death investigation reports (coroner report, autopsy, toxicology screen), hospital discharge records, emergency department data and vital records. CA-PMSS is an ongoing effort that will continue in order to provide timely and accurate information about pregnancy-related mortality trends. Deaths in 2008-2012 from obstetric-related causes are currently under review with a plan to continue onward.
- MCAH will also continue to lead the California Pregnancy-Associated Mortality Review (CA-PAMR) project, which is a topic-specific, in-depth review of pregnancy-associated mortality cases focused on a particular cause of death, or a related set of causes. While CA-PMSS reviews cases to determine cause of death, timing, and pregnancy-relatedness, CA-PAMR seeks to identify opportunities for quality improvement in maternal health care and support before, during and after pregnancy and generates recommendations for change to prevent future deaths in the pregnant and postpartum population. This hallmark feature of CA-PAMR that has led to best practices in the clinical setting. The most recent in-depth review focused on pregnancy-associated suicide. MCAH and its partners will use findings from CA-PMSS to determine the next focused topic for an in-depth review. MCAH will continue to evaluate potential enhancements to its ongoing surveillance of pregnancy-related mortality. MCAH (with CMQCC and PHI as appropriate) will produce surveillance reports and data products that describe pregnancy-related mortality, including trends over time, health disparities, gaps in maternity care up to one year after pregnancy and potential strategies to bridge those gaps.
- The California maternal mortality review effort will also begin review of maternal deaths from obstetric and medical causes from more recent years.
- MCAH will implement a new process to track rates of pregnancy-related deaths and their causes. This effort will be modeled after the CDC's Pregnancy Mortality

Surveillance System process and will entail a small team of medical epidemiologists reviewing death certificate, coroner and other types of information to identify the underlying cause of death and timing of death. This new process will provide more accurate information than data relying solely on analysis of vital records while also providing more timely information about the cause and timing of death compared to formal mortality reviews.

- MCAH in collaboration with the CMQCC and the Public Health Institute (PHI) will implement a hybrid Pregnancy Mortality Surveillance System (PMSS) to monitor Pregnancy-Related (PR) deaths in California.
- In collaboration with CMQCC and PHI, MCAH will continue its Pregnancy Associated Mortality Review (PAMR) project to identify pregnancy-related deaths, to determine opportunities for quality improvement, and to make recommendations for change. MCAH (with CMQCC and PHI as appropriate) will produce surveillance reports and data products describing maternal mortality, in terms of trends and disparities.
- MCAH will consider and evaluate potential enhancements to its ongoing surveillance of maternal mortality.

Objective 4:

By June 30, 2020, California will reduce the prevalence of mistimed or unwanted pregnancy among Black and Latina women with live births from 45.4% and 38.2% to 43.4% and 37.1%.

Objective 4: Strategy 1:

Provide local data by age/ethnicity to LHJs of untimed or unwanted pregnancy.

- The Maternal, Child, and Adolescent Health (MCAH) Division will continue to use pregnancy intention data from the Maternal and Infant Health Assessment (MIHA) Survey in planning and evaluating family planning interventions by local MCAH programs and partners. Aggregated MIHA data (2014-2016), to be released in Spring 2019, will provide information on mistimed or unwanted pregnancy for the 35 counties with the greatest number of births. Our local partners will be able to use these data to guide health policies and programs as well as monitor health outcomes at the local level. Additionally, MCAH will request an updated list of contraceptive providers from the National Campaign and will plan to produce county level data on “contraceptive deserts” defined as areas where number of providers of a full range of contraceptive services is not enough to meet the needs of the county’s population, with at least one clinic to every 1,000 reproductive-age women in need of contraception.

Objective 4: Strategy 2:

Conduct/Update an environmental scan of reproductive life planning and preconception health efforts within the state-level MCAH Program, local MCAH programs, and other statewide efforts to identify best practices, areas of need and opportunities.

- MCAH will conduct key informant interviews and focus groups with stakeholders including members of the target population, State MCAH program and Program Evaluation and Data Systems (PEDS) Branch team, Local MCAH, State agency partners, medical providers, researchers, to identify areas of need and capitalize on existing opportunities for preconception care, support professional knowledge and practice, identify best practices.
- MCAH will complete a literature scan to identify key health outcomes related to preconception health as well as relevant evidence-based practices.
- MCAH will analyze data collected to identify themes and priorities.
- With stakeholder's input, select the highest priorities in inform strategic planning efforts.

Objective 4: Strategy 3:

Assess framing around reproductive life planning and preconception health efforts, in collaborations with members of the target population including youth, to improve relevance and effectiveness of messaging.

- MCAH will complete a literature scan to understand what previous/current work has been completed in this area.
- MCAH will gather additional information from Local MCAH staff and other key stakeholders.
- MCAH will conduct focus groups with members of the target population in MCAH programs to learn about participant's awareness and perceptions of preconception health messaging, as well as recommendation for effective messaging.
- MCAH will create a white paper, brief, or other dissemination product to share lessons learned and recommendation.

Objective 4: Strategy 4:

Identify National, State, and Local programs/initiative that address reproductive life planning and assess available resources, and disseminate culturally and linguistically appropriate tools.

- MCAH is currently recruiting for the State's Preconception Coordinator. By summer of 2018, the Preconception Coordinator will lead efforts to identify and

implement across California evidence-based or informed initiatives, resources and tools.

- State MCAH will continue to maintain relationships with CDC and identify research and articles to address racial/ethnic disparities to include but not limited to chronic disease, mental health and substance use among reproductive age women and the role preconception/Interconception care.
- The BIH Program will promote collaborative activities with partner agencies such as MCMC and Perinatal Service Coordinators in order to utilize the National Preconception Curriculum & Resources Guide for Clinicians training module 4 "In Between Time: Interconception Health Care Part 1: Routine Postpartum Care for Every Woman" with BIH Participants during Life Planning Meetings and group sessions with BIH Family Health Advocates and Group Facilitators.
- MCAH will produce and distribute an education campaign focused on preconception health. This will include a digital story, social media and toolkit that promotes local programs, resources and tools that address reproductive life planning and overall health and wellness before or between pregnancies.

Objective 4: Strategy 5:

Integrate pregnancy intention into the Title V program (BIH, AFLP, CHVP, CPSP, Adolescent Health, and CDAPP) to promote appropriate contraception counseling to match pregnancy desire and timing.

- MCAH Preconception Coordinator will develop a plan to integrate pregnancy intention into the Title V programs (BIH, AFLP, CHVP, CPSP, CDAPP Sweet Success) to ensure counseling services and the provision of desired contraception are offered during the postpartum and inter-conception period.
- MCAH Preconception Coordinator will make available resources on evidence informed models, best practice interventions and tools to work with MCAH programs and identify opportunities for technical assistance. Efforts can include hosting webinars and sharing local community practices, attendance at local collaborative meetings, and/or presenting at the State MCAH Director's meetings.
- The BIH State and Local Programs will work on developing and disseminating Reproductive Life Planning materials via Webinars, PowerPoint presentations, and toolkits that focus on the phases of preconception, pregnancy and inter-conception to stakeholders providing services to black women to integrate into their service delivery protocols.
- The BIH Program will continue to introduce Reproductive Life Plans with participants as they receive services throughout their participation in the

program. On a as need basis, staff will update the participant focused “About Me” booklet utilized to assist in making personalized Reproductive Life Plans. The State MCSH Communications Team will produce and distribute an education campaign focused on preconception health and wellness.

- BIH local staff (Family Health Advocates and Group Facilitators) will continue to support participants to set short and long-term goals during Life Planning meetings, inclusive of reproductive life planning (developing strategies, tools, and resources for participants can utilize as their best option in planning for future pregnancies.
- The BIH State team will continue to update, as necessary, the Participant-focused “About Me” booklet utilized to assist them with making personalized Reproductive Life Plans.
- State MCAH Communications will produce and distribute an education campaign around preconception health and wellness. See activity in Strategy four.

Objective 4: Strategy 6:

Integrate preconception health into the Well-Woman visit.

CDPH/MCAH was recently funded to lead a three year HRSA Funded Preconception CoIIN (Collaborative Improvement & Innovation Network) focused on developing a preconception risk-screening tool and clinic implementation processes using a human-centered design approach. The goal is to identify tools to integrate preconception care seamlessly into Well Woman Visits, a Title V national priority.

- Tools will be developed and piloted in three clinic sites (Northern, Central and Southern), belonging to managed care health systems or clinic networks, throughout CA. Preconception tools will be implemented throughout the other clinics belonging to the managed care plans and clinic networks.
- CDPH will continue to work with participating clinics and will begin work on pre-intervention facility survey to provide baseline information about the clinic, available services, staff composition, etc. and other activities include assisting clinics with the design of the clinic team.

Objective 5:

Train MCAH LHJ workforce to address IPV at the community level.

Objective 5: Strategy 1:

Create or adapt a range of culturally competent, evidence-based, and trauma-informed education materials on IPV for LHJs public health professionals.

- State MCAH will compile and promote a list of evidence based/informed IPV practices and resources.
 - MCAH will survey State and National IPV agencies to understand current evidence based screening tools and resources that can be made available to LHJ's and other MCAH programs.
 - MCAH staff will conduct an abbreviated environmental scan to determine whether there are other programs beyond the CDPH Safe and Active Communities Branch that provide support to LHJs for I and reproductive and sexual coercion.
 - MCAH will facilitate peer-to-peer connections and cross-sharing of evidence-based best practices that have been employed by LHJs.
 - The BIH Program materials will continue to include an overview of IPV and reproductive and sexual coercion prevention strategies that participants can utilize to assist them with having healthy relationships, avoid birth control sabotage and reproductive coercion.

Objective 5: Strategy 2:

Identify training/technical assistance opportunities to support MCAH funded Programs and LHJs in implementing IPV and reproduction, and sexual coercion prevention strategies

- MCAH will continue to work with LHJs identified as addressing IPV, and/or reproductive and sexual coercion in their scope and assess, coordinate and provide appropriate resources and/or customized technical assistance, or training to meet specific need and/or requests.
- MCAH will work with appropriate Subject Matter Experts and CDPH/Safe and Active Communities, and UCSF/FHOP and Violence Prevention Agencies, such as Future without Violence to host trainings that support implementation of evidence-based screening tools, referral protocols and processes, safety planning, birth control sabotage, pregnancy pressure and coercion.
- The BIH Program will continue collaborative efforts with partner agencies to provide IPV training, to local BIH Mental Health Professionals and Public Health Nurses so that they may provide additional supportive services when participants reveal IPV issues.
- Mothers enrolled in home visiting and AFLP will continue to be screened for IPV/teen dating violence. Staff will continue to receive training on IPV issues. When IPV is a risk factor, the home visitor or case manager will continue to provide resources and referrals as well as provide support and build protective factors.
- Local BIH and AFLP Programs will continue to assist with ensuring that

participants understand the characteristics of healthy relationships and provide resources that can help participants deal with abuse, reproductive coercion or birth control sabotage and also provide referrals and promote linkages to family planning providers including Family Planning, Access, Care, and Treatment (Family PACT).

Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active lifestyle.

Objective 6:

By June 30, 2020, increase the percent of women with recommended weight gain during pregnancy from 34.3% (2013 BSMF) to 36.1%.

Objective 6: Strategy 1:

Conduct surveillance of preconception weight and weight gain during pregnancy, including measurement of trends and disparities.

- MCAH will continue to use the Birth Statistical Master File to monitor preconception weight status and weight gain during pregnancy among females with a recent live birth by various maternal characteristics at the state and local level, including measurement of trends and disparities.
- MCAH will use MIHA data to assess food insecurity during pregnancy as it is strongly linked to obesity and excessive weight gain during pregnancy.
- MCAH will release a data brief on maternal weight and weight gain.

Objective 6: Strategy 2:

Improve capacity for nutrition and physical activity for women of reproductive age including optimum preconception weight and prenatal weight gain through collaboration and technical assistance, especially by sharing science-based resources with key partners such as CPSP, WIC, CMQCC, BIH, AFLP, and CHV.

- Ensure CDPH/MCAH nutrition and weight gain guidelines and educational materials, resources and assessment forms exist and are utilized by local MCAH funded CDAPP Sweet Success, CPSP, AFLP, BIH, and CHVP programs.
- Promote the national Dietary Guidelines for Americans and Physical Activity Guidelines weight assessments, counseling and referrals for

women of reproductive age.

- MCAH will add web resources for perinatal weight security.
- MCAH will promote four weight gain grids in the CDAPP Sweet Success Guidelines for Care and the Steps to Take Guidelines as free patient education resources.
- CDAPP Sweet Success will address both preconception and prenatal weight gain by having a special CDAPP Sweet Success newsletter on this topic, sharing relevant articles, our own weight gain grids, and an excerpt of the guidelines for care that discusses these things.
- Preconception/interconception/prenatal nutrition and exercise will be topics of training modules that CDAPP Sweet Success posts. They will emphasize maintaining optimal weight.
- The CDAPP Sweet Success Resource Center will share links from other organizations who have resources that address this topic.
- The CDAPP Sweet Success Materials and Resources Work Group will either update resources in regards to weight before/during/after pregnancy; create an entirely new resource on this topic; look into other resources put out by other diabetes organizations and get permission to post on the CDAPP Sweet Success website.
- The CDAPP Sweet Success Evaluation Plan Working Group will focus on evaluating postpartum follow-up rates and preconception health, tying in the topic of weight before/after pregnancy.
- BIH will utilize MyPlate for Moms and MyPlate to encourage healthy eating while pregnant and breastfeeding and will include aspects of nutrition and physical activity in life plans. BIH will also continue to assist participants in understanding behaviors that contribute to overall good health, including: stress management, sexual health, healthy relationships, nutrition, and physical activity.

Objective 7:

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%.

Objective 7: Strategy 1:

Provide review and technical assistance of all materials in state programs to ensure culturally congruent messaging and education regarding folic acid intake among women of reproductive age.

- MCAH will continue to maintain the CDPH/MCAH Folic Acid web page as a

central location to disseminate resources to promote daily preconception intake of 400 mcg folic acid.

- MCAH will promote folic acid through the Interconception Care Project of California, Every Women California website.
- MCAH will continue to promote folic acid by distributing English and Spanish folic acid posters and pamphlets to local agencies to promote daily preconception intake of 400 mg folic acid.
- MCAH will promote the January 2020 National Folic Acid Week to MCAH programs, partners and contacts through emails encouraging use of state and national resources.
- BIH will distribute Folic Acid information to all potential and enrolled participants.
- MCAH will continue to monitor folic acid intake through the MIHA and use MIHA data to monitor daily folic acid use during the month prior to pregnancy among women with a recent live birth by various maternal characteristics at the state and local level.

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Priority 2: Reduce infant morbidity and mortality.

Objective 1:

By June 30, 2020, decrease the percentage of preterm births, less than 37 completed gestational weeks, from 8.4% (2013 BSMF) to 8.3%.

Overall, the state rate for NPM 3 or the percent of very low birthweight infants delivered at Level III NICUs increased from 83.4% in 2015 to 84.0% in 2016. A high percent of these infants were born in Level III facilities by all mothers except those identified as American Indian or as other race-ethnicity (75.0% and 50.0%) respectively.

Data reported in the California birth file revealed that for Objective 1, the percent of preterm births with less than 37 weeks gestation increased from 8.3% in 2014 to 8.5% in 2015. In addition, data from the National Vital Statistics System show the percent of preterm births in 2016 was 8.6%. The percent of preterm births was highest among Black women (11.7%) and American Indian-Alaska Native women (10.8%).

In the five-year period from 2012 to 2016, data from the National Vital Statistics System shows the percent of early term births remained stable at 24.6%. The percent of early term births in 2016 was about 24.7%. The percent of early term births was highest among Asian women (27.7%) and lowest among White women (21.0%).

In the period from 2012 to 2015, data from the National Vital Statistics System show the infant mortality rate stable at 4.5 per 1,000 live births. In 2015, the infant mortality rate was 4.4 per 1,000. The infant mortality rate was highest among Black infants (9.6 per 1,000).

Objective 1: Strategy 1:

Define new and existing partnerships with state and local agencies, community-based organizations, academia, provider networks and hospitals to maximize resource capacity in addressing preterm birth reduction.

CDPH/MCAH continued to fund 61 Local Health Jurisdictions (LHJs) with Title V Block Grant Funds and lead efforts to address preterm birth and reduce infant mortality and morbidity. LHJs contribute local agency funds and drawdown Title XIX, when allowable. Each LHJ develops their scopes of work based on local need. Some of the LHJ activities include:

- Fresno County - the Fetal Infant Mortality Review (FIMR) coordinator was added to the Preterm Birth Initiative Care Coordination Committee to gain insight and collaboration opportunities to address developing training, education and outreach materials specific to prematurity awareness for pregnant and/or parenting mothers.
- Orange County - collaborated with the March of Dimes to compile a prematurity information packet, including 17P, which was distributed to CPSP providers as well as other partners in the community.
- Shasta County - distributed Women's Connect materials regarding the importance of stopping or reducing substance use during pregnancy to local doctors' offices, community organizations, and at local events.

California Perinatal Service Program (CPSP) and Regional Perinatal Programs of California (RPPC): In order to develop greater understanding and ways to leverage intersecting activities between the CPSP program and the RPPC program, the CDPH/MCAH invited an RPPC Director liaison to participate on the monthly CPSP Executive Committee calls. In addition, RPPC Directors worked with birthing hospitals to address disparities in and develop strategies to reduce preterm birth rates.

Black Infant Health (BIH): The BIH Program continued to collaborate with the American Congress of Obstetricians and Gynecologists (ACOG), the Centers for Disease Control (CDC) and Prevention, and the March of Dimes (MOD) to provide resources, education and strategies related to the reduction of preterm birth (PTB) to BIH participants. In order to support women with knowledge related to PTB, local BIH staff provide participants with information and educational materials from ACOG, CDC and MOD that assist in empowering women to advocate for themselves when accessing prenatal care as they speak with healthcare providers in order to have healthy pregnancies. The information from local BIH staff is provided via individual case management meetings, home visits and group sessions. Due to the persistent elevated rates of PTB in the African American (AA) community, women who are not able to enroll in BIH due to various circumstances are provided with PTB resources and information to assist them with having healthy pregnancies.

During Black Infant Health Awareness Week, February 19-25, 2018 the BIH Program collaborated with the MCAH Communications Team to provide local BIH programs with social media campaign messages. The messages were utilized on various social media platforms such as Facebook and Twitter that focused on poor birth outcomes affecting AA women such as PTB, Infant and Maternal Mortality rates and Sudden Infant Death Syndrome (SIDS)/Sudden Unexplained Infant Death (SUID).

CDPH/MCAH, in collaboration with March of Dimes and Los Angeles County Department of Public Health, hosted the Community Birth Plan (CBP) Summit September 5, 2017, at the California Endowment in Los Angeles. Summit attendees included various stakeholders from hospitals, provider networks, hospital payers, communities, and AA parents with a history of PTB. The goal of the Summit was to build consensus on at least two mutually agreed upon strategies with the intention to develop additional interventions that would be included in a CBP Toolkit with the goal of reducing African-American preterm births to 8.1% by 2020 and 5.5% by 2030.

In September 2017, The BIH Program participated in discussions with the Roots Community Health Center and the Santa Clara County BIH Program for the purpose of expanding outreach, community awareness and program services to improve prenatal and postnatal outcomes for AA women in Santa Clara County. Roots Community Health Center staff participated in the MCAH-BIH Basic training in order to gain a better understanding of the BIH Program goals and objectives.

During November 2017, the BIH Program and MCAH Communications Team provided education resources and social media messages for Prematurity Awareness Month to share with community partners and BIH Participants on Facebook, Instagram and Twitter. An important goal of the messaging was to highlight PTB risk factors for African American women in order to empower them to be even better advocates to have healthy pregnancies. The Communications Team also collaborated with the Sacramento County BIH Program to make a video of one of their BIH alumni groups. This group of women has maintained contact with one another after completing the BIH Program together. The “Friendsgiving” video made during the Thanksgiving holiday period, highlighted the comradery, empowerment and support that each of the women still emulate, skills they obtained from their BIH FHA and GF, which were also included in the celebration video.

In April 2018, CDPH/MCAH lead the Black Infant Health Conference with all local BIH program staff and experts in the field. For example, representatives from the MOD hosted a breakout workshop session entitled “Healthy Moms. Strong Babies.” Workshop attendees were provided with an overview of the MOD prematurity campaign roadmap and key interventions to reduce PTB as well as strategies to assist with identifying women at risk for PTB and linking them to care. Overall, the workshop had excellent evaluation feedback from those in attendance.

During May 2018, the CDPH/MCAH Communications Team collaborated with the Solano County BIH Program and interviewed a former BIH Participant to make a video, who became part of the staff with the Solano County program as a Family Health

Advocate (FHA). She spoke about the support she received from her BIH FHA during a very stressful time in her life. The encouragement and support that she received enabled her to set short and long-term goals and see them come into fruition.

During June 2018, the BIH Program collaborated with staff from the UCSF Preterm Birth Initiative (PTBi) to gain a better understanding of the work that our respective programs are involved in related to PTB reduction efforts. The UCSF PTBi is very active with the BIH LHJs in Alameda, Fresno and San Francisco.

Examples of local efforts:

- Contra Costa – BIH Coordinator chairs the FIMR Community Action Team: Contra Costa Health Services (CCHS) African American Perinatal Health Disparities Task Force. Various partner agencies meet quarterly to work towards the mission of *Creating Health Equity for AA women and Infants in CCHS*. The goal for 2017-18 was “surveillance, Monitoring and Assessing CCHS services for AA women and babies.”
- San Diego – Community Advisory Board (CAB) meetings provide an opportunity for BIH County and Subcontractor staff to share information related disparities and poor health outcomes for AA moms and babies, goals of BIH to assist in the reduction of PTB as well as discuss strategies on how partner agencies can assist in this endeavor.
- Solano – BIH Coordinator co-led the Solano HEALS (Health Equity for AA/Black Lives in Solano). It is part of a three-year cohort through CityMatCH to develop grass-root community based strategies to address the health disparities in birth outcomes for AA women and infants.

California Home Visiting Program (CHVP): A core component of both the Healthy Families America (HFA) and Nurse Family Partnership (NFP) home visiting models is the development and maintenance of a community advisory board to support local stakeholder engagement and the improvement of service access for program participants. Additionally, the MIECHV program requires that grantees measure coordination and referral for community resources and supports. The result is a local and state level focus on early childhood systems integration to improve health outcomes for mothers and babies, including improved birth outcomes.

American Indian Infant Health Initiative (AIIHI): IHP expanded the home visitation program availability by adopting an evidenced-base home visitation model called Family Spirit (FS), which provided home visitation for all women pregnant with an American Indian baby and does not restrict the curriculum to only high-risk mothers. Home visitors supported mothers by assisting with scheduling visits to see their OB providers as well as needed medical, dental, and behavioral health services. AIIHI clinic staff also offered

transportation to increase the likelihood of patients receiving timely prenatal care, preventive health care, and to ensure that high-risk cases received proper monitoring by an OB provider. AllHI staff at times meet with the mothers and the providers to help patients understand instructions from the physician. During this funding cycle 122 families participated in the home visitation program and there were thirteen pregnancies documented and twelve of the pregnancies received prenatal care. There were no preterm births reported among AllHI participants during this funding period

California Perinatal Quality Care Collaborative (CPQCC): CDPH/MCAH provides Title V funds to support CPQCC's Perinatal Quality Improvement Panel (PQIP). CDPH/MCAH and the RPPC Directors help to distribute CPQCC toolkits and partner with CPQCC to improve quality of care in California Neonatal Intensive Care Units. PQIP sets CPQCC's quality improvement agenda and strategy, chooses topics for QI collaboratives, and assigns projects to the subcommittees. The 18-month long Neonatal Antibiotic Stewardship Collaborative, working with 28 NICUs across California, came to a close in December 2017. With data from over 7000 patients, early results show a statistically significant reduction in antibiotic utilization rate across participating hospitals, decreasing the risk of antibiotic resistance and adverse drug events in the babies in the participating NICUs.

In addition, CPQCC has continued to collaborate with DHCS California Children's Services (CCS) on their joint High Risk Infant Follow-Up (HRIF) project/program whose 2017-18 goal was to develop a Statewide Toolkit/Bundle for their NICU and HRIF Programs. Their High Risk Infant Follow-up Quality of Care Initiative monitors the needs and outcomes of California's high-risk infants and their families through age 3.

In January 2018, CPQCC affiliates received federal funding to study the quantification of neonatal transport networks through network analysis to study neonatal regionalization in the clinical and transport data sets. This project works with Beth Israel Deaconess Medical Center/Harvard Medical School. Another CPQCC affiliate received funding from the Child Health Research Institute at Stanford University to study family centered care measures as part of the effort at CPQCC to develop a "disparities dashboard" for member hospitals to display their outcomes by racial/ethnic groups. They also received funding from the Stanford University Maternal Child Health Research Institute to study CPQCC data to characterize risk factors and outcomes for NICU infants and the effect of nurse staffing on patient outcomes, and to develop an adjusted nurse staffing metric for NICUs.

In Spring/Summer 2018, CPQCC launched Simulating Success, a two-year project designed to help NICUs implement an on-site, simulation-based, neonatal resuscitation

program that aims to optimize team performance and bring about a reduction in neonatal morbidities - such as BPD and hypoxic-ischemic encephalopathy - and their associated costs. CPQCC is developing their new Learning Collaborative, “Grow, Babies, Grow!” for launch in fall 2018 to optimize growth and nutrition, which are critical and modifiable factors for long-term neurodevelopmental and health, for low birth weight babies in the NICU.

The last revision of a CPQCC toolkit (Severe Hyperbilirubinemia Prevention) was completed and released. PQIP members and others are working to update the Nutrition Toolkit for launch in September 2018; the Nutrition Toolkit has historically been the most-downloaded of all of CPQCC’s tools. Downloads continue to be available for all other CPQCC toolkits.

Evidence-based and evidence-informed practices utilized for this strategy

Local Health Jurisdictions (LHJs):

- Mendocino County – The MCAH program utilizes the 4 P’s Plus Screening tool (questionnaire).
- Modoc County - PHNs refer clients to 1-800-no-butts, which has been shown to be effective for supporting with smoking cessation.

American Indian Infant Health Initiative (AIIHI): Home visitors used the Family Spirit curriculum, which teaches mothers the importance of early prenatal care, healthy diets, avoidance of drugs and alcohol, as well as the importance of stress reduction.

CDPH/MCAH Programs: NFP and HFA are evidence-based home visitation models and BIH and AFLP are evidence-informed program models that assist in helping pregnant adolescents and women with achieving optimal birth outcomes.

Challenges for this strategy

Challenges and opportunities for improvement from the LHJs include:

- Imperial County – A significant challenge in Imperial is related to women accessing timely and high quality prenatal care. Some barriers include, transportation, fear of seeking prenatal care due to citizenship, and personal beliefs that prenatal care is not needed.
- San Francisco County - Challenges to strategies, such as case management, aimed at reducing preterm births among adolescents included: youth changing their mind at the last minute regarding their birth plans, youth missing appointments or refusing services provided, or they experience challenges

around their life circumstances (housing, parental, school or partners issues). Doula services were a challenge due to late referrals, lack of Spanish speaking Doulas, or choosing to have a parent or family member as their primary support system during the birth process. This past year we had an increase with even younger teen pregnancies (13-14 year olds) receiving services, which poses challenges with linking them with prenatal providers while they had a different journey of coping with accepting their pregnancy and beginning prenatal services at a later stage.

American Indian Infant Health Initiative (AIIHI): Statewide only 7 out of 40 American Indian health programs provide OB services on-site. Of the four AIIHI grantees, two provide OB services on site. At times, Tribal clinics can be at a unique disadvantage since they are often located in isolated areas. Some clinics may offer limited OB services and services for high-risk cases must be coordinated through providers outside of the community. Women may miss scheduled appointments when they require traveling a distance to access the services. Consequently, the lack of nearby OB care affects ongoing efforts to reduce preterm births in American Indian communities.

Additionally, due to a variety of stressors, some AIIHI participants may not readily accept all services provided by the home visitation team or the health program. When a woman receives health care from a provider outside of the Indian clinic, this creates additional challenges of coordinating transportation, childcare, and other social support programs such as WIC. Despite these challenges, home visitors are able to provide care and coordinate services to meet the objectives of the program.

Black Infant Health Program (BIH): From the LHJ perspective, identifying local champions that can speak about the goals and objectives of the BIH Program to their stakeholders and partner agencies continues to be a concern that the CDPH/MCAH team is addressing.

Objective 1: Strategy 2:

Facilitate the coordination of perinatal activities between MCAH LHJs and the RPPC by supporting the local perinatal advisory councils to provide regional planning, coordination and recommendations to ensure appropriate levels of care are available and accessible to high-risk pregnant women and their infants.

Regional Perinatal Programs of California (RPPC): CDPH/MCAH added guidance in the MCAH Policies and Procedures Manual to work with the perinatal community, including clinic providers, managed care plans and other health and human service

providers to reduce barriers to care, avoid duplication of services, and improve quality of perinatal care. CDPH/MCAH continued discussions with the local MCAH Directors, PSCs and RPPC Directors to identify activities to strengthen state and local ties and provide continuity of care for at-risk pregnant women during pregnancy and upon hospital discharge after birth. RPPC Directors participated on a committee or workgroup focused on improving perinatal outcomes. They are the link between delivery hospitals and the community they serve.

Local Health Jurisdictions:

- Colusa County – The MCAH program met with the local RPPC Northwestern Manager and developed a plan for RPPC to provide training to Emergency personnel on one of the Evaluation and Treatment of Antepartum and Postpartum Preeclampsia and Eclampsia in the Emergency Department tool kit.
- Placer County - Northeastern Region RPPC Coordinator partners with the public health nurse in the county's Family Birth Center. This relationship allows Placer MCAH staff to be aware of developments, new hospital procedures/protocols and trainings.

Objective 1: Strategy 3:

Co-lead the California Community Birth Plan Task Force (previously referred to as California Prematurity Leadership Council) and integrate prematurity prevention strategies that are recommended into relevant MCAH program curricula and activities with a focus on reduction of preterm births in the African-American population.

California Community Birth Plan (CBP) Task Force: MCAH continued to co-lead the CBP and integrate recommended prematurity prevention strategies into relevant CDPH/MCAH program curricula and activities with a focus on reduction of PTB in the AA population. Activities continue to include providing county-specific data, ongoing technical assistance and PTB health education resources.

CDPH/MCAH, in collaboration with March of Dimes and Los Angeles County Department of Public Health, hosted the Community Birth Plan (CBP) Summit September 5, 2017, at the California Endowment in Los Angeles, a major planning activity of the CBP during 2016-17. The goal of the Summit was to build consensus on strategies with the intention to develop additional interventions that would be included in a CBP Toolkit to unite hospitals, providers, payers, communities and AA PTB parents with the goal of reducing African-American preterm births to 8.1% by 2020 and 5.5% by 2030.

Attendees included representatives from the State's MCAH, WIC and Black Infant Health Program, March of Dimes, ACOG, Los Angeles County Department of Public

Health representatives and leaders from six of Los Angeles County's hospitals with the highest African-American preterm birth rates. MCAH selected a national MCH consultant and skilled meeting facilitator to assist with content expertise and strategic design for the Summit.

The Summit objectives included:

- Expanding local awareness and understanding of PTB
- Leveraging and aligning current best practices and local assets
- Building trust and galvanizing community engagement
- Prioritizing local strategies

As a result of the discussions and feedback received from the 'Round Robin' exercise held during the Summit, four workgroups were established to develop CBP Action Plans that can be utilized to reduce PTB rates in Los Angeles County:

- Health Promotion
- Health Plan
- Clinical Interventions
- Quality of Care and Patient Experience

CDPH/MCAH continued to convene bi-monthly one-hour calls with the CBP Task Force and LA community champions to discuss strategies for the buildout of the CBP toolkit

Local Health Jurisdictions (LHJs):

- City of Berkeley - BIH staff and the WIC Director were active in African American Breastfeeding Cultural Outreach Taskforce whose mission is to revive the art of breastfeeding birth to age 1 among African American women through systems change and culturally competent media, educational and community outreach, and has partners from Alameda County, Contra Costa County, and Berkeley.
- Los Angeles County – disseminated the 2016 Los Angeles Mommy and Baby (LAMB) Surveillance Report (received 5,595 completed surveys, which represents 122,941 live births in Los Angeles County in 2016) to perinatal providers and other stakeholders. The report provides key perinatal indicators related to prematurity/low birth weight births. LAMB data were used to support the countywide initiative of closing the Black-White gaps in infant mortality- AAIM HIGHER (African American Infant Mortality Health Initiative).
- San Francisco County – San Francisco Collective Impact to Prevent Preterm Birth is mobilizing leaders from multiple sectors in San Francisco to work together for racial and health justice for Black and Pacific Islander women

before, during and after pregnancy, increasing housing and perinatal support access for our prioritized populations.

Evidence-based and evidence-informed practices utilized for this strategy

The CBP Task Force utilized evidence-based materials, resources and data from the MOD as well as statewide data from CDPH/MCAH to guide discussions related to reducing AA PTB rates and hospital delivery rates of preterm births.

Challenges for this strategy

The challenge is that there are no dedicated time or resources for the CBP Task Force. Partners and the community stakeholders have a common mission and are dedicated to the work; however, are volunteering their time and it has been challenging to execute all of the goals efficiently.

Challenges and opportunities for improvement from the LHJs include:

- San Mateo County - Clients might not be available for a 6-month follow-up visit because they have moved or returned to work, loss of contact with the client due to moving out of county, and timing of the follow-up visit does not always coincide with the reporting period.
- Solano County - The barriers encountered were low numbers of African American women ages 24 years and younger at 3 out of the 4 events, insufficient staffing at outreach events to ensure all necessary information is able to be provided.

Objective 1: Strategy 4:

Assist local agencies/partners in developing materials to educate pregnant women/women of reproductive age on the signs and symptoms of preterm labor.

Local Health Jurisdictions (LHJs): There were 55 local MCAH programs or their partners that disseminated information about signs and symptoms of preterm labor and 36 had implemented prematurity prevention education protocols. There were 34 LHJs that partnered with their local MOD chapter to disseminate prematurity prevention educational materials while 40 LHJs collaborated with their RPPC coordinator to reach out to local birthing facilities (Source: 2017-18 Year End Survey).

Some examples of LHJ activities to reduce the rates of preterm births are:

- Butte County - Planned a consistent, sustained public education effort designed to increase client knowledge about the importance of early prenatal care and how

to obtain prenatal care and healthcare coverage during pregnancy. Identify low cost advertising strategies to reach target populations. Identify materials readily available for use to use in media blitz (radio, movie theaters, malls, grocers, Laundromats, bust stops, busses, websites, FACEBOOK, pregnancy testing sites). Create checklists for patients at prenatal care/pregnancy testing sites with documentation requirements, online information sites, application process, time requirements for applying for Presumptive Eligibility and Medi-Cal.

- Fresno County - Collaborated with the Preterm Birth Initiative to institute a group prenatal care model in the County. Providers will complete needed applications to bill Medi-Cal at Lighthouse for Children. All practitioners acting as facilitators for “Glow” will be certified by “Expect With Me” to be able to provide the program with fidelity to the model. All providers that are currently CPSP Certified will apply to be CPSP Certified for the Lighthouse for Children in order to be able to bill for prenatal care and group education. The Glow group prenatal care model has enrolled 60 women to date.

Fifty-seven out of 60 LHJs (95%) performed activities to address prematurity, which included collaborating with MOD local chapter to disseminate prematurity prevention materials; implementing prematurity prevention education policies or protocols; and disseminating information about signs and symptoms of preterm labor.

Comprehensive Perinatal Services Program (CPSP): The Steps to Take Manual is a comprehensive resource used in CPSP provider offices by their staff. It includes patient handouts in English and Spanish and a few example related to preterm birth are: If Your Labor Starts too Early; Did You Have Complications During Pregnancy; Signs and Symptoms of Heart Disease; Diabetes While You are Pregnant; Welcome to Pregnancy Care, and Drugs and Alcohol When You Want to STOP.

California Home Visiting Program (CHVP): The NFP PHNs complete a Prenatal Health Assessment – which includes danger signs - at each visit and after 22 weeks gestation, they additionally review and assess for preterm labor and cover topics such as fetal kick monitoring and when to call a care provider. HFA home visitors encourage pregnant women to attend prenatal appointments and adopt healthy eating habits. They help mothers-to-be and their families develop goals around having a healthy pregnancy and healthy baby. They provide guidance and support around reducing stress, increasing social connections, and planning for birth and the baby.

Regional Perinatal Programs of California (RPPC): RPPC Directors continue promote the CMQCC toolkits with hospital administration as needed based on their

quality improvement support to hospitals and with local coalitions and providers in order to maximize resource capacity in addressing preterm birth reduction.

American Indian Infant Health Initiative (AIIHI): Home visitors at health clinics engage American Indian mothers and provide basic health education during visits on the importance of maintaining a healthy pregnancy to promote full-term births. AIIHI clinic staff also provided transportation for pregnant women to prenatal care visits and accompanied mothers to their prenatal examinations to facilitate communication between mothers and their health care providers.

Black Infant Health (BIH): The BIH staff continue to utilize PTB materials from the MOD and the CDPH/MCAH Communications Team in order to provide education and guidance on the signs and symptoms of preterm labor with participants. This education is provided during group sessions focused on labor and delivery, during one-on-one case management meetings and home visits by the Public Health Nurse or Family Health Advocate, per the requirements of the BIH Policy and Procedures. Women not able to enroll in BIH due to personal circumstances are provided with PTB materials related to having a health pregnancy.

The BIH Program also utilized PTB Factsheets developed by the MCAH Communications Team to share with local program staff. The Factsheets have been provided to BIH Participants upon enrollment and during their stay in the BIH Program. During November 2017, local BIH Programs utilized social media campaign posts and taglines to share on Facebook and Twitter during Prematurity Awareness month in order to highlight the importance of knowing the signs, symptoms and risks of PTB for AA women.

CDPH/MCAH Communications Team: The Communications Team produced and distributed a first-person story of a young mother who had a preterm birth of twins. The story included data on health disparities and description of preterm symptoms. The materials developed for use by local agencies/partners included a video, handout and social media. The Communications Team created a social media campaign for November 2017 Prematurity Awareness Month for local agencies/partners to share on Facebook and Twitter. This campaign included messages and graphics about preterm birth data, symptoms, risk factors and interventions.

Additionally, the team developed “Key Facts about African-American Preterm Births” to share with attendees at the Community Birth Plan Summit on Sept. 15, 2017 in Los Angeles. It described preterm birth risk factors, costs, long-term health effects, health disparities and successful interventions. The document was developed into a two-page Preterm Birth Fact Sheet for women and providers,

and was distributed to Community Birth Plan Task Force members for dissemination to partners, local agencies and providers.

Evidence-based and evidence-informed practices utilized for this strategy

NFP and HFA are evidence-based home visitation models and BIH and AFLP are evidence-informed program models that assist in helping pregnant adolescents and women with achieving optimal full-term birth outcomes.

Challenges for this strategy

Challenges in implementing the social media strategies included working with LHJs who do not control their own social media account and who do not have training in social media management. CDPH/MCAH in turn provided trainings on social media best practices and how to provide social media to their county office of public affairs. CDPH/MCAH also began working directly with the county public information officers (PIO), and implemented a monthly PIO email with prepared social media posts.

Objective 2:

By June 30, 2020, increase the percentage of women who report exclusive breastfeeding at 3 months from 26% (2012 MIHA) to 27.2%.

In the three-year period from 2013 to 2015, 67.3% of women with a recent live birth in California reported that they were still breastfeeding their infant at three months, while only 29.1% reported exclusive breastfeeding through 3 months. Racial/ethnic disparities in exclusive breastfeeding persist with Hispanic women (22.5%), Asian/Pacific Islander women (23.3%) and Black women (24.9%) less likely to report continued exclusive breastfeeding through 3 months compared to White women (43.3%). ([Source: MIHA Data Snapshot, California by Race/ethnicity, 2013-2015](#))

Objective 2: Strategy 1:

Conduct surveillance and evaluation of breastfeeding outcomes, including measurement of trends and disparities in breastfeeding initiation, duration and exclusivity, and the quality of maternity care related to breastfeeding.

Breastfeeding data from the Genetic Disease Screening Program (GDSP), the Maternal Infant Health Assessment Survey, and the California-specific Maternity Practices in Infant Nutrition and Care (mPINC) Survey was used in planning and evaluating breastfeeding interventions by local MCAH programs and partners.

In August 2017, the 2016 in-hospital breastfeeding initiation data for local hospitals, counties and the State were released. A letter was mailed to nearly 250 hospitals encouraging their use of these data to integrate Quality Improvement (QI) efforts within the perinatal unit. Stakeholders use these results to guide health policies and programs and monitor breastfeeding outcomes at the local level. The MIHA website has over 5,000 hits annually. The breastfeeding data website continues to be a popular website for local MCAH programs, and other breastfeeding advocates throughout the state. The Surgeon General's Call to Action to Support Breastfeeding provides 20 recommended actions to promote optimum infant feeding through public health. One recommendation is to track breastfeeding behavior as well as policies and environmental factors that affect breastfeeding. We continue to use the GDSP and MIHA data to monitor these indicators.

Local Health Jurisdictions (LHJs):

- San Francisco County - Child Development Specialist provides small group educational workshops and 1-1 sessions on preparing teen mothers to breastfeed their babies and to provide supplemental support to address challenges clients are facing with breastfeeding. During intake TAPP clients are given a youth outcome survey to determine their breastfeeding plans. TAPP promotes and encourages teens to breastfeed their children by creating a safe space and posting informational flyers advertising the health benefits of breastfeeding for infants in our office and Young Family Resource Center.
- Yuba County - 183 Yuba County mothers delivering at local birthing hospitals were offered lactation assistance by lactation-educated PHNs. Breastfeeding class information was posted on Facebook, in the Health and Human Services lobby, during hospital rounds, during home visits, during CHDP provider rounds, shared with California Health and Wellness and Anthem managed care liaisons, and at the Yuba County Community Baby Fair.

California Home Visiting Program (CHVP): CHVP collects performance measure data on the percent of infants – among mothers who enrolled in home visiting services prenatally – who were breastfed any amount at 6 months of age. The rate was 56% for FFY 2017-18.

American Indian Infant Health Initiative (AIIHI): The Department of Health Care Services-Primary, Rural, and Indian Health Division (PRIHD)-Indian Health Program (IHP) will continue to collaborate with American Indian primary care clinics to deliver training and technical assistance (TA) on the importance of breastfeeding. During the spring AIIHI workshop in April 2018, all home visitors and PHNs received a two-day update on breastfeeding by instructors from First Five San Diego. The Family Spirit

curriculum follows the American Academy of Obstetricians and Gynecologists guidelines for breastfeeding. AllHI home visitors conducted 1,626 visits and provided instructions to mothers who were nursing on the benefits and importance of breastfeeding.

Evidence-based and evidence-informed practices utilized for this strategy

Home visiting program models are evidence-based and case management programs are evidence-informed. In addition for following literature or guideline supported activities for this strategy:

- The Surgeon General's Call to Action to Support Breastfeeding
<https://www.surgeongeneral.gov/library/calls/breastfeeding/index.html>
- BFHI <http://www.who.int/nutrition/topics/bfhi/en/>
- Breastfeeding Model Hospital Policy Recommendations, 2005
<https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/Hospital-Policy-Recommendations.aspx>
- Birth and Beyond
http://www.amchp.org/programsandtopics/BestPractices/InnovationStation/ISDocs/Birth-and-Beyond-CA_2015.pdf
- Legislation
<https://www.cdph.ca.gov/Programs/CFH/DMCAH/Breastfeeding/Pages/Laws.aspx>

Challenges for this strategy

Local Health Jurisdictions (LHJs):

- Long Beach– The greatest challenge are clients needing to return to the workplace and not having a supportive work environment promoting the ability to pump and store breastmilk and misunderstanding in regards to formula supplementation also poses a challenge.
- Placer County - Postpartum women are not always receptive to home visitation services. Sometimes breastfeeding issues are resolved in the first few days after birth, before an initial home visit is scheduled.

Objective 2: Strategy 2:

Promote culturally congruent breastfeeding best practices by providing education, resources and technical assistance to funded MCAH programs and partners for the promotion of environmental change practices and programmatic policies.

Local Health Jurisdictions (LHJs): Local MCAH programs built capacity by training staff in lactation. BIH continued to focus on improving breastfeeding rates in the participants through the curriculum, handbook and assessments. Additionally, local jurisdictions were encouraged to collaborate with local agencies to promote Black Breastfeeding Week. California Breastfeeding Month (August 2017) included a social media campaign

Local training examples include:

- Colusa County - The Tri Counties Breast feeding Alliance (TCBA) and MCAH programs work to create official policies for breastfeeding friendly and breastfeeding workplace that they can present to the community to adopt.
- Imperial County - Sixty-one childcare providers were trained via the Healthy Beginnings: Supporting Healthy Sleep and Nutrition Practices for Infants and Young Children evening workshop. Fifty-six providers were provided with one-on-one education. The goal was to have family childcare providers adopt/implement at least one breastfeeding focused policy, system, and/or environmental change that supports breastfeeding moms and employees. The majority of the sites offer/provide lactation accommodation and promote the welcoming environment. A key change in many sites was/is the preparation of brought in breastmilk – many would prepare the breastmilk as formula - in very hot water and shaking it.
- San Bernardino County – 77 CPSP staff received breastfeeding support education during the annual CPSP quality improvement (QI) visit. During the CPSP QI visits information was distributed including posters, and handouts promoting the 211 breastfeeding warm line, as well as the order form to request more materials. Breastfeeding benefits for Managed Care Plans members include breastfeeding counseling and education after delivery, and breast pumps (when determined medically necessary). During QA it was identified that most providers were given breastfeeding resources during postpartum visit (being too late for mothers that had problems after delivery).
- Los Angeles LHJ developed an Asian Breastfeeding Task Force, created a South LA Breastfeeding Welcome Here community initiative, prepared local advocacy to health plans to ensure adequate Medi-Cal breast pump reimbursement, and proposals to

train and provide lactation resources to home visitors serving high-risk families.

CDPH/MCAH supports RPPC Directors, who are quality improvement experts for hospital breastfeeding policies, as they provide technical assistance and support to labor and delivery facilities and breastfeeding-friendly community health clinics that provide recommended care for lactating mothers and their babies. CDPH/MCAH continued to evaluate breastfeeding promotion within safe sleep messaging.

CDPH/MCAH was instrumental in developing a plenary for the 2018 California Breastfeeding Summit presentation entitled “The Status of Improving Hospital Breastfeeding Support Policies and Practices in California,” which covered: the status of the number of hospitals designated Baby-Friendly and how many CA hospitals are in each level on the pathway of the Baby-Friendly Hospitals Initiative (BFHI); number of hospitals choosing to implement the Model Policies per RPPC communication; number of hospitals choosing an alternate process adopted by a health care service plan that includes evidenced-based policies and practices and targeted outcomes per RPPC communication; the Vision of Breastfeeding in California; related laws; the CDPH Breastfeeding web page; CDPH programs that promote breastfeeding; and the Let’s Get Healthy Website breastfeeding page.

State BIH encouraged local BIH staff to consider becoming lactation educators and encouraged promotion of Black Breastfeeding Week. Many sites engaged with community partners to create events and promote awareness about the benefits of breastfeeding. CHVP home visiting staff were trained in lactation support, adding to the lactation experts available at the local level.

Late 2017, CDPH (MCAH, WIC, Chronic Disease) and the California WIC Association and the California Breastfeeding Coalition was selected for the Children’s Healthy Weight Childhood Obesity Collaborative Improvement and Innovation Network (CoIIN) Project with technical assistance and stipend funding from the Association of State Public Health Nutritionist. The purpose of our state’s Children’s Healthy Weight CoIIN project is to build capacity to support workplace, school lactation accommodation, and reduce related infant feeding disparities in California. This CoIIN’s breastfeeding work is to establish new policies or practices that address social and ecological barriers to breastfeeding.

California builds upon the “Reduce Breastfeeding Disparities in CA through the Lactation Accommodation” workgroup activities to address racial inequities. The project expands upon this Workgroup’s efforts by taking high-level information from this

workgroup and present it in an easy to understand format with time to dialogue via webinars across California. The first statewide webinar was conducted on April 25, 2018 on “Lactating Employees Workplace Rights” with presenters from CBC, CWA and Legal Aid. There were 105 attendees and 115 later views of the recording. A majority (71%) of attendees reported the webinar helped clarify lactation accommodation laws; many asked to be kept updated on changing laws. Most attendees (92%) felt better prepared to access and explain lactation accommodation laws

California Home Visiting Program (CHVP): CHVP promotes culturally congruent breastfeeding support and education by bringing services into the homes of pregnant and newly parenting families across California, using home visitors who reflect the communities they serve and receive on-going training on issues related to infant feeding and diversity.

Black Infant Health (BIH): The BIH Program continues to provide education and support to participants who intend to breastfeed by utilizing materials from WIC, MOD, CDC and other state/national agencies. Many of the BIH Programs in the Southern CA region participate in trainings and workshops sponsored by CinnaMomms, an Afro-Centric breastfeeding organization that partners with five local WIC locations to provide support to AA moms and families. BIH Programs in North and Central California collaborate with their local breastfeeding coalitions in order to support participants when concerns are identified. Breastfeeding Coalition members are also available to provide support during BIH groups sessions when necessary.

Evidence-based and evidence-informed practices utilized for this strategy

See Objective 2: Strategy 1 as strategies are the same.

Challenges for this strategy

An on-going challenge to maintaining a work force educated in breastfeeding is staff attrition. Training and resources in breastfeeding education are in continuous need and CHV collaborates with state, local, and national stakeholders to provide on-going support and guidance to LHJs.

Objective 2: Strategy 3:

Build and sustain partnerships and collaborations with national, state and local partners to promote breastfeeding.

State MCAH continue to support CDPH partners, such as WIC, and NEOPB to coordinate nutrition efforts, including breastfeeding.

Local Health Jurisdictions (LHJs): At a local level, MCAH programs coordinated with partners to promote breastfeeding.

Some examples of local efforts are:

- Fresno LHJ Community Regional Medical Center's exclusive breastfeeding rates have increased from 29.7% in 2010 to 72.3% in 2016. This rate of increase was highlighted at the California State Summit in January 2018. CRMC experienced one of the most dramatic improvements in the State.
- Alameda LHJ planned Sustaining Breastfeeding Together Education Forum and Resource Fair, hosted by WIC and Alameda County Breastfeeding Coalition. Participants learned how to work with breastfeeding families in Alameda County, including milk expression, counseling approaches and culture, and pumping.
- In Merced County, a community partnership has been formed with Dignity Health Mother- Baby, WIC, healthcare providers, breastfeeding coalition, and independent lactation contractors to support the baby friendly efforts of the hospital.

MCAH completed work with a Pediatric Obesity Nutrition Mini CoIN to promote policies and practices that support behaviors to increase the proportion of children ages 0-5 years that fall within a healthy weight range - this included promoting breastfeeding policies. The project culminated with a web resource for childcare providers. This web page highlights on the Emergency Medical Services Authority (EMSA) childcare nutrition website-training standards as required by law and vetted resources approved by the mini Children's Healthy Weight CoIN.

California is fortunate to have laws that mandate hospitals have an infant-feeding policy and that hospitals will adopt "Ten Steps to Successful Breastfeeding*," or an alternate process adopted by a health care service plan that includes evidence-based policies and practices and targeted outcomes, or the Model Hospital Policy Recommendations by January 1, 2025. RPPC is working to increase the number of hospitals that provide recommended care for lactating mothers and their babies The Perinatal Advisory Council: Leadership, Advocacy, and Consultation (PAC/LAC) and other RPPC regions are revising the Providing Breastfeeding Support: Model Hospital Policy Recommendations (2005). Two out of three birthing hospitals (161 hospitals) in California were designated or on the pathway to become Baby Friendly as of December 2017. Of the remaining hospitals (95), the RPPC found that 60% reported that they will implement our Department's Model Hospital Policies or similar science based policies, while others are still undecided. We are making significant progress towards meeting this legislative requirement by 2025.

Evidence-based and evidence-informed practices utilized for this strategy

See Objective 2: Strategy 1 as strategies are the same

Challenges for this strategy

- Kings County - was challenged to find the site “champion” to push for and carry through the nine Steps to Breastfeeding Friendly: Guidelines for Community Health Centers and Outpatient Care Settings. The site reported needing someone to advocate for the change and ensure it is upheld.
- San Benito County - County employee unions must be consulted and approval must be obtained prior to policy implementation. A county-wide policy must be approved by the Board of Supervisors and there is currently the perception that a lactation policy is not needed and is low on the list of HR priorities.

Objective 3:

By June 30, 2020, reduce the rate of Sudden Unexpected Infant Deaths (SUID) from 54.4 per 100,000 live births (2013 BSMF) to 50.3 per 100,000.

Objective 3: Strategy 1:

Provide the latest American Academy of Pediatrics 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 (SC), public health professionals (PHP), and emergency personnel.

SUID is a term used to describe any sudden and unexpected death occurring during infancy, whether explained or unexplained (including SIDS, Unknown/Undetermined, or Accidental Suffocation and Strangulation in Bed (ASSB)). SIDS is a subcategory of SUID. SIDS is a cause assigned to infant deaths that cannot be explained after a thorough case investigation including autopsy, death scene investigation, and review of the infant’s clinical history. According to the CDC, SIDS is one of the top three causes of infant deaths in the United States and in California.

According to the CDPH Birth Cohort File, the California SUID rates decreased from, 51.4 in 2013 to 45.1 per 100,000 live births in 2015. The SIDS rate also decreased from 33.4 to 26.6 per 100,000 live births. The Unknown/Undetermined rate saw a slight decrease from 11.7 to 11.0 per 100,000 live births during the same time period. However, ASSB rates increased from 6.3 in 2013 to 7.5 per 100,000 live births in 2015.

The rate of SUID, SIDS, Unknown/Undetermined, and ASSB declined for all racial/ethnic groups, however, the disparity between Black (non-Hispanic) infants and

infants of other racial ethnic groups remain. The Black (non-Hispanic) SUID rate was 150.0 in 2015, over six times the rate of 20.6 per 100,000 live births for Asian/Pacific Islander (non-Hispanic) infants. The Black (non-Hispanic) SIDS rate was 100.0 per 100,000 live births, almost five times the rate of 20.1 for Hispanic infants in 2015.

CDPH/MCAH and the CSUS SIDS program, funded by Title V, collaborated and delivered the 2017-2018 Spring Trainings for SIDS Coordinators, Public Health Professionals, and emergency personnel in Sacramento and in Bakersfield. There were 124 attendees in Sacramento and 137 attendees in Bakersfield for a total of 219 Spring Training participants. All participants received the latest 2016 American Academy of Pediatrics (AAP) Policy Statement and Technical Report, *"SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for Safe Infant Sleeping Environment"*. The following Continuing Education Units (CEUs) were provided to social workers, emergency medical personnel, and registered nurses.

Lastly, the AAP Report was provided to all participants at the 36th Annual California SIDS Conference was held on October 5, 2017, in San Diego, CA with 116 attendees. Participants included 19 SIDS parents/family members; 72 SCs/PHPs; five coroners; five in the field of education; five from community-based organizations; four in the medical/hospital setting, and 6 attendees who did not report any specific job category.

Local Health Jurisdictions (LHJs):

- Lake County - LHJ Nursing staff was trained in Safe Sleep education, and AAP Safe Sleep Recommendations. Materials were compiled from the NIH Safe to Sleep campaign, including: safe sleep door hanger, poster of safe sleep for your baby, and safe sleep checklist. A PHN worked directly with Adventist Health Clear Lake Hospital Birth Center to create safe sleep education kits which included sleep sacks, bath towels, and safe sleep handouts from safe to sleep campaign. Birth Center staff were trained on Safe Sleep messaging and distribution of safe sleep kits prior to discharge home.
- Los Angeles County - partnered with Nursing Universities and Colleges to incorporate SIDS /Safe Infant Sleep education into the Nursing Curriculum through videos, brochures, flyers and administering a knowledge assessment test.
- Riverside County - 250 Safe Sleep kits were created and distributed to the local Riverside region childcare licensing program who used them to promote safe sleep education during their orientation of new childcare providers. Communication with the regional childcare licensing coordinator continues to ensure kits are being used and will be replaced as needed. The childcare

licensing staff received a safe sleep review by the SIDS Coordinator and were updated with trends in the County and new education on safe sleep positions and tips they need to teach their clients.

- San Bernardino County - collaborated with nine agencies to provide SIDS education training and 11 other agencies to provide SIDS information, educational materials, teaching topics, campaign materials and posters to ensure their success with distributing material and educating their clients.

Black Infant Health Program (BIH): New local program staff are required to attend the Annual SIDS Conference in order to have the most up-to-date information related to safe sleep practices to share with BIH participants. New BIH local staff are also required to attend the annual SIDS training in their respective Northern or Southern region to learn strategies developed to assist and support families that experience the loss of an infant due to SIDS/SUID.

BIH Coordinators document the efforts of staff in BIH quarterly reports regarding lessons learned from participants as they hear about safe sleep strategies they have utilized and have shared with caretakers of their infants.

The MCAH-BIH team has shared safe sleep resources from AAP, CDC and MOD on SharePoint for local BIH program staff to utilize with participants.

Evidence-based and evidence-informed practices utilized for this strategy

CDPH/MCAH is using the 2016 AAP Policy Statement and Technical Report to promote and integrate evidence-based or evidence-informed information.

Mono County - The Plan, Do, Check, Act (PDCA) cycle and Model of Improvement are used to improve policies and processes on an ongoing basis

Challenges for this strategy

CDPH/MCAH continued to experience various challenges, including the lack of standardization in determining cause of death for infants who die suddenly and unexpectedly by coroners throughout the State. This challenge makes it difficult to get accurate risk factor data on the different categories of SUID, SIDS, Unknown/Undetermined, and ASSB. In addition, all sudden unexpected infant deaths are not reported to the local health department each year. The CDPH/MCAH is working collaboratively with the California Coroners Association to mitigate and/or eliminate this challenge.

Another challenge included instructing AllHI families on new theories regarding SUIDs, which may conflict with some traditional cultural practices regarding ceremony and teachings from respected elders. AllHI home visitors will continue to provide respect for elders while promoting the new awareness regarding safer techniques to protect infants in the home.

Local Health Jurisdictions:

- Mariposa County – Barriers to infant safe sleep education and SIDS risk reduction include Nurses’ personal belief that it is “ok for co-sleep on the bed”. They do not work in the MCAH program- they work in the Clinic services. Family members (grandmothers) were influential in swaying the moms to co-sleep on the bed. When provided safe sleep information for grandparents, they did not agree with the recommendation.
- San Diego County – Barriers to safe sleep recommendation include non-supportive partners, family members, and childcare providers, cultural beliefs, inability to afford safe sleeping environment (crib) so feel the need to bed share or co-sleep, and conveying that we cannot prevent, but we can reduce the risk of SIDS.

Objective 3: Strategy 2:

Update SIDS curriculum to include current recommendations on infant safe sleep practices, SIDS risk reduction for hospital staff, and childcare provider training sessions.

CDPH/MCAH SIDS Program and CSUS SIDS Program, in collaboration with the State SIDS Advisory Council, collaborated, coordinated, and participated in curriculum development for the 2017-2018 SIDS Spring Trainings, and the 2017 36th Annual SIDS Conference. The curriculum development included editing and finalizing the training agenda, training objectives, and training materials. Training curriculum included, latest research on SID/SUID, and safe sleep recommendations, parent panel, coroners reporting, and the nurse home visit

CDPH MCAH/SIDS Program partnered with the CDSS, CCLD, the SSAC, and the CSUS SIDS Program to provide eight, half-day trainings for CCLD LPAs on SIDS research, role of the Coroners, PHN role, and SIDS parents’ Grief/Bereavement perspectives.

Local Health Jurisdictions:

- Los Angeles County - contacted eight LAC birthing hospitals who had the highest number of infant deaths to provide SIDS data at their facility. The staff educated

nurses and unit staff about SIDS /Safe Infant Sleep environment; evaluated hospital interventions and evaluated change of behavior and implementation as part of QI activities. Each hospital was provided with SIDS/safe infant sleep materials (NICHD brochures, flyers and DVDs (English/Spanish) by mail and electronically.

- Merced County - In conjunction with Merced County Office of Education (MCOE), the county oversee the development of a video for early childcare providers and SIDS and safe sleep practices. The SIDS coordinator has worked with the Merced County Office of Education in the coordination of the video for early childcare providers.
- Santa Cruz County - 49 family childcare providers, private and contracted with Migrant Head Start, were trained on SIDS risk reduction education. A PowerPoint lecture incorporating data from the NIH with small group scenario practice was given. Handouts in English & Spanish: brochures from NICHD (Safe Sleep for your Baby, Grandparents) and California Childcare Health Program (Safe Sleep Policy for Infants in Childcare Programs, Safe Infant Sleep: Reducing the Risk of SIDS and other Sleep-Related Infant Deaths).

Evidence-based and evidence-informed practices utilized for this strategy

- Mendocino County - Local MCAH/SIDS program implemented SIDS Risk Reduction Training and administered the Eunice Kennedy Shriver National Institute of Child Health and Human Development, Pre and Post Test the Family Resource staff.
- Monterey County - Plan Do Study Act (PDSA) tool was utilized to improve safe sleep education in hospital settings. Presentations, materials, and resources were provided to the two hospital sites as scheduled. L&D Nursing Staff were provided with information about how to keep infant sleep environment safe within the hospital. Attendees were very engaged and verbalized that they had learned new information and will incorporate this information into their practice

Challenges for this strategy

The disproportionate number of safe sleep-related infant deaths in California's childcare facilities remain a concern for SUID stakeholders/policy makers, and consistent and comprehensive education of childcare providers is still lacking. In collaboration with the CSUS SIDS Program and the SSAC, MCAH will continue to support comprehensive training for the CDSS/CCLD personnel annually.

Additionally, the CDPH/MCAH will continue to provide lead roles to support hospitals, RPPC, LHJs, and community based organizations to adopt new safe sleep strategies,

provide educational resources consistent with approved maternal/infant safe sleep guidelines, and promote SIDS risk reduction recommendations.

Local Health Jurisdictions:

- Imperial County - Barriers include some attendees have shared that they have raised or are raising/caring for infants that “are just fine” on their tummy or side and do not see the need or importance of the infant sleeping on their backs for any sleep/resting times; Some continue to acknowledge that they have always placed infants on their tummies “in case they throw up”; Some of the issues seem to be tied to cultural beliefs.
- Orange County - Parents who reported receiving safe sleep information still slept with the baby in bed with them or another person, and allowed the baby to sleep with an item (blanket or pillow). As the baby got older, people allowed more items with the baby at sleep time. As babies get older, it appears that parents are comfortable allowing the baby to sleep alone in other spaces – such as a couch or adult bed. Important to continue to stress safety for babies in sleep environments as they age.
- San Mateo County - The main challenge encountered is a language barrier. There is a large percentage of day care providers that are mainly Spanish speaking. This year, Laura Garcia, SIDS PHN developed a Spanish presentation format that was used during the Spanish speaking child care providers’ presentation for the San Mateo County Child Care Coordinating Council. It was noticed that the providers were more engaged during the presentation.

Objective 3: Strategy 3:

Disseminate to LHJs the latest infant safe sleep practices, SIDS risk reduction health education materials, message to outreach and engage parents of infants regarding safe sleep practices.

The CDPH/MCAH SIDS and CSUS SIDS Program continue to provide new SIDS Coordinators with a Welcome Packet that includes resources and information regarding safe sleep practices, SIDS risk reduction materials can be found on the CDPH/SIDS website. Any additional resource requests are provided by CSUS SIDS Program.

Local Health Jurisdictions:

- Sutter County - 444 Sutter County parents of newborns who delivered at Rideout Memorial Hospital were educated on infant safe sleep practices and SIDS risk reduction and 377 demonstrated understanding and intent to follow infant safe sleep practices and SIDS risk reduction. 456 outreach folders with safe sleep

information was mailed to new mothers. Created “Safe Sleep” Billboard in waiting area of Public Health and WIC office. 54 people were reached with the Safe Sleep message on Facebook. Several public health and WIC employees provided positive feedback about the billboard display and safe sleep messaging.

- Tulare County - Families enrolled in the local MCAH Safe Sleep program receive a Pack N Play (Play Yard) in order to provide a safe sleep area for infant and promote safe sleep and SIDS risk reduction. 212 parents demonstrated increased knowledge and intention to follow infant safe sleep practices and SIDS risk reduction. Of the 212 parents educated 53 were new parents. 87% of parents demonstrated increased knowledge regarding infant safe sleep and SIDS risk reduction.

American Indian Infant Health Initiative (AIIHI): IHP collaborated with American Indian primary care clinics to deliver training and technical assistance (TA) on Sudden Unexpected Infant Deaths (SUIDs). Training on SUIDs is provided to home visitors and PHNs during AIIHI workshops. In addition, SUIDs is included in the Family Spirit curriculum.

Black Infant Health (BIH): The BIH team continues to share safe sleep resources from AAP, CDC and MOD on SharePoint for local BIH program staff to utilize with participants due to the persistent elevated rates of SIDS/SUID in the AA community. Safe sleep information continues to be included as part of the BIH group curriculum and case management meetings conducted by the BIH Public Health Nurse (PHN) or Family Health Advocate (FHA). An additional resource utilized by BIH during group sessions is the video “Safe Sleep for your Baby”, produced by the U.S. Department of Health and Human Services National Institute of Health which highlights strategies that families can implement to reduce the risk of an infant loss due to SIDS/SUID.

BIH PHNs and/or FHAs continue to utilize the BIH Safety Checklist form with all participants during home visits before and after delivery to discuss safe sleep practices and provide education related to SIDS/SUID risk reduction strategies. BIH Participants are provided safe sleep materials such as “Back to Sleep” flyers, door hangers, posters and brochures during home visits to stress the importance of implementing safe sleep practices every time their infant is placed down for sleep.

Local BIH Program staff have shared that participants feel that the safe sleep information is valuable in reducing the risk of SIDS/SUID and often share the information with family members and caretakers of their infants.

Examples of Local Efforts:

- Contra Costa – During BIH Program orientation, the Mental Health Professional (MHP) discusses safe sleep recommendations with each BIH participant; each woman is given a Halo Sleep Sack at a prenatal group session.
- Riverside – During enrollment, group sessions and PHN home visits, participants are provided with SIDS/SUID educational information. The BIH team receive annual in-services regarding SIDS/SUID risk reduction with a focus on current information and practices. The Riverside BIH Program has been fortunate to not have experienced an infant loss due to SIDS/SUID.
- San Diego – All BIH participants receive written materials on Safe Sleep for Babies and are provided the opportunity to review and demonstrate the appropriate manner in which an infant is to be put to sleep during home visits by the PHN and/or FHA. Participants have the opportunity to purchase cribs or bassinets with baby dollars if this is a need for their family.

Evidence-based and evidence-informed practices utilized for this strategy

American Indian Infant Health Initiative (AIIHI): The Family Spirits curriculum is a culturally tailored home-visiting program for American Indian Health to promote optimal health and wellbeing for parents and their children and includes lessons on safe sleep practices for infants.

California Home Visiting Program: CHVP home visitors provide SIDS awareness and Safe Sleep education to participants during pregnancy and in the first months of baby's life. Home visitors in both NFP and HFA models discuss intentions for infant sleep prior to the baby's birth and then are able to discuss sleep arrangements, address barriers, and provide ongoing education and support throughout the infant's first year.

Challenges for this strategy

Local Health Jurisdictions (LHJs):

- Modoc County - One of the barriers is the different messaging that parents receive from various agencies, friends, and family related to bed sharing; there is limited guidance for the nurses who attempt a harm reduction strategy. There is concern on the part of our staff that if Public Health continues to have such strict messaging regarding bed sharing that we will lose credibility in other areas of education. There is concern that the research regarding the connection between bed sharing and SIDS is not sufficient.
- Solano County - Challenges included cultural barriers, lack of resources to provide a safe sleep environment, and/or resistance by a parent or other caregiver in the household to adopt safe sleep practices. To address cultural barriers, home visitors continued to provide education regarding the significant of

safe sleep practices in the context of cultural norms/traditions. To address resource barriers, all home visitors were trained to disseminate information about safe sleep environments using creative alternatives, such as using playpens or Pack 'n Plays in lieu of a crib. However, car seats, sofas/couches, futons, and other soft and potentially unsafe environments, were strictly advised against as alternative sleeping environments.

American Indian Infant Health Initiative (AIIHI): A major challenge for some home visitors when conducting lessons regarding SIDS/SUIDS in the home is the presence of respected and cherished elders who gave birth, raised children, and did not utilize the current recommendations. Due to crowded conditions, infants may not have a crib or the crib may contain toys or items that hold cultural beliefs but are contraindicated. In order to be respectful of elders, home visitors have requested some mothers meet at the clinic in an office, in a park, or at a local business. This meeting allows mothers to interact with home visitors during the lessons without the presence of the elder or a member of the family who may try to insert their personal beliefs during the lessons.

Black Infant Health Program (BIH): BIH Participants share with local BIH Program staff that the safe sleep information is not always well-received by AA grandmothers of their infants and other relatives due to the historical placement of infants in a prone position with no adverse outcomes. BIH Program staff would like to see more culturally relevant, safe sleep materials that represent the ethnicity of participants of the program.

Perinatal/Infant Health – Application Narrative (FY 2019-20)

Priority 2: Reduce infant morbidity and mortality.

Surveillance: MCAH will review the national performance and national outcome data included in the Federally Available Data report prepared by MCHB by May 2019. Meanwhile, throughout FY 2018-19, MCAH will monitor select quantifiable characteristics to track the health of California infants as part of its routine health surveillance efforts. The following select indicators and measures, as listed in the table below, are continuously and systematically collected, analyzed and interpreted to guide program planning and implementation; and, evaluation of our interventions. These indicators will be analyzed by state, county, race/ethnicity and other sub-state levels to identify specific improvement opportunities.

Select Infant Health Indicators and Measures	Data Source
Birth weight- low, moderately low, very low	2017 CA Birth Statistical Master file
Premature birth-early term, early preterm, late preterm	2017 CA Birth Statistical Master file
VLBW births in Level III+ NICU	2017 CA Birth Statistical Master file/ 2017 NICU Hospital List
Mortality-infant, neonatal, post-neonatal, perinatal, SUIDS	2015 CA Birth Cohort file
Infant Sleep practices	2015-2016 Maternal and Infant Health Assessment Survey
Breastfeeding Intent	2015-2016 Maternal and Infant Health Assessment Survey
Facilities that provide recommended care for lactating mothers and their babies	Maternity Practices in Infant Nutrition and Care

Objective 1:

By June 30, 2020, decrease the percentage of preterm births, less than 37 completed gestational weeks, from 8.4% (2013 BSMF) to 8.3%.

Objective 1: Strategy 1:

Develop new and sustain existing partnerships with state and local agencies, community-based organizations, academia, provider networks and hospitals to maximize resource capacity in addressing preterm birth reduction.

- CDPH/MCAH will lead implementation of a new program, the Perinatal Equity Initiative, funded through State General Fund aimed at implementing perinatal health interventions to fill gaps in current services offered through the BIH Program. PEI will be implemented by LHJs receiving BIH funds to will work with selected organizations (partners) to provide designated intervention services to reduce the black:white infant mortality disparity rate. CDPH/MCAH will continue to collaborate with DHCS on the implementation of maternal and infant levels of care in California, promoting toolkits and participation in the RPPC statewide meetings and regional taskforces.
- CDPH/MCAH will continue to collaborate with the MOD and CMQCC, and UCSF to promote recommended evidence-based prematurity prevention strategies among CPSP providers to reduce pregnancy complications and to reduce pre-term births. PSCs will work with local CPSP providers to promote evidence based/informed resources, educating on the use of low dose aspirin in the prevention of preeclampsia, the use of 17-P to prevent subsequent preterm births, supporting the use of LARCs, and promoting preconception health and birth spacing.
- CDPH will coordinate with organizations such as Black Mommas Matter and the National Birth Equity Collaborative on toolkits and/or best strategies per their research, family centered collaboration, and advocacy to decrease preterm births.
- Conduct peer-learning webinars to share toolkits, and/or inform local projects of promising practices/strategies to reduce preterm births.
- The DHCS PRIHD/IHP will continue to collaborate with American Indian primary care clinics to deliver training and technical assistance that supports the continued operations of these critical primary care providers and ensures access to preventive care for women of reproductive age, including access to prenatal care.
- IHP will continue to focus training and technical assistance on the importance of preventive health visits, first trimester prenatal care, and postpartum follow-up visits to decrease the likelihood of birth complications and preterm labor.
- DHCS IHP will fund up to eight new partners through a competitive award process to implement the American Indian Perinatal Services program designed to focus on the health of American Indian women during and after pregnancy as well as provide care of American Indian infants for their first year of life. These services will include ensuring access to prenatal care (pregnancy through birth) and postnatal care (six-week period following birth), coordination of services, providing social support, reducing stressors, and

providing health education services.

- DHCS IHP will be engaging new partners to identify specific strategies and interventions based on the results of a comprehensive needs assessment, which will be completed prior to FY 2018-19. The needs assessment report will provide context for future funding priorities for the American Indian MCH program by reviewing California American Indian population-based data; current perinatal health status and perinatal delivery systems; the Indian health delivery system in California; expectations and suggestions from community Talking Circles (focus groups); relevant research; as well as a review of evidenced-based/informed best practice interventions.
- CDPH/MCAH will continue to partner and provide IHP with support, technical assistance, and resources on the promotion of evidence based prematurity prevention strategies (i.e. birth spacing, low dose aspirin, LARC, and 17-P for the reduction of preterm births).
- CDPH/MCAH will collaborate with IHP to attend Tribal stakeholder meetings and provide leadership, consultation, and data analysis (where appropriate) on home visitation model efficacy, model impact, and intervention/delivery modifications/adjustments in order to maximize improvements in the health status of American Indian at-risk women and their children.

Objective 1: Strategy 2:

Encourage and support regional perinatal systems by facilitating coordination of perinatal activities between local MCAH programs, RPPC, CPSP by supporting the Regional Perinatal Advisory Councils to provide regional planning, coordination and recommendations to ensure risk-appropriate care is available and accessible to all pregnant women and their infants.

- CDPH/MCAH will coordinate and conduct a web-based training between local MCAH Programs, RPPC, and CPSP for information exchange on new initiatives to reduce disparities and to explore how to further coordinate with local providers, hospitals, clinics, etc. to improve clinical and patient services to reduce preterm births.
- The CPSC Executive Committee and RPPC Directors will continue to coordinate and collaborate through key activities such as participation at annual Statewide Meetings for CPSP and RPPC and attendance at regional meetings and monthly calls.
- CDPH/MCAH will continue to facilitate the coordination of perinatal activities between MCAH LHJs and RPPC Directors by sharing resources and data and developing activities that address the needs of women from preconception through postpartum. Activities include:

- Conducting regional hospital assessments and providing technical assistance to support quality improvement
- Developing a communication network among agencies, providers, and individuals
- Disseminating education materials and providing resource directories and referral services
- CDPH/MCAH will continue to work with the California Maternal Quality Care Collaborative (CMQCC) to disseminate the Quality Improvement toolkits such as the CDPH Cardiovascular Disease and Venous Thromboembolism toolkits to improve maternal care.

Objective 1: Strategy 3:

Co-lead Community Birth Plan Task Force and integrate prematurity prevention strategies that are recommended into relevant MCAH program curricula and activities with a focus on reduction of preterm births in the African-American population.

- CDPH/MCAH will continue to co-lead the task force and the build out of the Community Birth Plan that will integrate recommended evidence based prematurity prevention strategies (i.e. birth spacing, low dose aspirin, LARC, and 17-P for prior preterm births) into the defined Community Birth Plan hospitals and communities.
- CDPH/MCAH staff will continue to participate in four Community Birth Plan workgroups with members of the CBP Task Force and other stakeholders to: build out the integration of the evidence based preterm birth prevention strategies; improve quality of care and the AA patient experience at the identified hospitals; solidify payer reimbursement for preterm birth prevention strategies; and engage the community in promoting preterm birth prevention activities within the community to reduce AA preterm birth rates.
- CDPH/MCAH and the CBP Task Force will also expand the membership of the task force to include Community Based Organizations, Faith-Based Community members, clinic providers and other community members at-large to assist in the roll out of the Community Birth Plan pilot.
- CDPH/MCAH will continue to review and track AA Preterm Birth data by hospital and zip code, additional data gathering and further exploration into the known and unknown causes of AA PTB rates as well as investigating how social determinants of health factor into clinical practice in various provider settings and hospitals.

- CDPH/MCAH and the CBP Task Force will develop the Community Birth Plan Toolkit to inform each identified group on the role they can play in implementing evidence based strategies to reduce AA preterm births. 1) Public Health/Prevention Programs, 2) Payers/Insurers and Funders, 3) Hospitals/Providers and 4) Women/Families.
- CDPH/MCAH will integrate lessons learned from the Community Birth Plan project into current MCAH program curricula and activities with a focus on the reduction of PTB in the AA population.
- CDPH/MCAH will continue to collaboratively work in conjunction with the CBP Task Force to unite the Black community: hospitals, perinatal healthcare providers, payers, and statewide organizations to develop a model Community Birth Plan for the reduction of Black preterm birth. The Community Birth Plan will target six hospitals in Los Angeles County with the highest prevalence of preterm births (Cedars Sinai, Kaiser Permanente (Los Angeles Medical Center, South Bay Medical Center, West Los Angeles Medical Center), California Hospital Medical Center, and St. Francis Medical Center).
- CDPH/MCAH will coordinate and conduct a training with BIH sites to share Community Birth Plan evidence-based best practice prematurity prevention strategies (i.e. birth spacing, low dose aspirin, LARC, and 17-P for prior preterm births) into the defined Community Birth Plan hospitals and communities.

Objective 1: Strategy 4:

Distribute and encourage MCAH programs to integrate evidence based preterm birth prevention activities and resources to educate women and providers about how to prevent preterm births.

- Identify, promote, and distribute March of Dimes tools and resources accessible on the prematernityprevention.org website at no cost inclusive of the following:
 - *ACT professional education and implementation slide deck*
 - *Elimination of non-medically indicated (elective) deliveries before 39 weeks gestational age: Quality improvement toolkit*
 - *IMPLICIT inter-conception care toolkit*
- CDPH/MCAH, in collaboration with other state partners and subject matter experts, have begun creating a communications plan to educate pregnant women/women of reproductive age on the signs and symptoms of preterm

labor. In fall 2017, CDPH/MCAH developed a preterm birth fact sheet and social media posts targeted at AA women, a segment of the population that has a 48% greater risk of preterm birth than all other women. MCAH will build on this effort, developing additional communications messages for dissemination to target audiences. Planned outreach includes an ongoing social media campaign, video storytelling, and the development of public service announcements.

Comprehensive Perinatal Services Program (CPSP):

- CDPH/MCAH, in collaboration with other state partners and subject matter experts, will update the Provider Handbook and the *Steps To Take* (STT) Manual and work with PSCs to ensure that providers offer information to their clients on preterm labor prevention strategies including birth spacing.
- PSCs will provide resources to provider staff and encourage use of STT patient handouts in English and Spanish on: Birth Spacing; If Your Labor Starts too Early; Did You Have Complications During Pregnancy; Signs and Symptoms of Heart Disease; Diabetes While You are Pregnant; Welcome to Pregnancy Care, and Drugs and Alcohol When You Want to STOP.
- CDPH/MCAH will continue to address Social Determinants of Health (SDOH) by conducting the educational webinars and technical assistance calls with MCAH Directors, Perinatal Services Coordinators and other interested partners on SDOH, infant health, late or inadequate prenatal care, and low birth weight and preterm birth.
- CDPH/MCAH will continue to identify pre-term birth (PTB) resources for local agencies and partners and encourage collaborative PTB activities such as roundtables and perinatal advisory committees.

Black Infant Health (BIH):

- The BIH Program will continue to partner with the California HealthCare Foundation and the California Maternal Quality Care Collaborative on the development of a planning grant to address disparities in hospital maternity care for African American women. The purpose is to develop a plan to work with hospitals to increase their awareness of the issues and create a community/hospital dynamic plan of empowerment for strategic, empathetic, conscious, cooperative birth plans.
- The BIH Program will continue collaborative efforts with the MOD, MCMC and CPSP Provider networks to discuss BIH Program goals and services and inform partner agencies on BIH Program preterm birth reduction strategies.

The program will encourage local BIH and CDPH/MCAH programs to integrate and distribute the following CDPH/MCAH PTB resources and tip sheets to educate black women and their providers on the prevention of PTBs:

- Reducing Preterm Birth: What Black Women Need to Know Tip Sheet
 - Reducing Premature Birth: What Providers Need to Know Tip Sheet
 - Reducing Premature Birth Discussion Points – guidance to encourage conversation with women
- The BIH Program will also continue to provide education and resources related to preterm birth (PTB) reduction to LHJs to share with BIH participants from the CDC and ACOG. The program will maintain collaborations with MOD, local county health departments, and the UCSF Preterm Birth Initiative for the development of up to date strategies and customized resources aimed at preventing preterm births.
 - The BIH Program will also continue collaborative efforts with the UCSF, Center on Social Disparities in Health to ensure that the most relevant information related to Social Disparities of Health (SDOH) and strategies to reduce PTB are included in the BIH Program materials and trainings utilized by local staff with participants.
 - Local BIH Programs will include at least one educational webinar for medical providers facilitated by MCAH-BIH and MOD focused on:
 - Roles and Responsibilities: Steps to Prevent Preterm Birth
 - The use of 17P to prevent preterm birth
 - Reducing Preterm Birth: Evidenced-Based strategies to Improve Outcomes
 - The BIH Program will also continue to convene joint Webinars for local staff in order to share resources and provide opportunities for networking and sharing of ideas related to PTB reduction challenges and successes occurring statewide.
 - The BIH Program will continue to collaborate with the MCAH Communications Team in order to provide support and guidance on materials developed for local BIH Program use. The State BIH staff will elicit and utilize feedback from local BIH staff and participants to ensure that messaging materials are culturally affirming to use with African American women, families and other stakeholders.
 - BIH will continue to work with the California Maternal Quality Care

Collaborative (CMQCC), March of Dimes, Hospitals, Health Plans, the community and other stakeholders to promote and implement evidence-based/informed solutions to prevent preterm births including but not limited to the following:

- Smoking Cessation
 - Birth Spacing – pregnancy intentionality
 - Elimination of non-medically indicated early elective deliveries
 - Low-dose aspirin to prevent preeclampsia
 - Access to 17 OH Progesterone
 - Vaginal progesterone and cerclage for short cervix
- BIH will work in conjunction with the Evaluations Team to clarify and implement model fidelity for LHJs to improve birth outcomes by linking birth files to assist with program targeting efforts to reduce preterm births, low birth weight, and infant mortality.

Objective 2:

By June 30, 2020, increase the percentage of women who report exclusive breastfeeding at 3 months from 26% (2012 MIHA) to 27.2%.

Objective 2: Strategy 1:

Conduct surveillance and evaluation of breastfeeding outcomes, including measurement of trends and disparities in breastfeeding initiation, duration and exclusivity, and the quality of maternity care related to breastfeeding.

- CDPH/MCAH will continue to track breastfeeding data by facilities to comply with California Health and Safety Code Section 123366 also known as the Hospital Infant Feeding Act of 2001, all general acute care hospitals and special hospitals that have a perinatal unit shall have an infant-feeding policy.
 - In August 2019, MCAH will release the 2018 in-hospital breastfeeding initiation data for local hospitals, counties and the State at: www.cdph.ca.gov/breastfeedingdata.
 - CDPH/MCAH will partner with RPPC to distribute data to maternity hospitals while offering technical assistance to raise breastfeeding initiation rates.
- Breastfeeding data from the State's Genetic Disease Screening Program and the Maternal Infant Health Assessment Survey will continue to be used in planning and evaluating breastfeeding interventions by State and local MCAH programs and partners.

- Breastfeeding data will be highlighted during California Breastfeeding Month and social media usage will be tracked.
- AFLP, BIH, and CHVP will continue to measure and monitor breastfeeding outcomes among home visiting participants.
- When administered and completed, CDPH/MCAH will review data from the California Health Care Foundation's survey of hospitals regarding treatment of maternal opioid addiction and the mother-infant dyad, including infant feeding practices.
- BIH will continue to measure and monitor breastfeeding initiation rates and outcomes among participants.

Objective 2: Strategy 2:

Promote culturally congruent breastfeeding best practices by providing education, resources and technical assistance to funded MCAH programs and partners for the promotion of environmental change practices and programmatic policies.

- CDPH/MCAH will continue to support RPPC Directors as they provide technical assistance and support to labor and delivery facilities on recommended care for lactating mothers and their babies through utilization of California's Model Hospital Recommendations, the Baby-Friendly Hospital Model or other evidence informed breastfeeding guidance to fulfill mandates of California Health and Safety Code 123367.
- Through the leadership of Perinatal Advisory Council/Leadership, Advocacy, and Consultation (PAC/LAC) RPPC, CDPH/MCAH will release an updated *Model Hospital Policy Recommendations* as the alternative framework to fulfill the above mandate.
-
- CDPH/MCAH will review BIH curriculum to confirm it includes up-to-date information regarding breastfeeding. BIH will continue to promote breastfeeding through education, support, guidance, and referrals and encourage local staff to become lactation consultants. BIH will encourage LHJs to participate in Black Breastfeeding Week to promote breastfeeding in the Black community through Social Media, employer-based fact sheets (where available), and the Chocolate Milk Cafe RI (CMCRI), an IBCLE approved breastfeeding support group.
- AFLP will continue to support young mothers with breastfeeding through

strengths-based case management with integrated life planning.

- CHVP will continue to promote breastfeeding through education, support, guidance, and referrals to participants.
- CDPH/MCAH will enhance the CDPH Breastfeeding topic web page and the MCAH Breastfeeding Initiative web page with a focus on reducing disparities.
- CDPH/MCAH programs will partner with WIC and Chronic Disease to continue to promote and market the [9 Steps To Breastfeeding Friendly: Guidelines for Community Health Centers and Outpatient Care Settings](#).
- CDPH/MCAH programs will provide breastfeeding information on cannabis and opioid use and breastfeeding.
- The ISCD, Medical Policy Section will compare CCS approved hospitals to the identified list of certified BFHI hospitals and consider addressing gaps in quality of care. ISCD will provide specialized assistance in support of their quality improvement project to increase breastfeeding rates among CYSHCN.
- CDPH/MCAH will investigate collaborating with DHCS Benefits Division, Policy Division and Child Health and Disability Prevention (CHDP) Program to provide guidance on lactation reimbursable service and durable medical groups benefits that support the ACA.
- CDPH/MCAH will promote breastfeeding within Safe Sleep messaging.
- The DHCS PRIHD/IHP will continue to collaborate with American Indian primary care clinics to deliver training and technical assistance on the importance of breastfeeding.
- As part of the Children's Healthy Weight CoIN with technical assistance from ASPHN, MCAH along with WIC, NEOPB, California WIC Association, and the California Breastfeeding Coalition is addressing lactation accommodation by offering training and promoting the California Infant Feeding Guide.

Objective 2: Strategy 3:

Build and sustain partnerships and collaborations with national, state and local partners (such as WIC, NEOPB, the United States Breastfeeding Committee, the California Breastfeeding Coalition, and the California WIC Association) to promote breastfeeding by offering webinars, conferences, developing and disseminating lactation accommodation and hospital breastfeeding best practices.

- CDPH/MCAH will continue as a member of “Reducing Breastfeeding

Disparities in California through Lactation Accommodation,” a statewide workgroup with key stakeholders, including representatives from several state departments. The workgroup works towards ensuring that all women, especially low-wage earners and adolescent mothers, have equal access to lactation accommodation at work and school, thus reducing disparities in breastfeeding duration. CDPH/MCAH is transferring leadership of this group to the California WIC Association and California Breastfeeding Coalition.

- CDPH/MCAH will continue to work to ensure implementation of statewide lactation accommodation policies by also participating as a Core member of a Childhood Obesity CoIIN. Other partners, such as the Chocolate Milk Campaign and the United States Breastfeeding Committee will be brought into the CoIIN when possible. The purpose of the California’s Children’s Healthy Weight CoIIN project is to build capacity to support workplace and school lactation accommodation and reduce related infant feeding disparities in California by October 2019. The CoIIN targets individuals and organizations providing lactation accommodation education and resources to communities with low breastfeeding duration.
- CDPH/MCAH, as a partner in the CoIIN, will produce sample social media posts, an infographic and factsheets for the California Breastfeeding Month campaign.
- CDPH/MCAH will continue to work collaboratively to advocate for supporting and improving lactation accommodation for CDPH employees and LHJs.
- CDPH/MCAH will participate in the planning of the 2020 California Breastfeeding Summit.
- CDPH/MCAH will continue to maintain a distribution list and provide funding, technical assistance and other notices to LHJ Breastfeeding Coordinators.
- CDPH/MCAH will continue to meet with CDPH partners, such as WIC, ISCD, Medical Policy Section, and NEOP to coordinate efforts, including breastfeeding. CDPH/MCAH will continue to have a representative sit on the United States Breastfeeding Committee.
- CHVP will continue to encourage local home visiting programs to include breastfeeding education and support agencies on their community advisory boards, in order to create a more seamless referral process and better serve breastfeeding families.
- BIH will encourage LHJs to partner with local and national partners to support participants’ in breastfeeding.
- CDPH/MCAH will investigate promoting the new WIC 1-800 breastfeeding

support line within MCAH local programs.

Objective 3:

By June 30, 2020, reduce the rate of Sudden Unexpected Infant Deaths (SUID) from 54.4 per 100,000 live births (2013 BSMF) to 50.3 per 100,000.

Objective 3: Strategy 1:

Provide the latest American Academy of Pediatrics guidelines on infant safe sleep practices/Sudden Infant Death Syndrome risk reduction through two SIDS trainings each year and the Annual SIDS Conference for SIDS Coordinators, public health professionals, and emergency personnel.

- CDPH/MCAH will utilize the local Fetal Infant Mortality Review (FIMR) Program tracking log to assess the number of case reviews and findings due to sudden unexpected infant deaths and identify sites that implement safe sleep interventions from the community FIMR action team.
- CDPH/MCAH will continue to provide the latest AAP guidelines on infant safe sleep practices and risk reduction to all new SIDS Coordinators (SCs)/ public health professionals (PHPs) as part of the SC/PHP Handbook and orientation packet.
- The CDPH/MCAH SIDS Program will continue to make available the latest publication on AAP guidelines to current SCs/PHPs, State SIDS Advisory Council, SIDS Regional Councils, and the SIDS community and all MCAH Programs on the CDPH/SIDS website.
- CDPH/MCAH will continue to include copies of the latest AAP guidelines to all attendees including SCs/PHPs, childcare providers, and emergency personnel in California during the 2018-19 SC/PHP Coordinator meeting, the SUID/SIDS Annual Conference, and the SUID/SIDS Spring Trainings.
- CDPH/MCAH SIDS program will work with the CDPH/MCAH Regional Perinatal Program of California (RPPC) Directors to ensure all participating birth facilities are provided with the latest AAP recommendations on infant safe sleep.
- CDPH/MCAH SIDS Program Consultant will work with the CDPH/MCAH RPPC staff to gather and assess the number of hospitals with safe sleep protocols.
- BIH staff will continue to partner with the CDPH/MCAH SIDS Program

Consultant and will participate on SIDS conference calls, webinars, and statewide meetings where feasible. Staff will work with the SIDS Program to stay aware of new guidelines and/or strategies for infant safe sleep aimed at reducing infant mortality. Staff will share/disseminate new resources and training materials with local BIH Programs.

- BIH staff will continue to participate in the quarterly SIDS Advisory Council meetings.
- Staff will identify collaborative educational opportunities to further promote safe sleep practices with BIH, CHVP, and AFLP at statewide trainings, conferences, and/or meetings.

Objective 3: Strategy 2:

Disseminate to LHJs the latest infant safe sleep practices, SIDS risk-reduction health education materials, messages to outreach and engage parents of infants regarding safe sleep practices.

- CDPH/MCAH will support LHJ efforts by distributing the latest data on sudden unexpected infant deaths by county and by race/ethnicity.
- CDPH/MCAH will continue to comply with California Health and Safety Code, Sections 123730-123735 to provide and distribute literature on SUID and SIDS for populations who interact with parents and caregivers and ensure LHJs are advised of the most current knowledge relating causes of SUID/SIDS.
- CDPH/MCAH will work with across the Division to identify program targets and develop culturally appropriate fact-sheets to promote infant safe sleep recommendations.
- CDPH/MCAH will re-engage with and foster an effective partnership with California's Department of Social Services/Childcare Licensing Division to support safe sleep education and counseling to all licensed childcare sites.
- The Department of Health Care Services/Primary Rural and Indian Health Division/Indian Health Program (IHP) will continue to collaborate with American Indian primary care clinics to deliver training and technical assistance on SUID/SIDS.
- IHP will be engaging new partners to identify specific strategies and interventions based on the results of a comprehensive needs assessment, which will be completed prior to FY 2018-19. The needs assessment report

will provide context for future funding priorities for the American Indian MCH program which may include further risk reduction efforts aimed at reducing the SUID rate among American Indian infants.

- CDPH/MCAH will continue to track retention of LHJ SCs/PHPs and assist in training/onboarding efforts of new SCs/PHPS. CDPH/MCAH will work to connect seasoned SCs/PHPs with new SCs/PHPS to assist in the transition and provide support and information to new SCs/PHPs.
- Local outreach examples include:
 - Alameda County - will continue to provide presentations to homeless shelters or shelters for women experiencing intimate partner violence in order to increase knowledge and the adoption of infant safe sleep practices into their organization.
 - Contra Costa County – will continue to review and update the MOU to provide SUID/SIDS education materials to the Contra Costa Regional Medical Center. The MOU addresses education and training to providers, dissemination of materials to patients upon discharge, and the modeling of AAP Safe Sleep Recommendations.
 - Los Angeles County – will continue to partner with nursing schools/universities to incorporate safe sleep infant education into the nursing curriculum through videos and brochures. In addition, LA will collaborate with 60 birthing hospitals and provide educational links and mass distribution of electronic materials about SIDS and safe sleep.

Objective 3: Strategy 3:

Review new literature on SUID/SIDS research, infant safe sleep campaigns, and other promising practices and develop a consensus document on California Safe Sleep Guidance for California communities.

- CDPH's Center for Family Health has initiated and convened a safe sleep internal workgroup to assess current literature in order to develop a consensus document on Safe Sleep guidance for MCAH programs. The document will identify strategies in guiding parents and professionals in implementing the AAP recommendations and infant safe sleep practices and identify and/or create tools and resources to assist parents and those staff who work families on infant safe sleep practices.
 - The internal safe sleep workgroup will continue to conduct meetings

that include partnerships with programs such as SIDS, WIC, CHVP, and BIH that provide education and counseling.

- CDPH/MCAH will be developing a communication plan that will identify and gather external stakeholder input to the proposed guidance.
- CDPH/MCAH is planning to gather the information and work with the Communication team to develop messages and guidance on safe sleep environments, safe bed-sharing, breastfeeding, and infant sleep and to release recommendations Fall/Winter 2018.

Objective 4:

By June 30, 2020, 100% of parents/caregivers experiencing a sudden and unexpected infant death will be offered grief/bereavement support services.

Objective 4: Strategy 1:

Provide training to coroners/medical examiners on the significance of referring to local health department all families who experience the sudden, unexpected death of their baby regardless of circumstances of death.

- CDPH/MCAH will continue to comply California Health and Safety Code Section 123740, whereby the LHJ is responsible, upon being informed by the coroner of any case in which sudden infant death syndrome is the presumed cause of death, to immediately contact the family for the purpose of providing information, support, referral, and follow-up services.
- The coroner position has been filled on the State SIDS Advisory Council which had been vacant. Heather Griffith, Sacramento County Deputy Coroner has been appointed by the CDPH Director of Public Health. CDPH/MCAH will utilize her expertise to develop sessions on Coroner's role and responsibilities for the SIDS Spring Training Curriculum.,
- CDPH/MCAH will continue to make available SIDS Autopsy and Death Scene and Investigation Protocols along with the Public Health Nurse Service Report on the CDPH/SIDS website and will host annual trainings for SCs/PHPs on ways to build relationships with their local coroner office.
- Annual trainings will continue to be provided to SCs/PHPs on ways to build relationships with their local coroner's office.
- SIDS/SUID Resources will continue to be made available on the CDPH/SIDS website or the SIDS SharePoint site, and through request to CSUS SIDS

Program. New resources will be promoted to SCs/PHPs, coroners, medical examiners, child care providers, emergency personnel, hospital staff and others working with pregnant women, families of newborns and infants, and families who have lost an infant suddenly and unexpectedly.

- To mitigate the non-report or delayed reporting by coroners to CDPH/MCAH and local SCs/PHPs of a sudden unexpected infant death, MCAH will continue to establish partnerships with coroners to improve voluntary and timely reporting of sudden unexpected infant deaths.
- CDPH/MCAH maintains an annual database of notifications of sudden unexpected infant deaths. Notification is either from the coroner and/or the SCs/PHPs. CDPH/MCAH will continue to follow up quarterly with LHJs on reporting updates and to be apprised on reporting trends in infant deaths regardless of the circumstances of the death including if any risk factors were present.

Objective 4: Strategy 2:

Make grief/bereavement support materials and peer support organizations available on the California SIDS Program website.

- The CDPH SIDS Program will continue to post materials on the MCAH/SIDS website and/or make materials available to the California SIDS community.
- The CDPH SIDS Program will continue collaboration and partnership with the CSUS SIDS Program and the SIDS Advisory Council to ensure that peer support organization information is updated and current and that grief/bereavement resources and materials are made available on the MCAH/SIDS website, and at trainings and conferences.
- CDPH/MCAH will update and continue to disseminate the SIDS Provider Handbook and the Home Visit Guide, and Parent Peer Mentor Tools to all new and current SCs/PHPs.

Objective 4: Strategy 3:

Provide training on grief and bereavement support services to public health professionals and emergency personnel who respond to sudden unexpected infant deaths.

- As required in California Health and Safety Code Section 123740, CDPH/MCAH will provide training to SCs/PHPs and emergency personnel to provide basic grief counseling skills for the purpose of providing information, support, referral, and follow-up services to families whose baby died suddenly and unexpectedly.

- CDPH/MCAH will continue to conduct the Annual SUID/SIDS training for all SCs/PHPs and emergency personnel. MCAH will continue to include the sharing of best practices from attendees for the purpose of skill building and real time examples of efforts that work in the field.
- CDPH/MCAH will continue to identify ways to increase attendance of emergency personnel at the annual spring trainings to improve interaction and communication between emergency personnel and families they serve. Strategies include providing specialized workshops during the trainings geared for emergency personnel. Suggested workshop topics include understanding what happens when a baby dies suddenly and unexpectedly and best practices for emergency workers when serving grieving families.
- CDPH/MCAH will provide other opportunities for training by hosting at least one webinar to support LHJs in building a competent workforce. Turnover of SCs/PHPs and others who are unable to attend in person trainings would benefit from webinar trainings.

Objective 4: Strategy 4:

Track if 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.

- CDPH/MCAH will continue to track notifications of sudden unexpected infant deaths through receipt of a Coroner Notification Card from the coroner and/or receipt of a Public Health Services Report from the SC/PHP.
- CDPH/MCAH continues to correspond quarterly with the 61 LHJs to track if a Coroner Notification Card was received and/or if a Public Health Services Report was received. This serves as a 'check and balance' system to inform the SC/PHP of deaths they may not have been notified of as well as informing the State of deaths not notified of for each LHJ. It also serves as a reminder for the SC/PHP to submit necessary paperwork for deaths in their jurisdiction. Continued tracking and correspondence by MCAH identifies unknown deaths and allows for immediate contact of the family by the SC/PHP.

Objective 5:

By June 2020, sixteen counties will conduct Fetal Infant Mortality Reviews (FIMR) and implement plans that improve systems of care for women and infants to reduce deaths in these counties.

Objective 5: Strategy 1:

Conduct community-based, action-oriented processes that examine fetal and infant deaths, determines preventability, and engages communities to take action.

- CDPH/MCAH funds 16 FIMR sites (Alameda, Contra Costa, Fresno, Humboldt, Kern, Los Angeles, Placer Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Solano, Sonoma, Ventura and Yolo counties) to conduct and complete case reviews or maternal interviews and convene case review team (CRT) to review selected cases to make recommendations to address fetal-infant death factors.

Examples of continued recommendations include:

- Alameda County: Interconception care/case management for women with conditions predisposing to future high-risk pregnancy.
- Los Angeles County: Promote infant safe sleep practices
- The 16 local site will continue to maintain a community action team (CAT) to recommend and implement community/systems changes that address the reviewed findings.
- Examples of systems change include the following:
 - Alameda County: Continue to collaborate with WIC sites to ensure 1500 pregnant/postpartum women will be screened for perinatal depression and to rescreen if possible if depression scores have improved.
 - Los Angeles: Continue to develop health briefs and factors describing associated fetal/infant loss. Briefs will continue to be developed and disseminated to local key perinatal stakeholders and posted on the County's website.
- During 2018-19, CDPH/MCAH will be re-evaluating the FIMR Program to assess areas of high infant mortality, geographic distribution of current FIMR funding, allocation of resources, program requirements, data collection and analysis for program planning.
 - Compile community action team plans to reduce infant mortality
 - Review African American fetal and infant deaths
- CDPH/MCAH will develop and produce a State Report on California Fetal and Infant Mortality and CAT action plans to address fetal and infant mortality.

Priority 3: Improve the cognitive, physical and emotional development of all children. (NPM 6)

Early identification of developmental, behavioral, and social delay in young children can increase the numbers of children receiving timely early intervention services, so they may develop to their fullest potential.

Objective 1:

By June 30, 2020, increase the rate of children ages 9 through 35 months screened for being at risk for developmental, behavioral and social delay, using a parent-completed standardized developmental behavioral screening tool in the past year from 22.2% (2016-17 National Survey of Children's Health) to 24.4%.

NPM 6 was redefined in 2018 to only include children ages 9 through 35 months. For the updated NPM 6 measure for children ages 9 through 35 months, the aggregated 2016-17 NSCH showed that 22.2 percent (95% CI: 14.5 – 32.5) of children ages 9 through 35 months in California received a developmental screening using a parent-completed screening tool. Data from this survey cycle are not comparable with previous NSCH surveys. The reasons for this incomparability are shifts in the survey's sampling frame and mode of survey administration as well as some adjustments to item wording where necessary. The redesigned NSCH also combined the Children with Special Health Care Needs (CYSHCN) survey into the NSCH instrument.

Objective 1: Strategy 1:

Collaborate with relevant partners to develop goals, objectives, and activities to improve rates of behavioral, social, and developmental screening and linkage to needed services for all children and youth, especially children ages 9 months through 35 months and at-risk populations.

California Statewide Screening Collaborative (SSC): MCAH, including the California Home Visiting Program (CHVP), actively participated in the California Statewide Screening Collaborative (SSC). CDPH/MCAH contributes Title V and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding for the Collaborative. The Department of Developmental Services (DDS) also contributes funding to the SSC. The SSC participants included representatives from CDPH/MCAH, DDS, First 5 Association of California, California Department of Education, Department of Social Services, American Academy of Pediatrics-California, DHCS's Indian Health Program, developmental-behavioral pediatricians, and child-focused non-profit organizations.

During 2017-18 additional outreach was made to local MCAH, medical provider organizations, and the Department of Health Care Services (Medi-Cal Managed Care and Integrated Systems of Care Division).

The Provider Developmental Screening Toolkit website (<http://www.cascreenbto5.org/>), developed by a subcommittee of the SSC, was shared with the SSC during its September 2017 meeting; the toolkit includes developmental and behavioral screening tools, sample workflow, billing and referral information, and national, state, and local resources. A webinar for local MCAH Directors about the Provider Developmental Screening Toolkit website was held to make local programs aware of this new resource and to elicit additional feedback. In March 2018, a Screening and Referral Information card was shared at the SSC meeting for dissemination at conferences and meetings to promote the new website.

The statewide Developmental Screening Landscape Analysis report developed in 2016-17 was disseminated to local MCAH Directors and posted on the Developmental Screening Toolkit [website](#).

During 2017-18, the SSC began the development of a one-page, Part C eligibility reference tool targeting birthing hospitals and other early care providers, so birthing hospitals would know who could be referred to Part C early intervention services directly from the hospitals.

The California Health Interview Survey (CHIS): CHIS is the nation's largest state health survey and a critical source of health data on Californians. CDPH/MCAH had representation in the CHIS Children's Technical Advisory Workgroup and the CDPH CHIS Users' workgroup to recommend subject matter content for the child questionnaire.

CDPH/MCAH developed a proposal to utilize a question using the wording of the NSCH developmental screening question for CHIS for the 2019-20 CHIS cycle.

Currently, two questions are asked of respondents (children's parents/guardians) as a base for the measure, "Administered a Standardized Development & Behavioral Screening tool":

- "Did they ever have you fill out a checklist about concerns you have about {his/her} learning, development, or behavior?" and
- "Did they ever have you fill out a checklist of activities that (child) can do, such as certain physical tasks, whether {her/she} can draw certain objects, or ways {he/she} can communicate with you?"

For these two questions integrated into “Administered a Standardized Development & Behavioral Screening (SDBS) tool” measure, the 2017 CHIS showed that 48.7% (95% CI: 37.7-59.7) of respondents with children ages 1-3 years old in their household completed a SDBS tool. Data by race/ethnicity using pooled years (2015-2017) showed data variability across subgroups: Asian (55.1%, 95% CI: 32.6 - 77.6), multiple race (53.6%, 95% CI: 33.5 - 73.7), White (52.2%, 95% CI: 40.1 - 64.4), and Hispanic (47.6%, 95% CI: 40.5 - 54.8). Data were unstable for Black and American Indian/Alaska Native populations.

Another question asked was: “Many professionals such as health providers, teachers and counselors do developmental screening tests. Tests check how a child is growing, learning and behaving compared with children of the same age. Did (CHILD)’s doctor, other health providers, teachers or school counselors ever do an assessment or tests of (CHILD)’s development?” Results from the 2017 CHIS showed that 66.6% (95%CI: 57.5-75.7) of children aged 1-3 years old had a developmental assessment or test. Data by race/ethnicity using pooled years (2015-2017) with the following percentages:

- 53.5% (95% CI: 45.9 - 61.2) Hispanic,
- 61.1% (95% CI: 41.4 - 80.9) Asian, and
- 72.3% (95% CI: 60.2 - 84.3) White.

Data for Black, American Indian, Alaska/Native, multiple race were statistically unstable so could not be reported.

The California Home Visiting Program (CHVP): CHVP provides two evidence-based home visitation models: Healthy Families America (HFA) and Nurse Family Partnership (NFP). Each of the models follows a different curriculum; however, the primary goal of the home visiting programs are to help ensure a healthy pregnancy and a healthy baby.

CHVP collaborates with early childhood partners through co-leadership of the State Interagency Team (SIT) workgroup to help identify opportunities to overcome systems barriers, with the goal of helping home visiting families receive needed services. The California Department of Social Services, California American Academy of Pediatrics (AAPCA), California Department of Education, WestEd Center for Prevention & Early Intervention, California Head Start Association, First 5 LA, and Family Resource Centers Network of California are some of the partners that participate in the SIT workgroup.

CHVP has created a System Integration Policy to provide guidance to local CHVP sites on the development and maintenance of a Community Advisory Board (CAB) that promotes a community support system for home visiting programs and the local early childhood system of services. Local CHVP sites convene a CAB that serves in a

consultative and/or governing capacity in the planning and implementation of program-related and systems-integration activities. This may include collaboration with their Regional Centers, schools, hospitals or any local agency that provides services to children with behavioral, social, and developmental needs.

In fiscal year 2017-18, the Nurse-Family Partnership (NFP) home visiting program enrolled 1,753 index children. Of the 852 eligible children aged 11-25.5 months, 795 (93.3%) completed at least one Ages and Stages Questionnaire-3 (ASQ-3) developmental screen. The NFP is funded by MIECHV, not Title V, but this program is within the CDPH MCAH Division.

In fiscal year 2017-18, the Healthy Families America (HFA) home visiting program enrolled 617 index children. Of the 232 eligible children aged 11-25.5 months, 225 completed at least one ASQ-3 developmental screen (97.0%). HFA is funded by MIECHV, not Title V, but this program is within the CDPH MCAH Division.

During this fiscal year, CHVP focused on improving the referral process at LHJ sites. Starting in October 2017, CHVP integrated the topic of Screening and Referrals into quarterly CHVP Technical Assistance (TA) calls with local health jurisdictions (LHJs) to improve developmental screening rates and referrals. Through these calls, CHVP has begun to understand site-level processes and system challenges that affect developmental screening and referral completion rates. For this purpose, CHVP developed tools and provided guidance through TA calls and webinars. The tools developed are the following:

1. Decision Trees: These provide instructions to home visitors for completing the required forms. They help home visitors understand how to report their referral efforts accurately in the data management system.
2. Referrals-to-Services Tracking Report: These tracking reports were developed so local teams could use their data to determine if their referral process is improving and to follow-up on outstanding referrals.
3. Referral Monitoring Tool: This tool allows home visitors to track positive screens and get real-time action steps and due dates for follow-up. This tool also gives the supervisors the ability to track home visitors' progress toward completion of referrals.

CHVP collects information about children who were read to, told stories to, and/or sang songs with every day during a typical week. This information is obtained by interviewing the parent and recording the response in a form. The results for 2017-18 are the following:

- NFP: of the 1718 eligible children, 1016 (61.7%) were reported to be read to, told stories to, and/or sang songs with every day during a typical week.
- HFA: of the 590 eligible children, 414 (70.2%) were reported to be read to, told stories to, and/or sang songs with every day during a typical week.

American Indian Infant Health Initiative (AIIHI): During FY 2017-18 the Department of Health Care Services-Primary, Rural, and Indian Health Division (PRIHD)-Indian Health Program (IHP) provided Title V funding to four American Indian health programs to administer a home visitation program called the American Indian Infant Health Initiative (AIIHI). Each of the funded programs utilized the Family Spirit (FS) model to provide health education and psychosocial support to families enrolled in the program. American Indian paraprofessionals conducted developmental screenings on American Indian children enrolled in the program during home visits. The FS curriculum included a focus on identifying infant cues and responding to meet the needs of the infant and promoted maternal-infant bonding. The program also taught parents to understand the challenges and needs of toddlers and to anticipate and prevent tantrums. Families learned the importance of stimulating the growth and development of their children by talking, reading, singing, and engaging them at an early age.

During this funding cycle, 140 children were enrolled in the home visitation program and, of the 92 eligible children (ages 2 months up to 3 years), 45 received a developmental screening using the Ages and Stages Questionnaire (ASQ). Of the number of children screened, six had a positive screen and were referred for additional evaluation to the Regional Centers.

In addition, AIIHI grantees received funding for the provision of primary care services for children. During this reporting period, providers in the Behavioral Health department evaluated and treated 1,160 children ages 0 to 10, 1498 children ages 11 to 14, and 1718 children ages 15 to 20.

DHCS Medi-Cal Managed Care: CDPH/MCAH continued to engage the DHCS Medi-Cal Managed Care Division regarding developmental screening and set up a presentation on their developmental screening focus study results to our local MCAH programs in February 2018. Recommendations of their study included working with MCPs to improve developmental screening and/or use of CPT 96110 and encouraging that MCPs include incentives or parental education on the importance of developmental screening and how to navigate referral pathways.

At the April 2018 DHCS Medi-Cal Managed Care Medical Directors meeting, both the San Bernardino MCAH program and Inland Empire Health Plan presented their

collaborative work to improve developmental screening and referral to the other local Medi-Cal Medical Directors. Developmental screening resources were also shared with the Medical Directors.

Medical Investigation of Neurodevelopmental Disorders (MIND) Institute:

CDPH/MCAH attended and participated in planning the annual MIND Summer Institute on Neurodevelopmental Disorders at the University of California, Davis in August 2017. Topics included Updates on Initiatives to Support Social-Emotional Developmental Monitoring with presentations on California’s Help Me Grow systems, CDC’s “Learn the Signs, Act Early” campaign, and the California DDS “Take A Minute” Campaign.

Evidence-based and evidence-informed practices utilized for this strategy

Evidenced-based and evidenced-informed practices that were utilized for this strategy included the following:

- Programs (NFP, HFA, and AIIHI) used validated developmental screening tools recommended by AAP’s Bright Futures (e.g., ASQ-3) to assess children in the areas of communication, gross motor skills, fine motor skills, problem solving, and personal-social skills to identify children that would benefit from further evaluation for developmental delays.
- MCAH programs used evidenced-based models of home visiting (NFP, HFA).
- The American Indian Health programs utilized Family Spirit (FS), an evidence-based home visitation model designed for American Indian families which was developed by the John Hopkins Center for American Indian Health. The curriculum includes lessons for parents regarding the importance of early and timely developmental screenings. Johns Hopkins recognizes the Ages and Stages Questionnaire as an accepted best practice developmental screening tool. In addition, the FS curriculum includes lessons on the behavioral needs of toddlers and ways to minimize their frustrations in communication. It also includes lessons regarding learning to read infant behavioral cues and the need to respond promptly to reassure and calm the infant.

Challenges for this strategy:

- There are reported delays after a child is noted to be at risk for developmental delay to receive an initial evaluation through the Regional Centers.
- Health care providers report long waits after referral to early intervention and lack of feedback regarding their referral.
- Developmental screening is currently not yet a HEDIS measure.
- Health care providers inconsistently report on developmental screening using

CPT 96110 to the Medi-Cal managed care health plan.

- Some AIHI personnel reported challenges in completing screenings due to families experiencing stressors. These families were provided intensive home visitation services and AIHI staff collaborated with the clinic's behavioral health department to provide needed additional support services.

Objective 1: Strategy 2:

Provide technical assistance to MCAH programs to implement their SOW, promote the use of Birth to 5: Watch Me Thrive! or other appropriate materials, develop protocols to screen and refer, all children in MCAH home visiting or case management programs to early intervention services and develop quality improvement plans to ensure CYSHCN are identified early and connected to needed and ongoing services.

Adolescent Family Life Program (AFLP): AFLP supports expectant and parenting youth up to age 19 in California. Case managers worked with youth and their children to complete the following related to child developmental screening:

- Provided child development and parenting education, including the use of validated early childhood developmental screening tools (e.g. ASQ, ASQ SE), education on positive parenting, linkage to preventive and primary care for the young parent and their child(ren), and linkage to early intervention support services when indicated
- Provided anticipatory guidance and education regarding child development and the importance of developmental screening and well child visits
- Modeled positive parenting skills and strategies for scaffolding child development, provided related educational materials and resources, and referred youth to parenting classes and other related resources

The AFLP team worked toward aligning program activities with other MCAH programs to ensure consistency and integration of best practices. A total of 1,448 youth and their 1,070 children were served through AFLP in FY 2017-18. Based on screening, the number of children needing child developmental interventions in FY 2017-18 was 102 (9.5% of the youth in the program had a child who needed this service). Twenty-seven were already receiving services, 75 were referred through AFLP to services (73%). Of those referred, 49 received services. Twenty-six had not received services at time of last follow-up (8 did not follow through, 8 refused services, and 14 did not give a reason (client had not gone yet) (AFLP MIS 2017-18).

The AFLP is an evidence-informed model. Additionally, evidence-based and evidence-informed materials and practices are utilized when possible in supporting youth and

their children in the program. Specifically, some AFLP sites utilize Triple P Positive Parenting Program, the Ages and Stages Questionnaire (ASQ) and the ASQ Social Emotional (SE). Some AFLP sites utilize, participate with, and collaborate with locally organized Birth to 5: Watch Me Thrive! and First 5 efforts.

Black Infant Health (BIH): Pregnant and postpartum BIH participants received information related to child development postpartum during session 12 of the BIH Group Curriculum. The curriculum provided an overview of brain development, screening of the “Promoting Healthy Brain Development” video, discussion of the role of parents play in infant brain development, discussion of developmental milestones with the “Learn the Signs” handout (a CDC/Act Early document), and discussion of developmental screening with a standardized tool, such as the ASQ, with the pediatrician during well-child visits. There were 301 women that attended session 12 where child development was discussed, and 77 referrals made during FY 17-18 for developmental services.

BIH sites are encouraged to work with their LHJ partners to share resources to ensure BIH participants are aware of developmental screening for their child as well as encouraged to speak with their child’s pediatrician.

In April 2018, CDPH/MCAH and BIH coordinated a panel presentation at the BIH Conference. Presenters included CDPH/MCAH, psychologist from the UC Davis MIND Institute, and a Leadership Education in Neurodevelopmental Disorders (LEND) fellow who currently leads a support group for African American parents. A general overview of developmental surveillance, screening, and referrals was provided. Information on specific developmental and autism screening tools were presented, and resources for families were shared, including Birth to Five: Watch Me Thrive!, ‘Learn the Signs. Act Early,’ California Healthcare Provider Developmental Screening Toolkit website, and AAP resources.

Challenges for this strategy:

The AFLP team continues work toward aligning program activities with other MCAH programs to ensure consistency and integration of best practices across sites. Currently, the provision of parenting education and child development education and support varies across sites. Additionally, the local partnerships and collaboratives vary across sites, leading to inconsistent practices. AFLP provides opportunity to highlight best practices during monthly group calls with local implementing agencies and provides technical assistance to local agencies as needed. The AFLP team plans to continue efforts toward integrating standards and best practices regarding child development and parent education and support more consistently within the program

model

Objective 1: Strategy 3:

Assist MCAH LHJs to implement developmental screening, referral and appropriate linkages for all children using a parent-completed validated screening tool; provide technical assistance to improve provider, family and community outreach, and develop centralized telephone access and data collection processes.

During FY 2017-18, three of nine CDPH/MCAH-sponsored training webinars were held for local MCAH programs that were related to developmental screening. The webinars were coordinated by the MCAH contractor, UCSF Family Health Outcomes Project (FHOP). CDPH/MCAH continued to promote the use of 'Birth to 5: Watch Me Thrive,' 'Learn the Signs. Act Early,' and AAP resources during presentations, webinars, and calls.

During the Fall 2017, CDPH/MCAH worked with an intern to interview seven state Title V programs and pediatric provider organizations regarding their efforts to improve developmental screening. States with the highest developmental screening rates, such as North Carolina, Colorado, and Oregon, target multiple activities. Quality improvement by health care providers was a key activity in these states. Technical assistance, free resources, and incentive metrics were strategies for this key activity. Most states had deep collaborative partnerships with other organizations or projects, such as ABCD, Project LAUNCH, and with their AAP Chapters. Parent outreach was also used in a number of states utilizing online developmental screening tools and information, such as 'Learn the Signs. Act Early. Materials'. Key barriers included high caseloads for early intervention programs, leading to evaluation delays, and need to link data systems to track patient referral, evaluation, and interventions.

In August 2017, a [webinar](#) on the Alameda county collaboration between WIC and Help Me Grow using 'Learn the Signs. Act Early.' Campaign materials was held for local MCAH programs. There were 22 reported participants and 100% of respondents agreed or strongly agreed that the webinar helped to address an educational/training need.

In November 2017, DDS presented on Early Start (California's early intervention program) and its Early Start Neighborhood website during a [webinar](#) with local MCAH Programs. There were 22 reported participants and 100% of respondents agreed or strongly agreed that the webinar helped to address an educational/training need.

In February 2018, a [webinar](#) entitled, 'Developmental Screening in Medi-Cal Managed Care' was held for local MCAH programs. Speakers included CDPH/MCAH, DHCS

Medi-Cal Managed Care, and San Bernardino County MCAH program. The Healthcare Provider Developmental Screening Toolkit and Landscape Analysis as well as other resources (Learn the Signs. Act Early, Birth to Five: Watch Me Thrive, Help Me Grow, and AAP resources) were shared with the local MCAH programs. [San Bernardino county shared information on their successful intervention to improve developmental screening and referral in San Bernardino county](#), a collaboration between the local MCAH program, the Child Health and Disability Prevention (CHDP) program, the local Medi-Cal Managed Care health plan (Inland Empire Health Plan), and local Regional Center. There were 70 participants; 100% of respondents agreed or strongly agreed that the presentation helped them to better understand developmental surveillance, screening and AAP recommendations. 99% agreed or strongly agreed that they learned about a local county collaborative to improve developmental screening and how their county might implement a similar program. 91% of respondents agreed or strongly agreed that the webinar helped to address an educational/training need.

In April 2018, a [webinar entitled, 'Setting up a Help Me Grow Call Center/Central Access Point](#) for Local MCAH Programs' was held for local MCAH programs. There were 45 reported participants; 95% agreed or strongly agreed that they learned about the unique processes to set up such a central access point; 95% found it helpful to learn about the barriers and challenges.

The local MCAH jurisdictions are required to follow AAP guidelines for developmental screening, promote AAP-recommended preventive visits, and to adopt protocols/policies to screen, refer, and link all children in MCAH home visiting or case management programs. Since 2016, in the MCAH Policy and Procedures Manual, there are guidelines for LHJs to create locally specific protocols to link all MCAH clients to health insurance and preventive visits.

LHJs were encouraged to collaborate with partners that have an interest in this work such as First 5, local CCS programs and other local children' advocacy groups in order to leverage resources and create systemic, collective impact changes.

LHJs conducted activities to improve rates of developmental screening and improve timely early intervention for children with special needs. Examples include:

City of Berkeley:

- The City of Berkeley's "BE A STAR" Program aims to identify and support children birth to age five and their parents who are at risk of childhood development challenges. BE A STAR (Behavioral-Emotional Assessment, Screening, Treatment, and Referral) Program works with local partners to:

- Educate parents on the importance of developmental screening
- Engage parents as partners in their child's healthy development
- Provide developmental screening for children ages birth to five
- Assist families with accessing parent education workshops, community support programs and other services
- Train and offer consultation to Public Health Nurses and pediatric providers who want to screen children in their practice
- Make available to providers and families resource materials.

A total of 1,280 ASQs were completed from Berkeley Unified School District (BUSD) [n=287], Berkeley pediatric sites [n=993], and by public health nurses [n=14]. This resulted in a total of 181 referrals, with 235 children scoring in the “of concern” range and 309 scoring in the “monitoring range.”

Lassen County:

The Lassen County Health Education Advocate Resource Training Screenings (HEARTS) program shares developmental screening tools (ASQ3 and ASQ-SE) during WIC outreaches with families. The HEARTS program also communicates regularly with our clinics to assure completion of developmental screens for all children as recommended. The HEARTS program scores the completed developmental screens from both WIC and the local clinics and makes appropriate referrals based on the results of the screens (e.g., Regional Center, Lassen County Office of Education and Pathways to Child and Family Excellence). Our program provides parenting and child development education and school readiness activities to support the children’s ages and stages. There were 200 ASQ3s and 14 ASQ-SEs scored through the program with three children referred to Pathways. The HEARTS program also has a 1-800 line for connecting community members to services and follows up to make sure the families follow through with referrals. They provide care coordination for perinatal women to receive needed services such as mental/behavioral health services, substance use, smoking cessation, pregnancy crisis center, parenting classes, breastfeeding support and Early Head Start. Forty perinatal women accepted 58 referrals for various services.

Napa County

The Early Childhood Social Emotional Wellness (ECSEW) Collaborative has been active since 2011 working towards planning, developing, and implementing a coordinated system of early childhood mental health care that includes universal developmental and social-emotional screening, collaboration across sectors, centralized access, and a system-wide data collection system. A subcommittee of this group is working on implementing universal developmental screening using the ASQ for childcare and preschool settings. A number of agencies (e.g., Early Head Start, Kaiser,

MCAH, home visiting programs, behavioral health) are already using the ASQ and ASQ-SE as well as other screening tools. From July 2017 through June 2018, Parents Can completed 104 ASQ screenings and, through its staff at a large pediatric practice, completed 130 more ASQ screenings. In 2017-18, MCAH completed 126 ASQs and 48 ASQ-SEs. All children with a score of concern are referred and assisted with navigating the early intervention system. In 2017-18, the Napa Infant and Preschool Program (NIPP), Napa County Office of Education's early intervention program) received 264 referrals for its infant program and 190 qualified were served by the program; the Napa Preschool program received 245 referrals and 183 children were qualified and served by the program. The local MCAH program received 337 referrals to the PHN for linkage and services, as well as 87 additional referrals to its multi-county collaborative.

Based on a 2017-18 survey of local MCAH programs, adoption of the core components of Help Me Grow by 61 LHJs was reported as follows:

52 LHJs had an updated resource directory for families with children at risk for developmental or behavioral health concerns; 49 LHJs had educational or informational materials targeting medical providers to conduct developmental screening; 41 LHJs maintained a designated phone number, warm line or hotline for parents guardians, pediatricians, social service agencies or organizations to call; and 42 LHJs collected information on the number of children that have been screened for behavioral or developmental concerns and linked to services. In all, 53 LHJs have adopted at least two of the components of the developmental screening protocol.

In the 2017-18 Year End survey, MCAH assessed the types of resources and services available in local communities to screen children for developmental and behavioral health concerns. 42 MCAH LHJs reported that 1,427 children who screened positive for developmental or behavioral concerns were linked or referred to services.

HMG is a national initiative and the core components are evidence based:
<http://helpmegrowca.org/index.php/resources/resources-and-references/>

Challenges for this strategy

It is important to note that, due to their organizational structure, funding, and available resources, not all LHJs see clients, are able to develop a data system and may lack the resources and capacity to implement these policies fully.

Staff turnover at the state and local level creates a knowledge gap and leads to delays

in progress in implementing SOW activities and participation on collaboratives.

LHJs state that providers are reluctant to screen for developmental delays due to barriers to referrals for additional evaluation, including lack of local resources, long waiting time for services, or limited knowledge of where to refer a child who screens positive.

DRAFT

Child Health – Application Narrative (FY 2019-20)

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

Surveillance: CDPH/MCAH will review the national performance and national outcome data included in the Federally Available Data report prepared by MCHB and made available to states by May 2019. Meanwhile, throughout FY 2019-20, CDPH/MCAH will monitor select quantifiable characteristics to track the health of California children as part of its routine health surveillance efforts. The following select indicators and measures listed in the table below are continuously and systematically collected, analyzed and interpreted to guide program planning, implementation, and evaluation of interventions. These indicators will be analyzed at the state and sub-state levels to identify specific improvement opportunities.

Select Child Health Indicators and Measures	Data Source
Referral to preventive services	2018 AFLP and Local MCAH program data
Preventive medical visits	2017 National Survey of Children’s Health
Developmental screening	2017 National Survey of Children’s Health; 2017 California Health Interview Survey
Hospitalizations- motor vehicle, mental health, substance use	2017 CA Patient Discharge data
Living in foster care	2018 CA Child Welfare Indicators Project
Population size	State Population Projections, CA Dept. of Finance
Insurance Status	2017 American Community Survey

Objective 1:

By June 30, 2020, increase the rate of children ages 9 months through 35 months screened for being at risk for developmental, behavioral and social delay, using a parent-completed standardized developmental behavioral screening tool during a healthcare visit from 22.4 percent (2016-2017 National Survey of Children’s Health (NSCH) to 26.9 percent.

Objective 1: Strategy 1:

Collaborate with relevant partners to strengthen systems to improve rates of behavioral, social, and developmental screening of children ages 9 months through 35 months.

- Adolescent Family Life Program (AFLP) will continue to provide training and technical assistance for locally implementing sites to continue case management efforts to coordinate and collaborate with relevant partners to improve rates of developmental screening.
- CDPH/MCAH will continue to meet with DHCS MCMC to discuss assessing and encouraging local MCMC health plans to work with health care providers to improve reporting of developmental screening to the health plans and encourage use incentives to improve developmental screening rates.
- CDPH/MCAH will begin to explore with DHCS MCMC the possible incorporation of an additional child health-related quality measure (e.g., developmental screening, school readiness) with the Medi-Cal managed care health plans.
- CDPH/MCAH will continue to participate in and fund (along with the Department of Developmental Services [DDS]) the California Statewide Screening Collaborative (SSC) and will work with members of the SSC to improve developmental screening in California and further disseminate the health care provider developmental and behavioral screening toolkit.
- CDPH/MCAH will explore with the SSC and its members current needs and how family engagement can be incorporated within the SSC.
- CDPH/MCAH will collaborate with DDS to promote DDS resources and other identified resource tools to improve the social-emotional development of young children with its local programs.
- CDPH/MCAH will continue to coordinate and collaborate with the UC Davis Medical Investigation of Neurodevelopmental Disorders (MIND) Institute on its annual meeting and other technical assistance and outreach related to developmental screening and neurodevelopmental disorders.
- CDPH/MCAH will continue to participate in the CDPH California Health Interview Survey (CHIS) Workgroup to assess whether additional questions related to developmental screening can potentially be added or modified to be consistent with the National Survey of Children's Health (NSCH).
- CDPH/MCAH will continue to participate in the UCLA CHIS Child Development Technical Workgroup committee along with the State First 5 staff to assess the

methodological issues surrounding questions related to developmental screening and referrals within the systems of care, specifically after identification of children who might be at high-risk of developmental delay. The current survey contains questions funded by State First 5 related to referrals about general concerns for child development and referrals for speech, language and hearing testing.

- CDPH/MCAH will analyze and review the updated CHIS and NCHS data regarding developmental screening using the new objective (NPM 6). The age range was changed from 10 months-5 years to 9-35 months per HRSA guidance to align with the AAP/Bright Futures screening recommendations.
- CDPH/MCAH will explore the possibility of participating in the NSCH oversampling, an option that will begin with the 2020 NSCH. Additional sample or increasing the number of completed interviews per state may support the analyses of smaller populations, rare outcomes or ability to produce county-level estimates with the goal of informing policy and programmatic efforts that are county-specific driven.
- CHVP will continue to collaborate with early childhood partners through co-leadership of the State Interagency Team (SIT) workgroup to help identify opportunities to overcome systems barriers, with the goal of helping home visiting families receive needed services. The California Department of Social Services, California Department of Education, WestEd Center for Prevention & Early Intervention, CA Head Start Association, First 5 LA and Family Resource Centers Network of California, are some of the partners that participate in the SIT workgroup.
- CHVP will continue to provide guidance to local CHVP sites on the development and maintenance of a Community Advisory Board (CAB) that promotes a community support system for home visiting programs and the local early childhood system of services. Local CHVP sites will continue to convene a CAB that serves in a consultative and/or governing capacity in the planning and implementation of program-related and systems-integration activities. This will include collaboration with their Regional Centers, schools, hospitals or any local agency that provides services to children with behavioral, social, and developmental needs.
- The DHCS IHP will implement home visitation activities to improve developmental screening and infant mental health, including providing health education by American Indian paraprofessionals to pregnant American Indian women to improve maternal-child health outcomes.

- The DHCS-IHP case management program will seek to promote healthy child growth and development by supporting maternal mental health, educating on the importance of bonding/attachment, and promoting maternal-child bonding.
- Through local community developed projects, Indian health programs will conduct needs assessments to identify gaps in services for American Indian women and infants and implement interventions that address identified needs of American Indian women and infants. Local projects to address this strategy could include staff training on maternal and infant mental health. Activities under this strategy may also include workforce development for staff to address identified issues that support developmental screening.

Objective 1: Strategy 2:

Collaborate with relevant partners to strengthen systems to improve referrals and linkage to needed services for all children and youth, especially children birth through five years and at-risk populations.

- CDPH/MCAH will continue to actively participate in the SSC and will work with members of the SSC to identify barriers and identify opportunities to improve timely referrals and linkage to early intervention services after a positive developmental screen.
- CDPH/MCAH and SSC will assess current data on referrals to early intervention and local models and processes from local Regional Centers in California to identify areas for improvement.
- CDPH/MCAH will work with the SSC to assess available county pediatric behavioral/mental health resources.
- CHVP will continue to use the ASQ-3 to screen for developmental delays in their clients and refer them to external agencies for evaluation and services if the screen is positive.
- CHVP will continue to improve the referral process (started in October 2017) to early intervention with local programs. CHVP will continue to use following the developed tools and provide guidance through TA calls and webinars. The tools include:
 - Decision Trees: These provide instructions to home visitors for completing the required forms. They help home visitors understand how to report their referral efforts accurately in the data management system.

- Referrals-to-Services Tracking Report: These tracking reports will help local teams use their data to determine if their referrals process is improving and to follow-up on outstanding referrals.
- Referral Monitoring Tool: This tool allows home visitors to track positive screens, get real time action steps and due dates for follow-up. This tool also gives the supervisors the ability to track home visitors' progress toward completion of referrals.
- CHVP will continue to collect information about children who were read to, told stories to, and/or sang songs with every day during a typical week. This information will be obtained by interviewing the parent and recording the response on a form.
- The DHCS-IHP home visitation activities to address this strategy would include providing health education, support services such as education on infant developmental stages, screening babies using an evidence-based developmental assessment tool, facilitating prompt referrals for needed follow-up, and assisting with referrals for infant mental health.
- Through local community developed projects, Indian health programs will conduct needs assessment to identify gaps in services for American Indian women and infants, including improvement of clinic referrals.

Objective 1: Strategy 3:

Provide technical assistance to MCAH programs to implement their SOW, promote the use of Birth to 5: Watch Me Thrive! or other appropriate materials, develop protocols to screen and refer all children in MCAH home visiting or case management programs to early intervention services and develop quality improvement plans to ensure CYSHCN are identified early and connected to needed and ongoing services.

- MCAH will work with CHVP to examine use of their new tools to improve referrals and evaluation for early intervention for potential sharing with other home visiting programs.
- CDPH/MCAH will continue to provide education and technical assistance related to developmental screening, referral and linkage to services for our state MCAH programs (e.g., BIH, AFLP, CHVP), as needed.
- MCAH will work with its programs to review current data on developmental screening and referrals as well as review current program efforts to promote

healthy brain development and attachment in the infants/young toddlers within the programs.

- CDPH/MCAH will update its website to include up-to-date information on developmental screening and resources to promote positive social-emotional development.
- AFLP case managers will continue to provide child development and parenting education, which includes use of validated early childhood developmental screening tools (e.g. ASQ, ASQ SE), education on positive parenting, and identification of a source of preventive and primary care for the client and his/her child.
- AFLP case managers provide anticipatory guidance and education regarding importance of developmental screening and well child visits. Case managers will model appropriate parenting skills and refer youth to parenting classes or other resources.
- The AFLP team will work to align program activities with other MCAH programs to ensure consistency and integration of best practices.
- AFLP will continue to provide education, resources for case management, and technical assistance on improving developmental screening, referral and linkage to services to other local and state MCAH programs as needed.
- The Black Infant Health (BIH) Program will continue to implement information related to child development during session 12 of the BIH Group Curriculum. BIH will also encourage participants to have the discussion around the ASQ with their pediatrician during well-child visits. “Learn the Signs” handouts will continue to be available during well-child visits as well as looking at the possibility of recommending other handouts that can be part of session 12 in the Group Curriculum.

Objective 1: Strategy 4:

Assist MCAH LHJs to implement developmental screening, referral and appropriate linkages for all children using a parent-completed validated screening tool; provide technical assistance to improve provider, family and community outreach, and develop centralized telephone access and data collection processes.

- MCAH will continue to support LHJs regarding local implementation of Help Me Grow or programs that promote the core components of Help Me Grow (pediatric

health care provider outreach, family/community outreach, central access point/call center, and data collection/analysis).

- CDPH/MCAH will continue to encourage LHJs to collaborate with partners, such as First 5, local CCS programs, local children's programs or organizations, Regional Centers, Family Resource Centers, and families to leverage resources, understand systems and gaps, and create systemic collective impact changes.
- CDPH/MCAH will provide technical assistance, best practices, and/or evidence-informed resources and tools to LHJs individually, via conference calls and/or webinars to help LHJs implement their SOW requirements on developmental screening and linking clients to services, health insurance, and preventive health care visits.
- The AFLP team will continue to align program activities with all MCAH programs for child developmental screening, referral and service linkage to ensure consistency and integration of best practices.
- AFLP case managers will continue to work with youth in the program to:
 - Provide child development and parenting education, which includes use of validated early childhood developmental screening tools (e.g. ASQ, ASQ SE), education on positive parenting, and identification of a source of preventive and primary care for the client and her/his child.
 - Provide education regarding child development screening and well child visits
 - Model appropriate parenting skills and referred to parenting classes or other resources.

Priority 7: Increase access and utilization of social services.

Surveillance: Throughout FY 2019-20, CDPH/MCAH will monitor select quantifiable characteristics to track social determinants of health (SDOH) as part of health surveillance efforts. Monitoring these indicators help to engage diverse partners and stakeholders to work together and shape policies that address social, economic and environmental factors that promote health, health equity and sustainability.

Select SDOH indicators as listed in the table below will be continuously and systematically collected, analyzed and interpreted to guide program planning and implementation.

Select Social Determinants of Health	Data Source
Poverty	American Community Survey; Small Area Health Insurance Estimates
Economic stability-employment	CA Employment Development Department
Education- dropouts	CA Basic Educational Data Systems
Adverse Childhood Experiences	Maternal and Infant Health Assessment survey; CA Behavioral Risk Factor Surveillance
Food Access	Maternal and Infant Health Assessment survey; CA Health Interview Survey
Air Quality	National Environmental Public Health Tracking Network
Housing and Income Inequality	County Health Rankings
Family Stability	American Community Survey

To provide a greater depth in understanding the how SDOH correlate to health disparities, analysis of these key indicators and measures will include stratification by state and sub-state level, given the specific measure and the data constraints.

Objective 2:

By June 30, 2020, increase the rate of children ages 1-17 years who received a dental visit in the last year from 75.3 % (2011/12 NSCH) to 79.1 %.

Objective 2: Strategy 1:

Under the guidance of the CDPH State Dental Director, MCAH and the Office of Oral Health (OOH) will collaborate to implement the State's Oral Health Plan to identify priorities, goals, objectives and key strategies.

- CDPH/MCAH will collaborate with the OOH who will continue to support 61 LHJs with funding from Proposition 56, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Prop 56), to plan and implement oral health efforts within their jurisdictions.
- Local MCAH will receive technical assistance on implementation of key dental health access objectives such as establishing school-based and school-linked oral health programs and exploring the virtual dental home model as a possible strategy to increase access to services where children live, work, play, and go to school. Technical assistance will be provided by the OOH-funded California Oral Health Technical Assistance Center (COHTAC) at UCSF.

- The State Dental Director will continue to collaborate with DHCS in the implementation of the four Domains of the Dental Transformation Initiative (DTI), which aims to reach children and other MCAH priority populations. The DTI efforts include preventive dental services, caries risk assessment, continuity of care, and ensuring a dental home is established. The objectives for the DTI align with the Title V plan and the COHP.

Objective 2: Strategy 2:

LHJ staff informs all eligible and enrolled clients of currently available dental benefits offered by Medi-Cal promote the dental home and Medi-Cal warm transfer service through 1-800 customer service phone number or other referral services.

- Local health jurisdictions will implement their OOH local action plan to build capacity and recruit non-traditional partners and maintain a local advisory committee to identify strategies to identify successful strategies and address barriers and gaps for eligible and enrolled clients.
- OOH-funded COHTAC will assess training needs to assist LHJs in their outreach efforts and implementation of evidence-based or evidence informed interventions.
- CDPH/MCAH will collaborate with the OOH to share information with local MCAH program's on Medi-Cal Dental Services' new campaign, Smile, California, to increase member's use of Medi-Cal's dental benefit. Smile, California is an integrated member and provider outreach plan developed by the Department of Health Care Services and Delta Dental, Medi-Cal Dental's administrative services contractor, to improve overall performance of the program.
- CDPH/MCAH will collaborate with OOH to ensure that oral health activities align with the Title V Action Plan and the COHP and that efforts are complementary and not duplicative.
- OOH and Medi-Cal Dental Services (MCDS) will assess current data to determine if specific outreach interventions are effective and identify gaps, strategies or recommendations for improvement.
- AFLP case managers will continue to work with youth in the program to assess needs and provide linkage and ongoing case management support for indicated medical and dental services.

Objective 1: Strategy 3:

Under the guidance of the CDPH State Dental Director, MCAH and the Office of Oral Health (OOH) will collaborate to implement the newly funded Local Oral Health Programs and pursue a coordinated system involving various State Programs that serve children's dental needs.

- The LHJs will continue to determine if identified strategies address vulnerable children. In addition to school-based/school-linked programs, and dental sealant programs, other interventions such as community water fluoridation, promoting dental visits by age one, and access to fluoride varnish by non-dental providers will be among those selected for implementation.
- OOH will continue to collaborate with MCAH programs to provide information and education regarding best or promising practices, establishing communities of practice, and identify opportunities for collaboration.
- The state AFLP team will provide local AFLP sites with information and share resources regarding the funded Local Oral Health Programs in order to facilitate use of the local resources within local case management services.

Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active lifestyle.

Objective 3:

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

Objective 3: Strategy 1:

Improve capacity for nutrition and physical activity for children through collaboration and technical assistance, especially by sharing science-based resources such as new nationally recognized guidelines and initiatives as well as trainings and funding opportunities with LHJ MCAH directors and MCAH funded program contacts.

- CDPH/MCAH will update links and resources on MCAH/Nutrition and Physical Activity (NUPA) Initiative page, including the Systems and Environmental Changes toolkit to support optimal nutrition, physical activity, and breastfeeding through fostering partnerships between LHJ MCAH

programs and existing organizations to promote healthy environmental changes.

- CDPH/MCAH will utilize MCHB funded technical assistance from UCLA to promote Policy, Systems and Environmental change for nutrition and physical activity.
- California will promote the EMSA Childcare Nutrition web page that MCAH was a partner in developing in a CoIIN process. MCAH will continue to maintain relationship with the ASPHN, including their MCAH nutrition and their obesity councils.
- MCAH will identify or develop and disseminate information and tools through key partners (CDPH/Nutrition Education and Obesity Prevention Branch [NEOPB], WIC CDE, Systems of Care, EMSA) to help low-income children meet the dietary guidelines for Americans. MCAH will continue to promote national guidelines on weight, nutrition and physical activity for young children by collaborating with CDPH/NEOPB.
- CDPH/MCAH will promote a two question validated screening tool for food security as recommended by AAP:
 - Within the past 12 months, we worried whether our food would run out before we got money to buy more (Yes or No)
 - Within the past 12 months, the food we bought just didn't last and we didn't have money to get more. (Yes or No)
- CDPH/MCAH maintains a relationship with the national and California Association of State Public Health Nutritionists (ASPHN), especially their MCAH nutrition and their obesity councils. MCAH will identify or develop and disseminate information and tools through key partners (CDPH/NEOPB, WIC, CDE, DHCS Integrated Systems of Care, EMSA) to help low-income children meet the USDA dietary guidelines. MCAH will continue to promote national guidelines on weight, nutrition and physical activity for young children by collaborating with CDPH/NEOPB's Early Childhood Education initiative. For example, CDPH/NEOPB may be providing training and materials on "Rethink Your Drink," to promote more water intake and reduced sugar containing beverages. A CDPH/MCAH staff will continue to participate at bimonthly meetings held by CDPH/NEOPB.
- CDPH/MCAH staff will attend and network at the 2020 state WIC Conference.
- The AFLP state team will continue to provide education, resources for case management, and technical assistance related to nutrition and physical activity for children and youth, including sharing science based resources.

- AFLP case managers will continue to support expecting and parenting youth with leading physically active lifestyles through education, referrals and goal planning regarding nutrition, physical activity and breastfeeding. Through one-on-one education, referrals and goal planning, case managers provided evidence informed and medically accurate materials to raise awareness and support youth with promoting their health and wellbeing.

DRAFT

CYSHCN Health – Annual Report (FY 2017-18)

CDPH/MCAH partners with the California Department of Health Care Services, Integrated Systems of Care Division (DHCS/ISCD) and local MCAH programs to promote developmental screening, improve local systems for referrals and linkages to needed services, increase access to primary and specialty care, and support provision of high quality health care including medical home and transition services for Children and youth with special health care needs (CYSHCN).

CYSHCN include infants, children and youth from birth to age 21 who have or are at increased risk for one or more chronic physical, developmental, behavioral or emotional conditions and require special health and support services beyond that required for infants, children and youth in general.⁵² The U.S. Health Resources and Services Administration, Maternal and Child Health Bureau, estimates (via the aggregated 2016-2017 National Survey of Children's Health) that 14.1 percent (95% CI: 11.5-17.1) of California children aged 0-17 have special health care needs. This translates to about 1.3 million children ages 0-17. However, due to low rates of developmental screening along with issues in reporting and data quality, it is likely that the true percentage of children and youth with special health care needs is higher than this estimate.

Although not statistically significant, the proportion of Hispanic children with special health care needs is higher at 15.2 percent (95%CI: 11.2-20.4) than the proportion of White children with special health care needs at 12.9 percent (95%CI: 9.6-17.2). The data for Black children with special health care needs appears much higher at 25.7 (95%CI: 12.9-44.7) but this estimate should be interpreted with caution as the confidence interval width exceeded 20 percentage points. The percentage of children with special health care needs in households with income below the poverty level is 5.1 percentage points higher than households with income at 400 percent FPL or greater (17.3% and 12.2%, respectively). The percent of children with special health care needs who have a medical home is 42.2 percent (95% CI: 32.3-52.8); however, this estimate should also be interpreted with caution as the width of confidence interval exceeded 20 percentage points and may not be reliable. Similarly, data on adolescents ages 12-17 with special health care needs who received services necessary for transition to adult health care (16.4%; 95%CI: 8.3-29.7) also need to be interpreted with caution as this estimate has a 95% confidence interval width exceeding 20 percentage points or 1.2 times the estimate and may not be reliable.

Overall, data quality has been a substantial challenge in accurately assessing the strength and availability of services as well as needs of this population. There is a need

⁵² McPherson et al (1998) Pediatrics 102/1.

for expanded data availability and reliability, particularly in the areas of medical home, transition, and being able to access stable estimates by race/ethnicity.

California's Title V program provides 30% (about \$11 million) of our block grant funding to support CYSHCN. A portion of the total Title V funding that the California Department of Public Health, Maternal and Child Health Division (CDPH/MCAH) receives for CYSHCN is allocated to California Children's Services (CCS), a state program designed to provide services to children and youth with the most medically complex health care needs. Currently, about 60% of the \$11 million supports the CCS program, while the remaining 40% is allocated to local MCAH programs and also provides support for state level coordination, information-gathering, and leadership.

The CCS program is administered by the Department of Health Care Services, Integrated Systems of Care Division as a partnership between county health departments, health plans, and DHCS. DHCS/ISCD also administers a number of other programs to meet the needs of CYSHCN. These programs, which do not receive funding from Title V but are nonetheless relevant for the overall picture of services available to the CYSHCN population in California, are described below.

The Medical Therapy Program is special program within CCS that provides physical therapy, occupational therapy, and medical therapy conference services for children with disabling conditions, generally due to neurological or musculoskeletal disorders. The High Risk Infant Follow-up Program identifies infants who may develop CCS-eligible conditions after discharge from a CCS-approved Neonatal Intensive Care Unit (NICU) and provides diagnostic services for children up to three years of age. The Child Health and Disability Prevention Program is a preventive program that delivers periodic health assessments and services to low income children and youth. The Health Care Program for Children in Foster Care is a public health nursing program located in county child welfare service agencies and probation departments that provides public health nurse expertise in meeting the medical, dental, mental and developmental needs of children and youth in foster care.

MCAH and ISCD are committed to working in close collaboration to meet the diverse needs of all CYSHCN throughout the state, through family engagement, increasing access to and quality of care, and improving systems of care at the state and local level. Both MCAH and ISCD are building efforts towards formalized family engagement. Some recent examples include partnering with Family Voices of California on a team action planning process coordinated by the National Center for Family-Professional Partnerships. Additionally, beginning in July 2018, ISCD implemented a contract with Family Voices of California to increase awareness and participation in activities that engage families into partnership with systems and services.

California's Title V program is currently engaged in a year of learning to connect with stakeholders, build partnerships, and expand our knowledge about the greatest needs and opportunities to support CYSHCN and their families. The information we gain will be integrated with priorities from the local MCAH program needs assessments to inform our state needs assessment and plan for 2020-2025. As local, state, and federal priorities for serving CYSHCN evolve, MCAH is committed to working closely and effectively with partners to respond proactively and ensure high-quality systems and services for CYSHCN and their families.

The majority of this year of learning is taking place during the 18-19 fiscal year and will be covered in next year's report. However, some activities began during 17-18 and are summarized below.

In March 2018, a new position was filled within CDPH/MCAH for a Project Director to guide and oversee CYSHCN efforts within MCAH as well as activities funded through our partnership with DHCS/ISCD. This position is the first within MCAH to have a full-time focus on CYSHCN and was created in response to growing recognition of the need to prioritize this population and structure CYSHCN efforts effectively.

Also in March 2018, the new CYSHCN Project Director and MCAH Division Pediatric Medical Officer attended a training presented by the National Center for Family-Professional Partnerships, hosted by Family Voices of California, on Leading by Convening.

Between March 2018 and the end of the fiscal year (and ongoing since then), the CYSHCN Project Director and Pediatric Medical Officer have scheduled meetings and calls with numerous stakeholders and experts to build relationships and gain expertise on existing systems and priorities for CYSHCN and their families. These stakeholders include: the California Perinatal Quality Care Collaborative and the Stanford University School of Medicine; the Lucile Packard Foundation for Children's Health; pediatricians with the University of California, San Francisco, and University of California, Davis; the National Academy for State Health Policy; and others.

In addition, in spring 2018 a Masters student at UC Berkeley interned in the MCAH Division and completed a number of interviews with other state's CYSHCN Directors on innovative practices in their state Title V-funded CYSHCN programs. As part of her capstone project, she produced a report of her findings, which later became the basis for a webinar shared with stakeholders in August 2018.

In early May 2018, MCAH convened a diverse group of stakeholders including state agencies, non-profit foundations, health care providers, family representatives and others to begin our year of learning and bring partners on board to our planning process

around CYSHCN. Meeting objectives included: assessing strengths, needs and gaps in services and support available to CYSHCN; identifying key partners and developing strategies for ongoing engagement; and starting the conversation around priorities related to access to specialty and support services, medical home and transition to adult care. Meeting feedback was overwhelmingly positive, and we continue to be in regular contact with our stakeholders. A national expert, Karen VanLandeghem from the National Academy for State Health Policy, presented at the meeting on the background of Title V CYSHCN programs and promising practices from around the country. Also in May 2018, MCAH presented at a meeting of local MCAH programs from all the local health jurisdictions in California to share initial updates from the stakeholder meeting and next steps for MCAH's CYSHCN-focused efforts. In addition, throughout the 17-18 fiscal year, MCAH provided a number of training and technical assistance opportunities for local MCAH programs on various CYSHCN topics including strategies for engaging parents, setting up a Help Me Grow central access point, and peer learning from best practices in other local MCAH programs.

Over the past year, a substantial investment has been made in learning, building relationships, and planning to improve California's Title V CYSHCN efforts. While still a work in progress, the CYSHCN objectives and activities have been substantially updated and refined with our partners at the Department of Health Care Services to ensure clarity, recognition of data challenges, and a collaborative working relationship in our effort to improve services for CYSHCN across the state. These changes are reflected in the 19-20 plan.

Priority 4: Provide high quality care to all CYSHCN within an organized care delivery system.

Objective 1:

By June 30, 2020, increase the children enrolled in CCS who receive primary and specialty care through a single system of care by 10%.

Objective 1: Strategy 1:

Refine the selected whole-child approach to optimize access to qualified providers.

Senate Bill (SB) 586 authorized DHCS to establish the Whole Child Model (WCM) program in designated County Organized Health System (COHS) counties to incorporate CCS program-covered services for Medi-Cal-eligible CCS program children and youth into a Medi-Cal managed care health plan contract. A beneficiary must meet financial, residential, and medical requirements to be eligible for the CCS program. The

WCM is briefly described as an organized delivery system that will provide comprehensive, coordinated services for children and youth with special health care needs through enhanced partnerships with COHS that will improve access to care for CYSHCN and their families. This approach is consistent with the primary goal of providing comprehensive treatment and focusing on the whole child/youth, including the child/youth's full range of needs rather than only CCS health condition(s) such as: cerebral palsy, sickle cell, cystic fibrosis, cancer, diabetes, leukemia, and hemophilia.

A stakeholder Advisory Group comprised of CCS providers, county CCS administrators, health plans and community/advocacy organizations provides expertise in the care of CYSHCN in the WCM. The goals of this stakeholder process include maintaining a patient- and family-centered approach, providing comprehensive treatment for the whole child/youth, improving care coordination through an organized delivery system, improving quality of care, streamlining care delivery, and maintaining cost neutrality. DHCS is implementing WCM in 21 COHS counties.

In preparation for WCM implementation on July 1, 2018, DHCS held implementation-planning meetings with health plans and counties, working with counties to finalize the WCM Allocation Methodology and issuing the Memorandum of Understanding guidance to health plans and counties.

DHCS ISCD maintains and updates the CCS Program standards for Hospitals, Pediatric Intensive Care Units (PICUs), Neonatal Intensive Care Units (NICUs), and Special Care Centers through the facility site review process. CCS-approved PICUs participate in the Virtual Pediatric Systems database and CCS-approved NICUs participate in the California Perinatal Quality Care Collaborative-CCS data reporting system. Periodic reviews of data enables CCS to perform statewide benchmarking and quality improvement (QI), including addressing QI targeted to the needs of individual facilities.

Evidence-based and evidence-informed practices utilized for this strategy

The WCM is an organized delivery system that provides comprehensive, coordinated services for children and youth with special health care needs through enhanced partnerships with County Organized Health System health plans. This approach, based on the evidence-based practice of the medical home, is consistent with the primary goals of providing comprehensive treatment and focusing on the whole child/youth, including the child/youth's full range of needs rather than only on the CCS health condition.

Challenges for this strategy

Several requirements, such as readiness and deliverables submission, need to be fulfilled by the health plans, counties, DHCS and the CCS Program in the identified WCM counties prior to the initiation of implementation in July 2018. Regular communications continue to occur between the involved entities to ensure that the necessary steps are being addressed and completed.

Objective 1: Strategy 2:

Conduct and analyze surveys of CCS families and providers to assess satisfaction with organized care delivery system.

There were no activities during this time period. DHCS will be conducting provider and family surveys with the upcoming 5-Year Needs Assessment.

Objective 2:

By June 30, 2020, increase the number of CYSHCN who receive care within a medical home by 10%, as measured by the medical home CCS performance measure.

Objective 2: Strategy 1:

Review existing national, state, and local medical home models and tools and identify best methods for CCS to promote medical homes for CYSHCN.

Strategy 1 was completed in FY 2015-16 with no further action needed.

Objective 2: Strategy 2:

Develop and disseminate materials to facilitate implementation of tools that promote medical homes.

Strategy 2 was completed in FY 2015-16 with no further action needed.

Objective 2: Strategy 3:

Increase the number of counties with a family advisory council, parent health liaison family-centered care workgroup or other role supporting CYSHCN.

DHCS convened the Performance Measures Technical Workgroup in February and March 2017 to standardize and align performance measures across CCS programs. The finalized measures included one on family participation in the CCS program and another on informational trainings for increasing awareness and participation in activities that engage families. Building on the work in 2017, DHCS convened the

Performance Measures Quality Subcommittee in January to June 2018 to discuss technical specifications for standardized data pulls for the performance measures established by the work of the Performance Measures Technical Workgroup in 2017. The details of the measures were discussed and a final list was determined. The family engagement proposed measures involve the implementation of separate annual surveys for family satisfaction and family participation. The latter incorporates trainings for increasing awareness and participation in activities that engage families. The subcommittee developed a technical specifications document that is going through the DHCS approval process.

Examples of family engagement include participation on advisory committees, task forces, or family advisory councils, and family advocacy, either as a private individual or as part of an agency advocating family-centered care, wherein family members with experience with CYSHCN needs are contracted to provide family perspective and experience relative to navigating the health care delivery system. Under the WCM, health plans are required to create and maintain a family advisory council.

DHCS ISCD finalized efforts to develop a Title V Family Delegate position by collaborating with Family Voices of California (FVCA) and developing a scope of work (SOW) for the proposed position. The SOW includes providing culturally appropriate outreach materials to CCS families enrolled in the WCM to assist them in navigating services and benefits; providing educational trainings to Family Resource Centers and families on the WCM; providing support to WCM families; collaborating with CCS on the design and implementation phases of needs assessments, strategic planning, annual reporting, public comment processes, and review of policy documents and outreach/educational materials; providing family experience input and perspective at CCS Advisory Group meetings and workgroups; and building and strengthening family and CCS county partnerships through participation, upon request, as the family representative on Medi-Cal managed care plan local advisory committees. The FVCA contract start date is July 1, 2018.

Evidence-based and evidence-informed practices utilized for this strategy

California's Title V Program seeks to align with the goals of the federal Title V funding; to provide "family-centered, community-based systems of coordinated care for CYSHCN," with family-centered services defined as "the partnership between families and professionals at all levels working together for the best interest of the child and the family."⁵³ MCAH and DHCS are committed to building our capacity to support authentic

⁵³ *Family Engagement in Title V*, published by AMCHP, May 2015.
<http://www.amchp.org/programsandtopics/family->

family/professional partnerships through engagement and diverse representation of families at the state and local level.

Challenges for this strategy

CCS currently uses the identification of a primary care provider as the proxy measure to ensure that CCS beneficiaries have a medical home. Consistent and reliable data reporting from all 58 counties is challenging to the State.

Objective 3:

By June 30, 2020, increase by 20% the number of 20-year-old CCS clients with a transition plan of care documented by CCS county staff.

Objective 3: Strategy 1:

Identify county CCS transition strategies and best practices.

ISCD continues to collaborate with Medical Managed Care Quality and Monitoring Division (MCQMD) on facilitating transition to adult services for CYSHCN. County CCS programs with robust transition programs provide input to ISCD on transition planning and communications with managed care plans regarding transition. ISCD has also discussed transition planning with county directors of the Medical Therapy Program, which serves clients with cerebral palsy and other movement disorders.

CCS counties engage in a variety of practices pertaining to transition services, including transition fairs and using county CCS parent liaisons and navigators that work with families to identify pertinent community resources. Counties implement transition planning, readiness assessment, and guidance on conservatorship. They have regular meetings with health plans and other community-based organizations to identify physicians and services for CCS clients as they transition to adulthood.

Evidence-based and evidence-informed practices utilized for this strategy

Transition practices and policies are based on evidence-based interventions of the Six Core Elements of Health Care Transition (version 2) available at www.gottransition.org

Challenges for this strategy

Consistent and reliable data reporting from all 58 counties is challenging to the State.

[engagement/ToolsandResources/Documents/FamilyEngagementinTitleV.pdf](#).

Objective 3: Strategy 2:

Increase the number of family members providing input into the development of state and local transition practices and guidelines.

CCS works with counties to increase family and youth input in transition policies by encouraging family and youth participation in transition planning and/or Special Care Center team meetings, participation in advisory committees or task forces, providing feedback regarding satisfaction with services, and/or serving as family advocates.

In January 2017, ISCD implemented a survey on transition services targeting county CCS administrators to understand local achievements and areas needing improvement. The data gathered from the survey provided information on transition practices and service gaps in the counties, including whether CCS programs were obtaining input from family members on transition policies. The survey questions were developed based on information on transition processes shared by counties and input from ISCD and MCQMD. Further input from families on transition practices will be obtained during the upcoming Needs Assessment.

Evidence-based and evidence-informed practices utilized for this strategy

Transition practices and policies are based on evidence-based intervention of the Six Core Elements of Health Care Transition (version 2) available at www.gottransition.org.

Objective 3: Strategy 3:

Identify options to track that CCS clients completed a visit with a managed care adult physician.

CCS county programs have indicated that barriers exist to transitioning CCS clients to managed care physicians as they age out of CCS services. These barriers include the limited number of adult providers willing to accept clients with complex medical needs; adult providers not accepting new clients; lack of managed care plan contracts with adult providers; long waiting lists for specialists; and lack of local specialists for specific conditions.

CCS determined that tracking a completed visit by CCS clients to managed care adult physicians should be part of transition planning. Options for tracking include coordinating with the adult providers in the managed care health plans to document a completed visit; following up with parents; and using the electronic health record if applicable.

Evidence-based and evidence-informed practices utilized for this strategy

Transition practices and policies are based on evidence-based intervention of the Six

Core Elements of Health Care Transition (version 2) available at www.gottransition.org.

Challenges for this strategy

Consistent and reliable data reporting from all 58 counties is challenging to the State.

Priority 5: Increase access to CCS-paneled providers such that each child/youth has timely access to a qualified provider of medically necessary care.

Objective 4:

By June 30, 2020, increase the percent of CCS families reporting that their child/youth always saw a subspecialist when needed from 72% to 90%, based on CCS/Family Health Outcomes Project (FHOP) data.

Objective 4: Strategy 1:

Identify barriers to access CCS-paneled providers.

To ensure that discharged babies from CCS-approved NICUs have adequate follow-up, the NICU discharge plan includes referral to the CCS High Risk Infant Follow-Up Program (HRIF), following determination of HRIF eligibility using specific medical criteria. HRIF ensures that there is a seamless referral to appropriate follow-up for these NICU babies, thus eliminating the issue of having to identify the appropriate follow-up provider when the patient does not have one.

The HRIF Quality Care Initiative (QCI) continues to use a web-based data reporting system established in 2009. Quality improvement opportunities for NICUs are identified pertaining to the reduction of long-term morbidity. The reporting system allows HRIF local programs to compare their activities with other sites throughout the state, enables assessment of site-specific successes, and supports real-time case management. Data are collected on high-risk infants up to their third birthday and linked with the CPQCC database to identify maternal and perinatal factors associated with child outcomes.

The HRIF summary reports provide information on the follow-up status of enrollees, demographic/social risk information, status of medical and special service needs, and neurologic and developmental outcomes. Infants discharged from CCS-approved NICUs with CCS-eligible medical conditions or who are at high risk to develop such conditions are followed in an HRIF Program. Three multidisciplinary outpatient visits are authorized by CCS up to age three to identify problems, provide and complete referrals, and monitor outcomes. HRIF works with parents to assist them in ensuring

return to follow-up by addressing issues such as barriers to transportation by working with a social worker, who is part of the HRIF team.

To assist in the delivery of preventive care for high-risk children, such as those in foster care, DHCS ISCD administers the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, known as the Child Health Disability Plan (CHDP). CHDP provides preventive services and referral to diagnostic and treatment services for Medi-Cal participants up to age 21. Uninsured children up to age 19 in households at or below 200% of the FPL can pre-enroll in Medi-Cal through the CHDP Gateway process.

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

The CHDP Program serves as technical advisors for health assessment schedules recommended by Bright Futures. It works with the Immunization Branch of CDPH to ensure that the administration of federally approved vaccines by Vaccines for Children providers is payable. The CHDP Program also supports follow-up referrals to dental providers.

Evidence-based and evidence-informed practices utilized for this strategy

Developmental screening and monitoring, as well as preventive screening are evidence-based practices.

Challenges to this strategy

A recent CCS Numbered Letter (policy letter) clarified the congenital heart disease eligibility criteria for HRIF after several questions were generated from an update of the HRIF Program and Numbered Letters. Constant communication, including data training webinars, provided prompt technical assistance to local HRIF Coordinators, ensuring the facilitation of eligible referrals.

Objective 1: Strategy 2:

Define and identify issues associated with access to durable medical equipment, pharmacy, home health and behavioral health providers.

Although CCS enrollees may be affected by issues that impact all Medi-Cal

beneficiaries with respect to access to durable medical equipment (DME), pharmacy, home health and behavioral health providers, local CCS programs and designated DHCS staff work to resolve barriers to care for individual enrollees as they occur. Local CCS programs frequently work with the county, regional, and statewide provider community in developing solutions to maintain the efficient authorization of needed services. As an example, in 2014, due to reimbursement rate issues, the major Medi-Cal DME vendors expressed their intent in writing to stop accepting authorizations for DME services for all CCS and Medi-Cal beneficiaries not previously authorized for DME. Local CCS programs worked to identify smaller active DME vendors willing to accept CCS authorizations and were able to maintain access to DME services until the major DME vendors withdrew their concerns.

Durable medical equipment and pharmacy services are accessible to CCS enrollees through the Medi-Cal Program's enrolled DME and pharmacy providers. Provider Enrollment Division (PED) is responsible for enrollment and re-enrollment of eligible fee-for-service providers into the Medi-Cal Program. One major activity performed by PED is to determine accessibility of providers to Medi-Cal beneficiaries, including CCS beneficiaries. PED instituted the PAVE (Provider Application and Validation for Enrollment) Portal, a web-based application system, greatly accelerating the provider enrollment process.

Keeping pace with changing pharmacy benefits resulting from newly approved and high cost medications is the greater challenge relative to maintaining pharmacy providers for the CCS program. The Medi-Cal Program's Pharmacy Benefits Division is the principal source of DME and pharmacy reimbursement policy, which extends to the CCS Program. The CCS Program provides additional policy and information directives to CCS county offices and to fee-for-service providers through publication of the CCS Numbered Letters and CCS Information Notices. For calendar years 2017 and 2018, there have been 20 published numbered (policy) letters and 4 information notices. In addition, Medi-Cal Program publishes monthly or bimonthly provider bulletins, including for DME and pharmacy providers, and as needed NewsFlash publications in the Medi-Cal website. Providers as well as interested public/organizations/individuals may subscribe to the Medi-Cal Subscription Service (MCSS) for email updates to the latest Medi-Cal news/changes.

CCS medical eligibility does not include behavioral/mental health disorders. However, mental health services are a CCS benefit for the evaluation and treatment of a mental health problem when the requested service:

- Assesses and/or treats a mental health problem that interferes with, modifies, or delays the treatment of the CCS-medically eligible condition; or

- Assesses or treats a mental health problem that is a complication of the CCS-eligible condition or the medical treatment of the condition.

Generally, CCS behavioral/mental health services are not frequently required but are authorized to appropriate behavioral/mental health providers when necessary. Inconsistency in the authorization of these services was addressed in 2002 through CCS policy communication to local CCS programs (CCS Numbered Letter 11-1002). Access to behavioral/mental health services has not been identified as a significant issue for the CCS program in recent years.

CCS enrollees are authorized for home health services when medically necessary. Broader access issues, including geographic variation in provider participation and lower provider participation related to provider reimbursement rates, have affected home health services provided to CCS and Medi-Cal beneficiaries. Local CCS Programs and the State CCS Program nurses worked to identify active service providers willing to accept CCS authorizations. Additionally, the State worked on increasing Home Health Nursing rates. Providers have indicated an increase should help the State recruit Home Health Independent RNs and LVNs, Pediatric Day Health Care Centers, and Home Health Agencies in the State

Evidence-based and evidence-informed practices utilized for this strategy

Challenges to this strategy

Objective 5:

By June 30, 2020, CCS county programs will demonstrate increased knowledge on billing processes for telehealth services.

Objective 5: Strategies 1-5:

1. *Updating existing telehealth codes in the Medi-Cal billing systems database.*
2. *Distribute the updated CCS Numbered Letter (Policy letter) on billing guidelines for telehealth services.*
3. *Develop and implement trainings for CCS providers on the billing guidelines for telehealth services.*
4. *As part of the telehealth billing services trainings, conduct pre- and post-test evaluations.*
5. *Post updated resources and FAQs on the DHCS Medi-Cal and Telehealth webpage.*

ISCD is working on including CCS specialized billing codes for Specialty Care Centers and specialty consultations in the Medi-Cal claims system and is providing continued guidance on authorization and claiming of telehealth services.

Based on recommendations from the report of the August 2015 survey of CCS Administrators on telehealth by the Center for Connected Health Policy in collaboration with ISCD entitled *Realizing the Promise of Telehealth for CSHCN*, the Numbered Letter (policy letter) on Telehealth Services Code Update for the CCS Program was developed and released in December 2017.

The training curriculum for telehealth services has been developed. ISCD conducted teleconference discussions with selected CCS facilities on telehealth and NICU care, Pediatric Intensive Care Units, Unite (PICU) care, genetics counseling, among others. The Telehealth Medical Consultant conducted discussions with UC Davis Center for Health and Technology on the use of telehealth for teleaudiology, CCS Medical Therapy Units, and rehabilitation medicine. ISCD provided technical assistance to various local health agencies and CCS providers on the process of billing for telehealth services, including problem solving with CCS programs and billing units in the California Medi-Cal Management Information System and the claims contractor.

Planning continues for the CCS training webinars on billing for telehealth services, in consultation with UC Davis and CCS providers.

Evidence-based and evidence-informed practices utilized for this strategy

The effectiveness of pediatric telehealth is well-established. ISCD participated in the August 2015 report published by the Lucile Packard Foundation for Children's Health: "Realizing the Promise of Telehealth for CSHCN".

Challenges for this strategy

Funding sources may have to be determined for CCS regional trainings and stakeholder workgroup meetings.

CYSHCN Health – Application Narrative (FY 2019-20)

Priority 4: Provide high quality health care to all CYSHCN within an organized care delivery system.

Surveillance: DHCS/ISCD will review the national performance and national outcome data included in the Federally Available Data report prepared by MCHB and made available to states by May 2020. Regarding state level data, consistent and reliable data reporting from all 58 counties is a challenge. ISCD and MCAH are aware of this as a limitation and are discussing and working on strategies to improve reliable data collection and interpretation.

Select CYSHCN Health Indicators and Measures	Data Source
CYSHCN enrollment in CCS (1-22 years of age and % by health coverage)	CMS Net
Newborn Hearing Screening	Natus database
CYSHCN in CCS with primary care provider (medical home)	CMS Net
CCS county informational trainings on Whole-Child Model	County documentation
Family participation in CCS transition policies	County survey
CYSHCN in CCS with transition plan of care	County survey
CYSHCN in CCS with select conditions having a subspecialist visit within 90 days of eligibility determination	CMS Net
Telehealth billing guidelines training webinars	Training documentation

Objective 1:

By June 2020, develop a detailed plan for the California MCAH program with strategies and activities to strengthen systems that support CYSHCN in California by assessing current data, engaging broad stakeholders, and identifying priority needs and best practices.

Objective 1: Strategy 1:

Identify priorities and strategies for filling gaps and addressing unmet needs in the state to improve systems of care for CYSHCN, with a specific focus on medical homes and transition to adult care.

- CDPH/MCAH will continue to identify data priorities and strategies for addressing data gaps as it relates to serving CYSHCN and their families/caregivers. This includes continued participation in the UCLA-led California Health Interview

Survey (CHIS) Children's Technical Advisory Workgroup and the CDPH CHIS Users' workgroup to recommend subject matter content for the child questionnaire. In addition, any data collected due to MCAH's proposal to include a developmental screening question in the 2019-2020 CHIS cycle will inform our work.

- CDPH/MCAH has established an internal CYSHCN Domain Work Group that will continue to meet bi-weekly to assess the needs of this population and identify evidence-based practices that can be shared and/or implemented in the state. The Work Group will build a stronger connection with other MCAH programs such as the California Home Visiting Program, Adolescent Family Life Program, Black Infant Health Program and other early childhood system providers, with the goal of identifying opportunities for cross sharing and collaboration.
- CDPH/MCAH will establish an ACES workgroup with local MCAH programs to identify needs and opportunities around prevention, screening and linkage to services for children youth that have experienced trauma.
- The third annual MCAH CYSHCN stakeholder meeting will take place in 2019-20 and will include diverse representation from parents (families/caregivers) of CYSHCN, partners from state agencies (Developmental Services, Health Care Services, Social Services, and Education), local health agencies, non-governmental organizations, foundations, health plans, provider organizations, research institutes, and more. The goal of this meeting will be to synthesize information gleaned from the local and statewide needs assessment process in order to support and inform the next Five Year State Action Plan and future CYSHCN planning efforts.
- As part of the overall assessment and program planning process, MCAH will identify successes, challenges, and lessons learned from other MCAH programs around the country. MCAH will share information and build partnerships with other states through meetings and other learning opportunities offered by HRSA and/ or other partners.
- CDPH/MCAH will continue to build a stronger partnership with DHCS Medi-Cal Managed Care to understand the current processes, data, and systems that support CYSHCN and their families/caregivers.
- As a result of the State Action Plan created in response to the needs assessment, MCAH will create a detailed work plan that outlines goals, objectives and activities to improve systems of care for CYSHCN, including strategies that are feasible and that will most effectively address the identified needs and gaps.
- CDPH/MCAH will partner with Family Voices of California and other key stakeholders to explore and implement mechanisms for formal, funded family engagement in state-level planning and decision-making processes. One

example that will take place during 2018-19 and continue into 2019-20 includes partnering with Family Voices of California on a team action planning process coordinated by the National Center for Family-Professional Partnerships (NCFPP). This collaborative process will focus on supporting curriculum updates to Family Voices of CA's Project Leadership Training (which prepares family members to serve on advisory groups and participate in family-professional partnerships) as well as providing technical assistance to local MCAH programs in the state on family engagement. This technical assistance will be tailored to the needs and strengths of the local MCAH programs in California. While the NCFPP-guided portion of the collaboration will take place during 2018-19, MCAH anticipates maintaining a close relationship with Family Voices of CA to continue implementing mutually beneficial technical assistance activities.

- MCAH will continue its close partnership and ongoing information-sharing with the Department of Health Care Services' Integrated Systems of Care Division, who administers the California Children's Services (CCS) Program. This partnership will continue to be administered through standing monthly meetings, including bi-monthly meetings with both the Title V MCAH and CYSHCN Directors in attendance, as well as ongoing informal communication between both teams. This commitment to communication will ensure responsiveness to the priorities that emerge throughout the state and local needs assessment processes as well as emerging issues on the national level.
- MCAH will continue to provide proactive technical assistance and state-level coordination to local MCAH programs on CYSHCN priorities. Technical assistance and training will be provided in close collaboration with our contractor, the UCSF Family Health Outcomes Project, who supports the needs assessment process as well as other areas where TA is needed or requested by local agencies. Training topics will likely include family engagement (as mentioned above), moving towards population-based health services, systems-level change, and other high-priority topical areas identified at the community level such as adverse childhood experiences (ACEs) and family mental health.
- In addition to the activities above, MCAH will explore mechanisms to increase the level of dedicated support and staff capacity at the state level to focus on CYSHCN efforts.

Objective 2:

By June 30, 2020, increase child and youth enrollment in the CCS program.

Objective 2: Strategy 1:

Refine the selected whole child approach to optimize access to qualified providers.

- Continue with the Whole Child Model (WCM) implementation. Phase 1 implementation started on July 1, 2018 with six counties. Phase 2 implementation began on January 1, 2019 with 14 counties. A final county will join WCM no sooner than July 1, 2019, to complete implementation in all 21 WCM counties.
- CCS will continue to work closely with the Department of Health Care Services' Managed Care Quality and Monitoring Division (MCQMD) to ensure the smooth transition of services to the appropriate health plans.
- Continue to maintain regular communication with WCM counties. Counties are encouraged to bring up issues promptly for discussion as they occur.

Objective 2: Strategy 2:

Conduct and analyze surveys of CCS families and providers to assess satisfaction with organized care delivery system.

- With the University of California San Francisco, Family Health Outcomes Project as the facilitator, DHCS will be working with stakeholders to compile and analyze input on key informant interviews, focus groups, a provider survey and a family survey as part of the Five-Year Needs Assessment.
- During Fiscal Year 2018-19, stakeholders provided valuable input on the key informant interview guide, focus group questions, and survey questions.
- Family Voices of California (FVCA) will be working closely with DHCS, family resource centers, and families to increase the survey response rate.

Objective 3:

By June 30, 2020, increase the number of CCS clients who receive care within a medical home.

Objective 3: Strategy 1:

Increase the number of counties with a family advisory council, parent health liaison, family-centered care workgroup, or other role supporting CYSHCN.

- CCS will continue to work closely with FVCA to increase family awareness and participation.
- FVCA will build and strengthen family engagement and CCS county partnerships through participation, upon request, as the family representative in Medi-Cal managed care plan local advisory committees. Each Medi-Cal managed care health plan in the WCM is required to have a family advisory council.

- FVCA will disseminate outreach materials that are culturally appropriate for CCS beneficiaries and families enrolled in WCM to assist them in navigating services and benefits; provide educational trainings for beneficiaries and their families on how to work with the health plan to benefit from its services; and collaborate with CCS in the design and implementation of the needs assessment, strategic planning, annual reporting, public comment processes, and review of policy documents and outreach/educational materials.
- FVCA will provide family experience input and perspective at CCS Advisory Group meetings and workgroups.

Objective 4:

By June 30, 2020, increase the number of CCS clients with a documented transition plan.

Objective 4: Strategies 1-3:

- 1. Identify CCS county and WCM managed care plans' transition strategies and best practices.*
 - 2. Increase the number of family members providing input into the development of transition practices and guidelines.*
 - 3. Identify processes to track CCS clients completed a visit with a managed care adult physician.*
- CCS will continue to collaborate with MCQMD on facilitating transition to adult services for CYSHCN.
 - CCS counties will continue with regular meetings with health plans and other community-based organizations to identify physicians and services for CCS clients as they transition to adulthood.
 - With assistance from FVCA, CCS will continue to increase family input in transition policies by encouraging family participation in transition planning and/or Special Care Center (SCC) team meetings, participation in advisory committees or task forces, provide feedback regarding satisfaction with services, and/or serving as family advocates.
 - CCS follows the national guidelines that recommend starting transition planning at 14 years of age for CYSHCN with chronic health conditions.
 - CCS convened a Transition to Adulthood Workgroup to discuss transition best practices and provide recommendations on transition services. Among topics discussed are the appropriate age to begin transition dialogue, transition activities that should be required, and the specific target population for these practices. Workgroup members included county CCS program

representatives, family members, health plans, providers and advocates.

Priority 5: Increase access to CCS-paneled providers such that each child has timely access to a qualified provider of medically necessary care.

Objective 5:

By June 30, 2020, ensure CCS clients receive appropriate care from a subspecialist in a timely manner.

Objective 5: Strategy 1:

Identify barriers to access to CCS-paneled providers.

- CCS High Risk Infant Follow-Up Program (HRIF) ensures that there is a seamless referral to appropriate follow-up for these NICU babies, thus eliminating the issue of having to identify the appropriate follow-up provider when the patient does not have one. The HRIF Program will follow infants discharged from CCS-approved NICUs with CCS-eligible medical conditions or who are at high risk to develop conditions with adverse neurological and developmental outcomes to ensure three (3) multidisciplinary outpatient visits.
- The HRIF QCI will use a web-based data reporting system to identify quality improvement opportunities for NICUs pertaining to the reduction of long-term morbidity.
- To assist in the delivery of preventive care for high-risk children, such as those in foster care, DHCS ISCD will administer the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, known as the Child Health and Disability Prevention Program (CHDP).
- CHDP will provide preventive services and referral to diagnostic and treatment services for Medi-Cal participants up to age 21.
- CCS will track the completion of the first subspecialist visit from the time of service authorization with SPM 4, which measures the percent of CYSHCN with select conditions (cystic fibrosis, cerebral palsy, sickle cell, acute lymphocytic leukemia and diabetes) who have a special care team report documenting the visit to a subspecialist within 90 days of CCS eligibility determination. This measure will assist CCS in identifying barriers to access to CCS-paneled providers.

Objective 5: Strategy 2:

Define and identify issues associated with access to durable medical equipment, pharmacy, home health and behavioral health providers.

- Local CCS programs work with the county, regional, and statewide provider community in developing solutions to maintain the efficient authorization of needed services. CCS will provide additional policy and information directives to CCS county offices and to fee-for-service providers through publication of the CCS Numbered Letters and CCS Information Notices.
- Local CCS programs and the State will work on identifying active services providers willing to accept CCS authorizations.

Objective 6:

By June 30, 2020, CCS county programs will demonstrate increased knowledge on billing processes for telehealth services.

Objective 6: Strategies 1 - 5:

- 1. Update existing telehealth codes in the Medi-Cal billing systems database*
 - 2. Distribute the updated CCS Numbered Letter (Policy letter) on billing guidelines for telehealth services*
 - 3. Develop and implement trainings for providers on the billing guidelines for telehealth services*
 - 4. As part of the telehealth billing services trainings, conduct pre- and post-test evaluations*
 - 5. Post updated resources and FAQs on the DHCS Medi-Cal and Telehealth webpage*
- CCS will disseminate the updated Numbered Letter on Billing Guidelines for Telehealth Services.
 - CCS will conduct training webinars on billing for telehealth services. In addition, the training webinar will be available on the Medi-Cal Learning Portal so that providers may access them at their convenience. Pre- and post-test evaluations of knowledge and skill gains are part of the trainings.
 - CCS will post updated resources and FAQs on telehealth services on the DHCS Medi-Cal and Telehealth website.

Priority 6: Promote and enhance adolescent strengths, skills and supports to improve adolescent health. (NPM 10)

Surveillance: Data from the aggregated 2016-2017 National Survey of Children’s Health for NPM 10 show that in California 76.2% of children aged 12 through 17 years had a preventive medical visit in the past year. NSCH data on NPM 10 from surveys prior to 2016 cannot be compared with the 2016-2017 NSCH data.

In California, the adolescent birth rate (ABR) for ages 15-19 declined 50% between 2010 and 2016. The largest decline occurred to Asian adolescents (66%); Black and Hispanic ABR dropped 53% and 51%, respectively, between 2010 and 2016.

The ABR for younger adolescents age 15-17 had an even greater decline between 2010 and 2016 at 57%; the largest decline occurred to Asian at 74% and followed by Black and Hispanic at 58% each. In one year, from 2015 to 2016, the ABR among age 15 to 17 dropped by 12% from 8.2 in 2015 to 7.2 per 1000 in 2016.

Objective 1:

By June 30, 2020, racial and ethnic disparities in adolescent birth rates (ABR), ages 15-19 years, in California will decrease by 10%.

From 2015 to 2016, the ABR ratio, a measure of disparity, declined slightly between Hispanic and White (5.7 to 5.3 per 1000) and between Black and White (3.6 to 3.5 per 1000) adolescents age 15-17.

Objective 1: Strategy 1:

Target all MCAH adolescent sexual health programs (ASH) to high need and/or historically underserved populations.

In recognition of the impacts health disparities have on expectant and parenting youth and the geographic variation in disparities, CDPH/MCAH developed the California Adolescent Sexual Health Needs Index (CASHNI) to target available resources for primary and secondary adolescent pregnancy prevention programs to areas of the state with the greatest need.

In early 2018, MCAH began work to update the CASHNI using the most recent data available including the:

- Birth Statistical Master Files, 2014-2016, California Department of Public Health, Center for Health Statistics and Informatics
- American Community Survey 5-year 2010-2014 aggregated data, United States Census Bureau / American FactFinder
- Census 2010 census tract population for youth aged 10-19 for California, United States Census Bureau / American FactFinder
- County Population 2010, 2014-2016, State and county population projections 2010-2060 [P-3: State and County Projections Dataset], California Department of Finance
- Medical Service Study Areas (MSSA) dataset, California's Office of Statewide Health Planning and Development
- Gonorrhea and Chlamydia 3-year 2014-2016 aggregated data MSSA level, California Department of Public Health, STD Control Branch,

CDPH/MCAH will use the updated CASHNI as a key element of applicant eligibility for the CDPH/MCAH Information and Education (I&E) Program and will target high need rural areas. The Request for Applications is scheduled to be released in Fall 2018. Preliminary 2016 data shows CASHNI countywide scores range across CA from less than 5 to 18435. High need counties are those with a CASHNI score of 400 or greater.

Of California's 58 counties, 26 are comprised only of rural MSSA (n=92), the geographic level of CASHNI analysis. Rural CASHNI score ranges from less than 20 to 2491.

With the release and targeting efforts for I&E, CDPH/MCAH continues to successfully targeted all Adolescent Health programs to areas identified as high need for adolescent sexual and reproductive health services in the state. In this case, with a specific focus on rural areas.

Geographic disparities between rural and urban areas exists for adolescent birth rates. In the United States, adolescent birth rates are higher in rural counties than in urban centers and suburban counties, regardless of race/ethnicity.⁽²⁰⁾ In 2010, the adolescent birth rate in rural counties was nearly one-third higher than the rest of the country (43 versus 33 births per 1,000 females aged 15 to 19 years). Rural adolescent females were significantly more likely to report they have ever had sex compared to metropolitan adolescent females (55% vs. 40%). In addition, a significantly smaller percentage of rural adolescent females used contraception the first time they had sex compared to metropolitan adolescent females (71% vs. 81%).⁽²¹⁾ Similar to trends in the US, the aggregated 2014-2016 California birth records demonstrated that adolescent birth rates

(ABR) in rural areas⁵⁴ were higher (20.8 per 1,000 females aged 15-19) than they were in urban areas (14.9 per 1,000 females aged 15-19). This translates into about 5.9 more births per 1,000 in rural as compared to urban areas. ⁽²⁾

We know from research that there are differences by race/ethnicity in sexual behavior and in contraceptive use and overall ABR disparities persist. In 2016, Black and Hispanic females aged 15-19 were 2.8 and 3.8 as likely, respectively, to give birth as their White peers.

Evidence-based and evidence-informed practices utilized for this strategy

The California Adolescent Sexual Health Needs Index (CASHNI) is a data driven solution used to maximize the impact of program funding and ensure program targeting to the greatest number of youth in need throughout California

Challenges for this strategy

Although the CASHNI provides targeting data at the sub-county level (California defined Medical Service Study Area), not all areas collect youth demographic data at this level. In addition, a main data source for the CASHNI (the California Birth Statistical Master File or BSMF) has a 2-year data lag. Therefore, the CASHNI published in FY 2018/19 will be using 2016 data.

Objective 1: Strategy 2:

Implement evidence-based, community-informed adolescent education approaches on pregnancy and sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV).

Through Title V, CDPH/MCAH leads and funds the Adolescent Family Life Program (AFLP). AFLP provides case management services to expectant and parenting youth under 19 years of age. The program aims to improve the life course trajectory of expectant and parenting youth through strengths-based case management with integrated life planning. In 2017-18, MCAH launched a new program cycle and funded 19 local agencies in 17 high need counties to implement the evidence-informed AFLP Positive Youth Development (PYD) Model.

In 2017-2018, key AFLP activities and program successes included:

- Launching a new program cycle which required implementation planning with 16 continuing and 3 new AFLP agencies.

⁵⁴ Rural areas in California are defined as Medical Service Study Areas with population densities of less than 250 persons per square miles while urban areas are those with population densities ranging from 251 to 31,000 persons per square miles.

- Further developing and refining of the evidence-informed AFLP PYD program tools to improve implementation with youth participants, including the following updates:
 - Implementation Manual: updated and released March 2018
 - Resilience Survey: launched in an online survey format and required for new youth entering the program starting in February 2018
 - Face-to Face Visit Summary: Consolidated care plan and chart note to support case management practice and documentation of program implementation
 - Data Collection Manual: Updated and released in July 2018
- Developing a new management information system, *Penelope*, to transition from a limited data entry system to a more user-friendly system to support case management processes and improve monitoring and evaluation efforts. This included the following:
 - Establishing a Local Consultation Workgroup to support the system development
 - Streamlining data collection tools and processes to increase efficiency
 - Updating data collection and data entry guidance, training, and tools
 - Developing guidance for the transition to new system
 - Providing training and support for the transition to new system
 - Piloting and refining the system
 - Planning for the full rollout of the new data system in August 2018.
- Organizing and facilitating a panel presentation titled “Engaging Youth, by Youth!” at the 2018 Youth Tech Health (YTH) Conference. MCAH, in partnership with the Adolescent Sexual Health Work Group (ASHWG) Steering Committee, engaged AFLP PYD program participants and alumni from across the state and other youth leaders from across the country to participate in the panel presentation. The presentation provided an opportunity for youth to share their experiences and perspectives on how they can be meaningfully engaged in programs and organizations designed to support them. State and local programs serving youth had the opportunity to hear directly from youth regarding how to create opportunities that are meaningful and rewarding, build capacity for youth advisors, and maintain youth motivation. The youth panelists led small group discussions during the workshop to brainstorm with attendees about the following: the guiding principles for youth engagement, recommendations for organization seeking to engage youth, and strategies to use technology to reach youth and effectively engage them in advisory roles.
- Creating and launching a statewide storytelling effort titled *Stories from the Adolescent Family Life Program*, which used video and written stories to

- highlight the resiliency and successes of youth in the program.
- Continuing to provide and strengthen ongoing technical assistance and training opportunities for local AFLP agency staff.
 - In addition to the PYD Basic and Skills trainings described in Objective 2, Strategy 2, training to support the PYD Model included the following:
 - AFLP Orientation and Adolescent Sexual Health Conference, 9/06-08/2017 (approximately 80 staff trained)
 - Interim PYD Training provided for new staff (all new staff, ongoing for staff changes) Data Collection Training and Question and Answer Session in 12/2017, 01/2018, 06/2018; recorded for on-going use (all local staff)
 - Data Entry/LodeStar Training (on-going individual training and technical assistance provided to each new staff through June 2018)

In addition to AFLP, CDPH/MCAH continued to provide comprehensive sexual health education to high-need youth across the state through the California Personal Responsibility Education Program (CA PREP) and Information and Education (I&E) programs.

CDPH/MCAH administered CA PREP, which is federally funded through the Family and Youth Services Bureau with state infrastructure and data support from Title V. CA PREP local agencies provided evidence-based sexual health education to youth 10-21, with a focus on clinical linkages and preparing for adulthood.

The I&E Program, funded through State General Fund, with infrastructure and data support from Title V, is authorized as part of CA statute (Welfare and Institution Code) and the program sites implement evidence-based or evidence informed comprehensive sexual health education and life skills education, engage parents, and link youth to clinical services.

Nearly all local agencies implementing CDPH/MCAH adolescent sexual health education programs (CA PREP and I&E) use one or more of the following five evidence-based interventions: Making Proud Choices!, Positive Prevention Plus, Sexual Health and Adolescent Risk Prevention, ¡Cuidate!, and Power Through Choices. Thirty-two of the 34 local funded agencies implement one or more of these interventions. Four of the 34 agencies use additional evidence-informed, community-based interventions.

In FY 2017-18, a total of 24,086 youth were served across all three adolescent health programs (AFLP, CA PREP and I&E). CA PREP agencies provided evidence-based interventions to 15,827 youth through twenty-two local agencies and achieved a 91.0% retention rate. The evidence-informed AFLP PYD program model served 1,448 youth through nineteen local agencies. I&E agencies served 6,811 youth through

fourteen agencies and provided either evidence-based or evidence-informed interventions.

Evidence-based and evidence-informed practices utilized for this strategy

All programs listed above are evidence-based or evidence-informed.

Challenges for this strategy

AFLP started a new contract cycle with local agencies and faced challenges with ensuring that new contracts were in place in a timely manner. In the future, MCAH will ensure that extra time is built in to allow for potential delays in contract processing. Additional federal Office of Adolescent Health grant funds were available to supplement AFLP, but spending the funds was challenging due to the reduction in grant award amount and shortened timeline to expend the funds (the three-year grant award was reduced to one year). MCAH worked closely with all AFLP agencies and other partners to develop plans and implement activities that would be meaningful and best support the expectant and parenting adolescent population served by the program.

Objective 1: Strategy 3:

Educate adolescents regarding the use of long-acting reversible contraceptives (LARCs), condoms and other birth control methods.

All CDPH/MCAH Adolescent Health programs provided education on reproductive health and information on local clinical services to ensure youth are able to make informed decisions about their sexual health. CDPH/MCAH continued to focus on evidence-based strategies to provide skill-based education to youth on prevention of pregnancy and sexually transmitted infections.

The following are activities implemented by AFLP case managers to support expectant and parenting adolescents in making informed and healthy sexual and reproductive health decisions:

- Discussing youths' needs and goals regarding pregnancy and sexual health to identify strategies that will work for them;
- Providing education on Food and Drug Administration (FDA)-approved medicines and devices for contraception, including LARCs;
- Making youth-friendly referrals to Family PACT and/or other providers for needed services such as contraception access and STI testing and treatment;
- Identifying and addressing barriers to correct and consistent use of contraception;

- Educating and supporting youth on key topics related to sexual health and healthy relationships.

To support this effort, in May 2018, MCAH delivered a 2-day training on reproductive and sexual health to AFLP case management staff. The training covered topics such as STI basics, FDA-approved contraceptive methods, and creating inclusive environments for LGBTQ youth.

Additionally, staff had the opportunity to practice having conversations around sexual and reproductive health and obtain support and feedback from the trainers and their peers.

CA PREP and I&E are adolescent sexual health education programs that provide skill-based instruction to youth on prevention of pregnancy and sexually transmitted infections. Per California law and MCAH program requirements, all CA PREP and I&E program services include standard information on all Federal Drug Agency-approved methods of birth control, including LARCs. In addition, youth receive information on the location, cost, and confidentiality of local sexual and reproductive health services (Family PACT and others).

In 2017-18, of youth active in AFLP at most recent follow-up, 29.8% were using a LARC and 59.0% of sexually active, female, non-pregnant youth reported always using contraception. Among sexually active youth in the program at most recent follow-up, 33.9% reported using condoms and 6.4% reported using condoms and another method (AFLP 2017-18 SOW Report).

For PREP, among participants who reported having had sex in the past 3 months, 53.1% reported using condoms or birth control most or all of the time (n=2,802). Among all PREP participants, there was a 39.0% point increase in correct overall knowledge of birth control methods, from 17.9% at program entry to 56.8% at program exit. (Data from PREP matched entry and exit surveys (n=7,290)).

For I&E, among participants who reported having sex in the past 3 months, 53.6% reported using condoms or birth control most or all of the time (n=394). Among all I&E participants, there was a 42.0% point increase in correct overall knowledge of birth control methods, from 16.4% at program entry to 58.4% at program exit. (Data from I&E matched entry and exit surveys (n=1,960)).

Evidence-based and evidence-informed practices utilized for this strategy

AFLP implements the evidence-informed PYD program model, which has integrated reproductive life planning and draws from the evidence-based around positive youth development and the practice of motivational interviewing to support youth in meeting

their goals around sexual and reproductive health. PREP and I&E implement evidence-based sexual health education interventions as listed in Objective 1, Strategy 2.

Challenges for this strategy

Typically, it is challenging to offer in-person trainings, such as the training on sexual and reproductive health for AFLP agencies, due to speaker availability and costs, especially with limited time and funds available for planning. CDPH/MCAH was fortunate to have in-house experts available to conduct a training on sexual and reproductive health who are familiar with AFLP and were able to tailor the training accordingly. In the future, MCAH will continue to build and use internal expertise, begin planning processes earlier, and consider offering lower-cost options, such as webinars and online modules, for local staff.

CDPH/MCAH continued to collect data on contraceptive use and reproductive health for the majority of local agencies; however, due to changes in the data system, the three new AFLP agencies did not have access to a data system and could not obtain summarized reports from CDPH/MCAH regarding their local data for fiscal year 17-18; in the future, this will be available from the new data system.

Objective 1: Strategy 4:

Link youth to preventive and reproductive health services that are affordable, accessible, confidential, and youth-friendly.

Adolescents in CDPH/MCAH programs are linked to timely prenatal care, when applicable, reproductive health services, and other preventive health services. CDPH/MCAH worked to address the barriers to accessing clinical services by first better understanding these issues and identifying strategies to improve access to and utilization of needed services.

AFLP Case Managers supported young people in the program with receiving primary care and timely prenatal care to maximize their health and deliver a healthy baby, if pregnant. Specifically, they helped youth enroll youth in Medi-Cal when eligible, referred youth to providers, and addressed barriers to keeping appointments, such as transportation, lack of youth friendly or culturally responsive services, and communication. Some agencies provide preventive health services on-site to reduce barriers for the youth in accessing the services. AFLP agencies built and/or maintained partnerships with CPSP and Family PACT providers, among other providers and linked youth to those services.

CA PREP and I&E health educators provided information to youth on the location, cost, and confidentiality of local sexual and reproductive health services. All CA PREP agencies provide standard information on local Family PACT providers, and all have active Memoranda of Understanding with their local Family PACT provider.

In FY 2017-18, funded through CDPH/MCAH and a partner in adolescent health monitoring and evaluation, UCSF completed a clinical linkages project that included research, analysis of program data, and focus groups with youth at local I&E and PREP agencies.

The goal was to assess how the CDPH/MCAH adolescent sexual health education programs provide information on youth-friendly reproductive health services, and to identify barriers and best practices in educating youth about these services.

The initial background report was completed in 2016-17 and key findings from this additional research are forthcoming. Next steps for 2018-19 include completing a Clinical Linkages Brief, analyzing the focus group data, and synthesizing findings and recommendations.

In FY 2017-18, 67.5% of youth in the program received primary preventive health care and 88.9% of pregnant youth received prenatal care (AFLP SOW Report 2017-18).

After completing PREP programming, there was a 22.8% point increase in the percentage of participants who reported they have heard of sexual and reproductive health services in their community, from 56.7% at program entry to 79.5% at program exit. (Data from PREP matched entry and exit surveys (n=7,227))

After completing I&E programming, there was a 28.7% point increase in the percentage of participants who reported they have heard of sexual and reproductive health services in their community, from 39.9% at program entry to 68.6% at program exit. (Data from I&E matched entry and exit surveys (n=1,960)).

Challenges for this strategy

Challenges related to youth accessing reproductive health and preventive services included transportation, lack of youth friendly or culturally responsive services, and youth being unsure if services are confidential.

According to data from CA PREP youth participant surveys from the FY 2017-18 program year, there were improvements in participants' concerns regarding sexual and reproductive health services between program entry and exit. Results for CA PREP participants were as follows: 1) worry about cost of services decreased by 4.9% points (39.5% entry and 34.6% exit); 2) worry about clinic staff judging them decreased by 2.9% points (29.0% entry and 26.1% exit); and 3) worry about services not being

confidential increased slightly (42.0% entry and 42.8% exit). (Data from PREP matched entry and exit surveys (n=7,299))

According to data from I&E youth participant surveys from the FY 2017-18 program year, there were also improvements in participants' concerns regarding these services between program entry and exit. Results for I&E participants were as follows: 1) worry about cost of services decreased by 4.4% points (51.8% entry and 47.4% exit); 2) worry about clinic staff judging them decreased by 2.5% points (35.1% entry and 32.6% exit); and 3) worry about services not being confidential increased slightly (49.4% entry and 53.9% exit). (Data from I&E matched entry and exit surveys (n=1,960))

Youth were also asked about factors that would facilitate their access to sexual and reproductive health services. For I&E youth participants in FY 2017-18, there were improvements in these factors, as follows. I&E youth: 1) knowing what to expect increased by 21.2% points (82.6% entry and 61.4% exit); 2) feeling comfortable talking with staff increased by 11.5% points (57.3% entry and 68.8% exit); 3) feeling that it would be easy to get to sexual and reproductive health services increased by 7.6% points (66.3% entry and 73.9% exit); and 4) reporting that they would go for sexual and reproductive health services if needed increased by 6.2% points (85.4% entry and 91.6% exit). (Data from I&E matched entry and exit surveys (n=1,960)).

Objective 1: Strategy 5:

Identify gaps in the availability of youth-friendly reproductive health services.

MCAH served as a core member in the CDPH department-wide Adolescent Preventive Health Initiative (APHI) to develop a framework for engaging with the health care sector and community organizations to improve quality and access to preventive health care for adolescents across the state. The core team engaged in a human-centered design process to work with many stakeholders and partners to plan and strategize about the opportunities and direction of the initiative. APHI also connected with the School-Based Health Center Initiative at CDPH to identify areas of overlap and opportunity and jointly leverage resources to improve adolescent preventive health efforts. Effective models, such as the California Perinatal and Maternal Quality Care Collaboratives and National Improvement Partnerships, are being considered as strategies that could inform the Adolescent Preventive Health Initiative.

To support APHI, MCAH calculated preterm births by county among adolescents and young adults for years 2007 and 2014 and developed an APHA presentation titled

“Improving birth outcomes among adolescents and young adults in CA: The role of small area analysis to reduce disparity”. The presentations outlines the descriptive study to explore the relationship between sub-optimal inter-pregnancy interval (IPI) and preterm birth (PTB) and identify communities (MSSA-level) that demonstrated both high sub-IPI and PTB. This information can help improve targeting of efforts to reduce health disparities in areas where this adverse outcome, preterm birth, disproportionately occurred.

CDPH/MCAH also participated in an initiative led by the Association of State and Territorial Health Officials (ASTHO) with support from the CDC, Centers for Medicare & Medicaid Services (CMS), and Office of Population Affairs (OPA). This initiative is known as “Increasing Access to Contraception: Reducing unintended pregnancy among women of reproductive age in California Learning Community.” One of the goals of this initiative was to identify geographic areas in California where high need for contraceptive services potentially exist. Through the learning community, MCAH worked to better understand where there are areas in the state with reproductive health deserts, i.e., gaps in the availability of reproductive health services. MCAH in collaboration with the National Campaign and the Family PACT Program developed a measure to assess contraceptive deserts in California using sub-county analyses. In FY 2017-18, MCAH shared the data analysis report pertaining to reproductive health deserts with the ASTHO team for feedback.

Evidence-based and evidence-informed practices utilized for this strategy:

APHI and the ASTHO project are collaboratives that engage diverse stakeholders. The teams established a structure, process and activities. Structured collaboratives have been widely considered as effective strategies to address key public health issues

Objective 1: Strategy 6:

Develop and implement programs to empower parents and caregivers with skills and knowledge to strengthen effective communication with adolescents regarding sexual health.

CDPH/MCAH continued to assess the feasibility of integrating evidence-based models/strategies into current programs related to empowering parents and caregivers with skills and knowledge to strengthen communication with adolescents regarding reproductive and sexual health. Strategies and increased focus on parent and caring adult engagement in adolescent sexual health education was integrated into the I&E RFA, which was released in November 2018.

CDPH/MCAH continued to participate in the CDSS Healthy Sexual Development Work Group. This groups was formed with the passage of Senate Bill 89, which requires that

social workers, caregivers, and other adults in the lives of foster youth be trained in reproductive and sexual health issues. MCAH has expertise with regards to sexual health education for foster care youth and is serving as a member of the work group to strategize and discuss opportunities to engage and support caregivers and adults of foster youth.

Challenges for this strategy

Regarding empowering parents and caregivers to address adolescent reproductive and sexual health, there is still a lack of resources and capacity at the state level; however, MCAH is integrating this component into programs and will identify training and technical assistance opportunities for local agencies to support them in effectively engaging and empowering parents and caring adults in the lives of young people..

Objective 2:

By June 30, 2020, all Title V programs serving adolescents will incorporate the Positive Youth Development (PYD)/Resiliency framework.

Objective 2: Strategy 1:

Develop tools and standards to incorporate PYD principles, resiliency framework and training on healthy coping skills in program implementation and materials.

CDPH/MCAH implements the evidence-informed AFLP PYD model, which is founded on PYD principles and a resiliency framework and integrates strategies to support youth with healthy coping skills and other key skills to help them thrive, such as, problem solving, planning, positive identity and accessing needed services. In 2017-18, MCAH further refined the program materials and training to build knowledge and skills around the principles of PYD. A new, comprehensive PYD Model Implementation Manual was developed and the Data Collection Manual updated. These serve as guides for implementing and documenting PYD Model activities. In addition, a medical review was conducted as well as a graphic redesign of the activities to be more appealing to youth and consistent in look and feel. Almost all program and data collection documents were updated throughout the year for clarity and formatting, with some content changes. For example:

- The *My Life and Me Activities* were updated to integrate additional content and best practices related to emotion regulation to enhance young people's ability to cope with difficult and overwhelming situations. In particular, MCAH added an activity called, *My Emotions*, designed to guide youth through an exploration of emotions and emotion regulation. This activity serves as a foundation for helping youth manage difficult situations and overwhelming emotions during and after

visits and is referred to and built on throughout the youth's time in the program. Additionally, the instructions for the *My Relationships* section were updated.

- The *My Life Plan* was modified to include updated STI messaging from the CDPH STD Control Branch, additional child development information, and the Education and Work section was revised.
- A new documentation tool, the *PYD Face-to-Face Visit Summary*, was developed and streamlined later in the year to combine content previously included in the care plan, chart note, and PYD Model fidelity logs.

Youth tools were translated into Spanish after being updated.

All youth who received the PYD model for case management in AFLP received resiliency informed programming and programming on healthy coping skills (n=977) (AFLP 2017-18 SOW Report). Both research and local input contributed to plans and improvements to the AFLP PYD model tools, standards, and data collection.

Challenges for this strategy

Challenges included revising, translating, and distributing updated materials to local agencies who were responsible for printing, learning, and implementing the changes within a short period of time. In the future, MCAH is planning to only update materials at designated time points during the year/contract cycle.

Objective 2: Strategy 2:

Train state and local staff on the principles of PYD, resiliency and healthy coping skills for adolescents.

On the following dates, MCAH provided Basic PYD trainings for local AFLP agencies that covered PYD principles, a resiliency framework and healthy coping skills:

- 10/24-26/2017 and 11/01-03/2017 in Northern California (approximately 80 staff trained)
- 5/24-25/2018 in Southern California (approximately 20 staff; make up session for those who did not attend the fall training)

MCAH continued to enhance the trainings to build knowledge and skills around the principles of positive youth development. On the following dates, skills/refresher trainings provided an opportunity for more learning and discourse around sexual and reproductive health, PYD Model fidelity, as well as opportunities for practice/skill-building, questions, and connecting with peers.

- 5/15-16/2018 in Northern California and 5/22-23/2018 in Southern California (approximately 76 staff)

An interim training was shared with case management staff so that they could implement programming prior to attending the next in-person basic PYD training.

After each training, evaluations were provided so that MCAH could assess how the training was received and identify opportunities for improvement. Evaluations were distributed and analyzed by the University of California, San Francisco (UCSF).

In 2017-18, UCSF published an article in the *Journal of Community Medicine and Health Education*, which was titled “Improving California’s Capacity to Implement a Positive Youth Development Intervention for Expectant and Parenting Adolescents.” The objective of the study was to “assess the effectiveness of the statewide training on participants’ knowledge, attitudes, and self-efficacy to implement AFLP PYD.” The paper concludes that “the training was well received and significantly improved participants’ knowledge, attitudes and self-reported ability to implement the AFLP PYD intervention.” Note: Multiple PYD trainings have occurred and been evaluated throughout the years; the training described in this paper occurred prior to fiscal year 2017-2018.

Challenges for this strategy

Due to it being the first year of the funding cycle, CDPH/MCAH hosted many trainings (this is separate from any trainings happening locally), making this year training-intensive for local agencies. The following years in the funding cycle should have fewer in-person trainings.

Not having staff hired in time (due to it being the first year of the funding cycle) and staff turnover presented challenges for ensuring that all staff implementing the evidence-informed AFLP PYD Model were fully trained. MCAH worked to schedule trainings regularly and meet the needs of the local agencies. MCAH also provided a pre-training / interim training protocol to support knowledge gain and preparation for implementing the PYD Model, prior to the in-person training.

Objective 2: Strategy 3:

Develop surveillance strategies to measure resiliency in adolescents.

MCAH launched a Resiliency Scale to collect intermediate outcome data for youth receiving the AFLP PYD Model. This scale includes measures related to the PYD protective factors (e.g., caring relationships and opportunities for participation and contribution) and key resilience strengths (e.g., emotion regulation, problem solving

skills, sense of purpose, positive identity and self-efficacy, and resourcefulness) that the program aims to enhance/build. The resilience survey is completed directly by youth, with youth reading through the questions and filling out the responses on their own on an electronic device. This enables youth to think through the topics and respond independently and privately, providing a unique source of youth-driven data. The resilience survey is administered at designated time points throughout the program, allowing MCAH to track changes over time. It is available in English and in Spanish.

Additionally, MCAH supports several statewide population surveys such as the Youth Risk Behavior Survey (YRBS), California Health Interview Survey (CHIS) among others that included the adolescent population. For the second time, California has been successful in maintaining sample size threshold to obtain statewide 2017 YRBS dataset. Additionally, an opportunity exists to include questions regarding adolescents' transition to adult health care in the 2019-20 cycle of CHIS.

Challenges for this strategy

Launching the AFLP Resilience Scale was challenging as it required developing and using an additional data collection strategy to survey youth directly. At the time, the AFLP data system was not conducive to collecting data in the field. To address this issue, MCAH identified an online survey program (Qualtrics) that was mobile-friendly. MCAH worked with local agencies to budget for electronic devices that would allow staff to collect the resilience information from the youth wherever they might be during a visit. To address lack of internet availability while in the field—which some local agencies mentioned was an issue—MCAH ensured the survey program would be able to save responses when internet was not available for transmission later. Because this survey was very different from other data collection strategies used in AFLP, it posed a learning curve for local staff. MCAH delivered training and provided technical support to local agencies to assist them through this process.

Objective 2: Strategy 4:

Streamline PYD messaging across state and local partners.

In 2017, MCAH launched a statewide storytelling effort titled *Stories from the Adolescent Family Life Program*. This new story series highlights the resilient youth from across the state who have participated in AFLP. Stories are comprised of three components: a written story, a digital (video) story and a promotional toolkit, which comes complete with sample social media posts and draft newsletter text. Stories are

simultaneously shared at both the state and local level and thus far, we have shared five participant stories from rural, urban and coastal counties. AFLP stories highlight key concepts in the PYD program model and display these concepts in action. Storytelling has been an opportunity for MCAH to create consistent, streamlined messaging about the program across the state and with our local partners. MCAH has also incorporated these youth stories into staff training for modeling program concepts and inspiring case management practice. AFLP success stories can be found here:

<https://www.cdph.ca.gov/Programs/CFH/DMCAH/Pages/Communications/Story-AFLP.aspx>

AFLP promotional flyers and postcard templates were also created for use by local agencies. These state-developed outreach materials allow MCAH to further streamline and make consistent PYD messaging across our agencies.

MCAH continued to hold a seat on the ASHWG Steering Committee and participated in the data and evaluation, tools and training, and youth engagement work groups. ASHWG is a strong collaborative of non-governmental and governmental partners committed to improve adolescent reproductive and sexual health. This group is also committed to developing consistent and well-informed messaging to disseminate across state and local partners. In May 2018, MCAH, in partnership with ASHWG, organized the youth panel at the YTH conference to talk about their perspective on meaningful youth engagement. See Objective 1, Strategy 2 for additional details.

As part of enhancing messaging about PYD, including the importance of building protective factors for young people to support their success, MCAH monitors data related to both bullying and youth that report having a caring adult. Research has shown that when schools, families and the community work together to provide developmental supports and there are caring adults they can trust, they are more likely to report more positive academic, social/emotional and health outcomes.

The aggregated 2016-2017 NSCH showed that the percentage of adolescents in California who bullied others was 4.4% and those who were bullied was 15.8%. The largest percent of adolescents who reported being bullied identified as Other (19.6%), Hispanic (15.1%), or White (15.7%). The data was suppressed for adolescents who identified as Black and data were unavailable for adolescents who identified as Asian, American-Indian, or Hawaiian/Pacific Islander.

The 2015-17 California Healthy Kids Survey showed an average of 23% of 9th grade students reported “very much true” on the caring adult relationships items, lower than students in the 7th grade (32%).

Adolescent Health – Application Narrative (FY 2019-20)

Priority 6: Promote and enhance adolescent strengths, skills and supports to improve adolescent health.

Surveillance: MCAH will review the national performance and national outcome data included in the Federally Available Data report prepared by MCHB and made available to states by May 2019. Meanwhile, throughout FY 2018-19, MCAH will monitor select quantifiable characteristics to track the health of California adolescents as part of its routine health surveillance efforts. The following select indicators and measures listed in the table below are continuously and systematically collected, analyzed and interpreted to guide program planning, implementation, and evaluation of interventions. These indicators will be analyzed at the state and sub-state levels to identify specific improvement opportunities.

Select Adolescent Health Indicators and Measures	Data Source
Referral to preventive services	AFLP program data
Adolescent birth rate, ages 15-19	2017 CA Birth Statistical Master file
Adolescent birth rate disparity ratio- Black: White; Hispanic: White	2017 CA Birth Statistical Master file
Unintended Pregnancy	California Maternal Infant Health Assessment (MIHA)
Intimate Partner Violence	MIHA
Contraceptive Use (Dual Use)	Youth Risk Behavior Survey
Sexually Transmitted Infections (STI)	STD Control Branch program data
Preventive medical visits	2017 National Survey of Children's Health
Hospitalizations- motor vehicle, mental health and substance use	2016 CA Patient Discharge data
Living in foster care	2018 CA Child Welfare Indicators Project
Population size	State Population Projections, CA Dept. of Finance
Insurance Status	2016 American Community Survey
High School dropout	CA Department of Education
Graduation Rates	CA Department of Education
California Sexual Health Needs Index	Multiple sources
Depression (related feelings; suicide ideation)	CA Healthy Kids Survey
Teen Dating Violence	CA Healthy Kids Survey

Select Adolescent Health Indicators and Measures	Data Source
School Connectedness	CA Health Kids Survey

Objective 1:

From July 1, 2015 to June 30, 2020, racial and ethnic disparities in adolescent birth rates (ages 15-19) in California will decrease by 10%.

Objective 1: Strategy 1:

Target all MCAH adolescent sexual health programs (ASH) to high need and/or historically underserved populations.

- CDPH/MCAH will update the California Adolescent Sexual Health Needs Index (CASHNI) with the 2014-16 aggregated data and utilize the results to target program efforts to high need and/or underserved populations. Specifically, MCAH will review the trends and assess programmatic use/definitions pertaining to the CASHNI. Given limited resources, CDPH/MCAH developed this data-informed solution to maximize the impact of program funding and ensure program targeting to the greatest number of youth in need throughout California.

The CASHNI is an objective, data-based tool to target available resources for adolescent sexual and reproductive health programs to areas in the state with greatest need. The CASHNI formula includes each county’s adolescent birth rate, annual number of live births to females under age 19, percentage of repeat teen births, gonorrhea incidence rate and percentage of youth living in concentrated areas of poverty. The CASHNI formula also includes percentage of youth living in racially isolated areas, percentage of 18 – 24 year olds without a high school diploma or equivalent; and, rural community status.

- CDPH/MCAH will update the Adolescent Health County Profiles to support counties in better understanding and assessing the needs of their local adolescent population.
- CDPH/MCAH will monitor, utilize and share Maternal and Infant Health Assessment (MIHA) data related to adolescents with a live birth to inform programmatic efforts and raise awareness about this high need population and disparities that exist in the state.

Objective 1: Strategy 2:

Fund, administer, provide technical assistance to local agencies to implement evidence-based or evidence-informed adolescent education approaches on prevention of unintended pregnancy and sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV).

- CDPH/MCAH will continue to fund and administer the Adolescent Family Life Program (AFLP). Through AFLP, MCAH will provide funding, training, technical assistance, monitoring and oversight to 20 LHJs and community based organizations (CBOs) to implement the evidence-informed, strengths-based Positive Youth Development (PYD) Model for case management to support expectant and parenting adolescents. The anticipated reach for AFLP for 2019-20 is 2000 youth. In 2019-20, CDPH/MCAH will release a competitive Request for Applications to fund agencies for the next program cycle.
- CDPH/MCAH will continue to fund and support LHJs and CBOs to provide comprehensive sexual health education to youth across the state through the California PREP (fund through the Family and Youth Services Bureau) and I&E (funded through State General Funds) programs. The 22 CA PREP local agencies select from MCAH approved evidence-based sexual health education curricula and implement with fidelity. The program also focuses on clinical linkages and adulthood preparation. The 9 I&E local agencies provide evidence-based or evidence/community-informed interventions, and is in the process of being aligned with CA PREP's successful program monitoring system. These programs focus on adolescent pregnancy prevention and STD and HIV prevention and linkage to testing and treatment, as well as healthy relationships and life skills education.
- CDPH/MCAH will continue to assess data collection and continuous quality improvement process for all MCAH Adolescent Health Programs and ensure that data is effectively used and provide to local agencies.
- CDPH/MCAH will disseminate program findings, successes and challenges through data dashboards, briefs, video storytelling, blog posts and social media.

Objective 1: Strategy 3:

Ensure local funded agencies educate adolescents regarding the use of long-acting reversible contraceptives (LARCs), condoms and other birth control methods.

- All CDPH/MCAH Adolescent Health programs will continue to provide education on reproductive health and referrals to/information on the location, cost, and confidentiality of local clinical services to ensure youth are able to make informed decisions about their sexual health. MCAH will identify and disseminate any new resources and/or address training needs related to effective strategies and skill-based education for youth on prevention of pregnancy and sexually transmitted infections, including abstinence and Food and Drug Administration (FDA)-approved medicines and devices for contraception, including LARCs and condoms.
- CDPH/MCAH will monitor pregnancy intention and use of LARCs statewide utilizing the Maternal and Infant Health Assessment (MIHA) data and program data (comparing LARC use at intake and most recent follow-up).

Objective 1: Strategy 4:

Identify and address gaps in the availability of youth-friendly reproductive health services.

- CDPH/MCAH will develop a summary brief related to access to sexual and reproductive health services for adolescents, based on findings in the MCAH report on contraceptive deserts in California. Continue to strategize within MCAH and with key partners about ways to address and identify gaps in preconception health and sexual and reproductive health services for adolescents.
- CDPH/MCAH will monitor utilization of pre and postnatal care for adolescents with a live birth statewide utilizing the Maternal and Infant Health Assessment (MIHA) data and continue to address gaps in services through MCAH programs. MCAH will develop additional strategies to work with partners to close the gaps in services.

Objective 1: Strategy 5:

Develop and implement strategies to empower parents and caregivers with skills and knowledge to strengthen effective communication with adolescents regarding sexual health.

- CDPH/MCAH added new requirements into the I&E program around empowering parents and caregivers with skills and knowledge to strengthen communication with adolescents regarding reproductive and sexual health. MCAH will support local funded agencies with sharing best practices and providing training, when needed, related to engaging parents of youth through

mechanisms such as parent nights, community presentations/forums, etc.

- CDPH/MCAH will provide technical expertise through the California Department of Social Services (CDSS) Healthy Sexual Development Work Group to support implementation of SB 89, through which CDSS is tasked with training social workers, foster parents, judges, and other partners to ensure youth receive the required sexual health education. CDPH/MCAH will provide consultation related to implementation on the local level and building connections between county social service agencies and local providers of sexual health education.

Objective 1: Strategy 6:

Lead and coordinate the Statewide Adolescent Sexual Health Work Group (ASHWG) to advance the sexual health and wellness of youth in California.

- CDPH/MCAH will maintain a position on the steering committee for ASHWG as well as participation in sub-committees that align with MCAH priorities and needs. ASHWG is driven by strategic governmental and non-governmental partnerships focused on advancing the sexual health and wellness of youth in California. The goals of ASHWG include improving sexual and reproductive health outcomes and health equity among California youth; increasing access to exemplary sexual health education among California youth; increasing access to sexual and reproductive health services among California youth; and promoting positive youth development and healthy relationships among California youth. ASHWG develops and broadly promotes toolkits, standards, integrated data tables, and effective tools and trainings that support the goals outlined above. CDPH/MCAH will support coordination of this group of key partners across the state in the field of adolescent sexual health. CDPH/MCAH will take a lead role in maintaining the membership application process, coordinating quarterly in person meetings, supporting the ASHWG website and maintaining the work group's guidance documents and work plan. MCAH will maintain leadership on the Data Integration Subcommittee and with youth engagement efforts.

Through the Data and Evaluation Subcommittee, MCAH leads the efforts to analyze adolescent (aged 10-19) and young adults (aged 20-24) birth rate trend data and coordinate data from STD and Office of AIDS to publish the Integrated Data Tables in the ASHWG website. MCAH will continue in this effort.

Objective 2:

By June 30, 2020, increase the percent of adolescents 12-17 with a preventive medical visit from 76.2% (NSCH 2016-17) to 80%.

Objective 2: Strategy 1:

Ensure effective MCAH program policies and procedures to support local funded agencies with linking youth in MCAH program to preventive and reproductive health services that are affordable, accessible, confidential, and youth-friendly.

- Adolescents in CDPH/MCAH programs will be linked to timely prenatal care, when applicable, reproductive health services, and other preventive health services. MCAH will work to address the barriers for youth to accessing clinical services by disseminating best practices through webinars and written guidance to all programs. These practices and guidance will be generated from information gathered from the current clinical linkages evaluation project.

Objective 2: Strategy 2:

Participate as a core member of the CDPH Adolescent Preventive Health Initiative (APHI) to develop and implement a statewide framework to increase access to and quality of preventive services for adolescents.

- CDPH/MCAH will participate as a core member of the Adolescent Preventive Health Initiative (APHI) in establishing the framework, partnerships, strategies and plan to work towards the goals of improving access to and utilization of preventive health care for adolescents. The Adolescent Preventive Health Initiative is an initiative focused on improving access to and quality of preventive care for adolescents. It is a CDPH department-wide collaborative effort that is being spearheaded by the Center for Infectious Disease, Division of Communicable Disease Control, Sexually Transmitted Disease (STD) Control Branch in collaboration with MCAH, Office of Health Equity, Environmental Health Investigations Branch, and Immunization Branch. The intent is to facilitate CDPH cross-program coordination and collaboration around the provision of our subject matter expertise, technical assistance, resources, training, and QI interventions and connect with the healthcare sector to improve key preventive health services for adolescents across the state.

Objective 2: Strategy 3:

Raise awareness among local health agencies and MCAH funded programs about the prevention, screening and other new Bright Futures recommendations.

- CDPH/MCAH will disseminate information and develop opportunities for local agencies and providers to learn about the new Bright Futures recommendations for adolescents.

Objective 2: Strategy 4:

Participate in and disseminate resources from the CDPH school-based health center initiative.

- CDPH/MCAH will participate in the School Based Health Center (SBHC) initiative, which has recently aligned with the Adolescent Preventive Health Initiative. Through this initiative, CDPH is working to better understanding the needs of and challenges facing SBHCs in order to identify opportunities to better link with and support them.

Objective 3:

By June 30, 2020, all Title V programs serving adolescents will incorporate the Positive Youth Development (PYD)/Resiliency framework.

Objective 3: Strategy 1:

Develop tools and standards to incorporate PYD principles, resiliency, trauma-informed care and healthy coping skills in program implementation and materials.

- CDPH/MCAH will monitor implementation of the AFLP PYD Model and seek feedback from local agencies to refine and enhance current program tools and trainings to build knowledge and skills around the principles of positive youth development. MCAH will continue to integrate content, trainings and best practices related to emotion regulation, enhancing young people's ability to cope with difficult and overwhelming situations, addressing ACEs and building resiliency.
- CDPH/MCAH will respond to and disseminate information about AFLP PYD program development, implementation and evaluation, in conjunction with the release of Federal Evaluation findings. This may include the submission of abstracts and manuscripts and lessons learned for the field. MCAH will continue to refine the program model package and explore options for broader dissemination, pending findings.

Objective 3: Strategy 2:

Train state and local staff on the principles of Positive Youth Development, resiliency and healthy coping skills for adolescents.

- CDPH/MCAH will train all AFLP local agencies' staff in best practices, enhanced tools and methods related to positive youth development, building resiliency and engaging youth in an advisory capacity for their programs.

Objective 3: Strategy 3:

Develop program evaluation strategies to measure resiliency in adolescents.

- CDPH/MCAH launched a resiliency survey to measure intermediate outcomes of the program related to resiliency constructs. In 2019-20, MCAH will analyze the data to both assess the utility/effectiveness of the scale at measuring change over time and assess results of the program.

Objective 3: Strategy 4:

Streamline and expand PYD messaging across state and local partners.

- To streamline PYD messaging, CDPH/MCAH will continue programmatic and collaborative efforts (through ASHWG and APhi). MCAH will also provide training on the ASHWG core competencies for providers of adolescent reproductive and sexual health services.

Objective 3: Strategy 5:

Increase ongoing youth engagement in state level MCAH efforts.

- CDPH/MCAH will explore mechanisms to create a youth internship program and/or establish a youth advisory network. This work will build on the previous efforts.

Priority 7: Increase access and utilization of social services.

Objectives 1-6:

See Women/Maternal Domain

Objective 7:

By June 30, 2020, increase the rate of children ages 1-17 years who received a dental visit in the last year from 75.3 % (2011-12 NSCH) to 79.1 %.

In the 2016-17 National Survey for Children's Health, the rate increased from 75.3% to 79.5% of children age 1 to 17 years who had a preventive dental visit in the past year. [The percent of children age one through 17 identified as having decayed teeth or cavities in the past year was 11.7%. The percentage was highest among Hispanic children (14.8%) and lowest among White children (9.3%).]

Objective 7: Strategy 1:

Under the guidance of the CDPH State Dental Director, MCAH and the Oral Health Program (OHP) will collaborate to develop the State's Oral Health Plan to identify priorities, goals, objectives and key strategies.

CDPH/MCAH participates and supports the States Oral Health Program which officially has been changed to the Office of Oral Health (OOH) by participating in the Oral Health Advisory Meetings. The State Dental Director, Dr. Jayanth Kumar, continued to collaborate with the Department of Health Care Services (DHCS) in the implementation of the four domains of the Dental Transformation Initiative (DTI), which aims to reach children and other MCAH priority populations. The DTI efforts included preventive dental services, caries risk assessment, continuity of care, and ensuring a dental home was established. The objectives for the DTI align with the Title V plan and the California Oral Health Plan.

In addition, one of the domains (4) included the development of Local Dental Pilot Projects to implement innovative pilot projects to achieve DTI goals and objectives such as including local case management initiatives and partnerships. These activities are based on evidence based/evidence informed practices.

The State Dental Director provided updates to the Oral Health Subcommittee of DHCS's Children's Health & Disability Prevention Program (CHDP) regarding the implementation of DTI efforts, the development of Local Oral Health Programs and

served as a subject matter expert regarding oral health. The subcommittee problem-solved and identified strategies and barriers to address gaps in access to services and addressed culturally appropriate information and education for Medi-Cal/Denti-Cal eligible children.

A key focus was to finalize the California Oral Health Plan and develop local oral health programs for all 61 local health jurisdictions. In addition, reviewed outreach and health education materials for the Medi-Cal/Denti-Cal priority populations.

Evidence-based and evidence-informed practices utilized for this strategy

Several evidence-based or informed practices were utilized within the Local Dental Pilot Projects (LDPPs). This includes community water fluoridation, school-based/school-linked programs, promoting a dental visit by age one, and access to fluoride varnish application by non-dental providers. 13 LDPPs have begun implementation of their innovative solutions including care coordination, Virtual Dental Home, patient and provider linkages and caries management in young children.

Challenges for this strategy

Limited staffing, length of time to execute contracts, and delay in the publication of the California Oral Health Plan (issued January 2018).

Objective 7: Strategy 2:

LHJ staff informs all eligible and enrolled clients of currently available dental benefits offered by Medi-Cal, promote the dental home and Medi-Cal warm transfer service through 1-800 customer service phone number or other referral services.

A major achievement was the ongoing collaboration between DHCS and the State Dental Director regarding the development and implementation of the Dental Transformation Initiative (DTI). Key activities included:

Participated in DHCS efforts to increase utilization for children. DHCS is enhancing beneficiary and provider awareness regarding eligibility, participation, and billing practices for the Medi-Cal dental program and associated initiatives. Collaborated with DHCS and its dental Fiscal Intermediary, Delta Dental to increase access to oral health services for high-risk populations, develop oral health materials, a provider toolkit, and assist LHJs with their objectives to increase the oral health status of all Californians. All LHJs were informed about the availability of a Delta Dental field representative to assist LHJs in the recruitment of dentists into the Medi-Cal Dental program. Collaborated with

DHCS to launch Smile, California campaign to increase member's use of their Medi-Cal's dental benefit. The centerpiece of the campaign is a new, mobile-enabled website SmileCalifornia.org. Smile California connects members through social media, direct mail, community events, and by partnering with programs such as WIC, and local health departments who also serve Medi-Cal members. Provided input into the development of a loan repayment program to attract dentists to serve the Medi-Cal population. DHCS will be developing criteria for the \$30 million loan repayment program.

Two other major achievements were the establishment of the Dental Hygienist Consultant (DHC) classification and exam for CDPH, and collaborating with DHCS to use their established list for a Dental Program Consultant (DPC) and approval to hire from CDPH. These are key positions for the Oral Health Program.

Challenges for this strategy

The challenge continues to be limited staffing and length of time to recruit and hire staff, time to establish positions, exams and TAU process. In addition, salaries for the DPC and DHC are lower than the private sector, which makes recruitment difficult.

Objective 7: Strategy 3:

Under the guidance of the CDPH State Dental Director, MCAH and OHP will collaborate to implement the newly funded California Children's Dental Disease Prevention Program.

Funding for the California Children's Dental Disease Prevention Program (CDDPP) was moved as part of the budget process. As a result, key elements of the CCDDPP were incorporated into the implementation work plans for the new local oral health programs funded by Proposition 56 (Tobacco Tax Initiative). The local oral health programs have two phases the Planning Phase and the Implementation Phase. The planning phase will go until December 31, 2018. The implementation phase will start January 1, 2019 and will go until June 30, 2023. The elements of the CCDDPP will not start until the implementation phase. However, school-based and/or school-linked sealant programs were highly promoted.

Evidence-based and evidence-informed practices utilized for this strategy

The evidence-based or –informed practices included school- based/school-linked programs and access to fluoride varnish application by non-dental providers.

Challenges for this strategy

The main challenge was the CCDDPP program will not exist as a separate program. Instead, elements of the program have been incorporated into the establishment of local oral health program work plans. There will be a delay in the implementation of school-based/school-linked programs while LHJs complete the planning phase.

Objective 7: Strategy 4:

Under the guidance of the CDPH State Dental Director, pursue a coordinated system involving various State Programs that serve children's dental needs.

The State Oral Health Program, convened an Oral Health Summit on June 19-20, 2018. There were approximately 200 attendees. The purpose of the meeting was to share the oral health landscape in California, launch the California Oral Health Plan and review the major focus areas, action steps and resources available for implementation, acquire feedback and define roles for major sectors to assist in the Plan's implementation, share best practice models and success stories. The goal was to obtain recommendations for a two-year work plan to address priority objectives/strategies and activities and to identify key partners to assist with the implementation. A considerable amount of effort went into planning the event, convening work groups, and arranging logistics and design of the first statewide Oral Health Summit. Participants were very engaged and evaluations were very positive.

Collaboratively with State MCAH, established monthly collaboration and coordination meeting with MCAH with key staff from both programs. Collaborated on activities throughout the year such as provide information for Project Director's Meetings, provide updates on the progress of the roll out of the Local Oral Health Program and identified common issues, challenges and strengths. MCAH provided guidance on policies and procedures as well as shared best practices for working on a statewide program with local health jurisdictions. Aligned policies/practices where possible. Oral health staff worked with home visiting programs, immunization. CHDP, and discussed working with the WIC program in future initiatives such as tailoring messages to include oral health, providing presentations, and assistance with the development of materials.

The State OOH continued to convene the Oral Health Advisory Committee Partnership (OHACP) which includes representatives from MCAH, DHCS, California Department of Education (CDE), California Dental Board, First 5, dental health professionals, dental schools, local health departments, school-based health programs, child health/education organizations, and other stakeholders who represent underserved communities to finalize the State plan and to develop a two-year work plan.

Established an Interagency work group with DHCS and serves as the convener to collaborate on Medi-Cal Dental program including working with Delta Dental regarding provider/beneficiary barriers, identify possible strategies, policies and procedures, In addition, partner with DHCS contractor's in the development of outreach campaigns and development of materials.

State OOH participated in the CDPH/DHCS quarterly meetings hosted by the California Dental Association. These meetings have expanded to include organizations and stakeholders interested in improving the delivery system and access to Medi-Cal eligible populations and other underserved populations. In addition, Dr. Kumar participated in other meetings with engaged oral health stakeholders. They problem-solved and identified strategies and barriers to address gaps in service access and cultural appropriateness for Medi-Cal/Denti-Cal eligible children. They discussed the development and implementation of the California Oral Health Plan, and reviewed outreach and health education materials for the Medi-Cal/Denti-Cal priority populations.

Challenges for this strategy

The Oral Health Program remained at limited capacity due to limited staffing and resources. Additional challenges included the development and approval of the Oral Health Program's Budget Change Proposal, the formal process required to obtain spending authority for Proposition 56's new funding. With limited staff and resources available, work continued towards collaborative planning and appropriate allocation of funding to each of the MCAH county health agencies to build or augment their oral health program capacity at the local level.

Priority 8: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy diet and lead a physically active lifestyle.

Objective 1:

By June 30, 2020, increase the percent of women with recommended weight gain during pregnancy from 34.3% (2013 BSMF) to 36.1%.

The percent of women having weight gain within IOM recommendations remained stable from 34.3% in 2013 to 34.6% in 2015. Asian women (40.8%) and White women (34.7%) were among those most likely to be within the recommended weight gain. Pacific Islander women and American Indian women were least likely to be within the recommended gain (24.1% and 27.9%, respectively).

Objective 1: Strategy 1:

Conduct surveillance of weight gain during pregnancy, including measurement of trends and disparities.

CDPH/MCAH Epidemiology, Surveillance, and Federal Reporting Branch conducted surveillance of maternal preconception weight status and weight gain during pregnancy, including measurement of trends and disparities using the MIHA Survey and BSMF datasets. The MIHA team released 2013-2015 MIHA Data Snapshots for County and Regional Subgroups by Maternal Characteristics. These snapshots include data on preconception weight status and weight gain during pregnancy for each of the top 35 birthing counties and all MIHA regions (which include all CA counties) by maternal race/ethnicity, age, education, income, prenatal health insurance, geographical area (urban vs. rural/frontier), level of neighborhood poverty, and total live births. The May 2018 release supported the Title V Local Needs Assessments and highlighted disparities to promote health equity for all mothers and infants in California. A one-year California Epidemiologic Investigation Service (Cal-EIS) fellow completed an in-depth assessment of maternal preconception weight status and weight gain during pregnancy using BSMF data from 2010 through 2016. This project focused on measuring trends and disparities by maternal characteristics to inform educational needs and provider practices related to maternal weight.

CDPH/MCAH Nutrition and Physical Activity (NUPA) Initiative, funded by Title V, ensured that CDPH/MCAH developed nutrition and weight gain guidelines, educational materials, resources and assessment forms exist and are utilized by MCAH Programs.

The CDAPP Sweet Success Program, contracted and funded by Title V, established a CDAPP Sweet Success Evaluation Plan working group. The workgroup is discussing evaluating postpartum follow up rates and preconception tying in the topic of weight before/after pregnancy.

Objective 1: Strategy 2:

Improve capacity for nutrition and physical activity for women of reproductive age including optimum prenatal weight gain through collaboration and technical assistance, especially by sharing science-based resources.

CDPH/MCAH NUPA promoted the National Dietary Guidelines for Americans and Physical Activity Guidelines via email and web. MCAH promoted California MY Plate resources for pregnant and parenting women and teens, as well as women with diabetes in pregnancy through the State's MCAH website, the CPSP Steps to Take

Manual, the AFLP nutrition guidelines, the CDAPP Sweet Success guidelines, and related program trainings.

CDPH/MCAH NUPA Coordinator continued to update the BIH curriculum, participant handbook, and assessments to reflect current information regarding nutrition and physical activity. At most group sessions, women are modeled a healthy meal and participate in a fitness activity.

CDPH/MCAH AFLP continued to support young mothers with nutrition, physical activity and breastfeeding through strengths based case management with integrated life planning. AFLP case managers promoted and disseminated evidence-informed, medically accurate, and developmentally appropriate materials to raise awareness and support youth with improving their health and wellbeing.

CDPH/MCAH NUPA identified and disseminated nutrition and physical activity for women of reproductive age including optimum prenatal weight gain information and tools through key partners (NEOP and WIC) to help the women of reproductive age meet the dietary guidelines for Americans. CPSP and CDAPP Sweet Success Programs continued to promulgate specific guidelines to address perinatal weight gain including four weight gain grids in the CDAPP Sweet Success Guidelines for Care and the Steps to Take Guidelines.

The CDAPP Sweet Success Resource Center posted a new Nutrition and Exercise online training in June 2018.

CDPH/MCAH updated links on the Systems and Environmental Changes toolkit to support optimal nutrition, physical activity, and breastfeeding through fostering partnerships between LHJ MCAH Programs and existing organizations to promote healthy environmental changes.

CDPH/MCAH encouraged programs and community health care providers to screen for food insecurity using a 2-question validated screening tool as recommended by AAP. MCAH networked with CDPH nutrition partners such as NEOPB, WIC, GDSP, CDSS, SCD, and Emergency Medical Services Authority (EMSA) to have a collective impact on reducing food insecurity and Identify or develop and disseminate information and tools through key partners to help low-income children meet the dietary guidelines for Americans.

Examples of local MCAH health jurisdictions use of Title V funding include:

- Alpine County's MCAH coordinator will establish and co-facilitate with the Alpine County Health & Wellness Coalition and/or Alpine County Behavioral

Health Services, a walking group for adolescents and women of reproductive age, that will meet bi-weekly from April 1st through October 31st. Participants receive cookbooks, pamphlets, and brochures from the SNAP Ed program to help with nutritional knowledge. In Kern County, the Perinatal Outreach Program (AKA PCG) collects BMI data on all clients pre/post-delivery and provides nutrition education, and counsels on exercise, and can then refer to Dignity Health Nutrition classes through Mercy and Memorial Hospitals.

Evidence-based and evidence-informed practices utilized for this strategy

Research-tested:

- Shields, L and Tsay, GS. Editors, California Diabetes and Pregnancy Program Sweet Success Guidelines for Care. Developed with CDPH; Maternal Child and Adolescent Health Division; revised edition, updated September 2015.
- U.S. Department of Health and Human Services and U.S. Department of Agriculture. 2015–2020 Dietary Guidelines for Americans. 8th Edition. December 2015. Available at <http://health.gov/dietaryguidelines/2015/guidelines/>
- Institute of Medicine and National Research Council of the National Academies. Weight Gain During Pregnancy Reexamining the Guidelines. 2009. Available at: <http://nationalacademies.org/hmd/reports/2009/weight-gain-during-pregnancy-reexamining-the-guidelines.aspx>

Challenges for this strategy

Moving to a new CDPH web site was time consuming; MCAH developed multiple new web pages and prioritized which materials to convert to ADA compliance and to move to new web site. No updates to the old site could occur after May 1, 2017.

San Joaquin County developed healthy beverage teaching materials/handouts and a YouTube video and a CD. Challenges they identified included: not all clients have a DVD player available. Successes have been utilizing the YouTube video or just personally showing the clients the proper way.

Objective 1: Strategy 3:

Improve capacity for nutrition and physical activity for children through collaboration and technical assistance, especially by sharing science-based resources.

CDPH/MCAH NUPA maintained the [Systems and Environmental Changes](#) toolkit to support optimal nutrition, physical activity, and breastfeeding through fostering partnerships between LHJ's MCAH Programs and existing organizations to promote healthy environmental changes.

To address food security, CDPH/MCAH promoted a two question validated screening tool as recommended by AAP to be incorporated in MCAH funded programs during client intake:

- a. Within the past 12 months, we worried whether our food would run out before we got money to buy more (Yes or No)
- b. Within the past 12 months, the food we bought just didn't last and we didn't have money to get more. (Yes or No)

AFLP case managers supported expecting and parenting youth with leading physically active lifestyles through education, referrals and goal planning regarding nutrition, physical activity and breastfeeding. Through one-on-one education, referrals and goal planning, case managers provided evidence informed and medically accurate materials to raise awareness and support youth with promoting their health and wellbeing. Out of the 1,312 AFLP youth participants for whom physical activity data was available, 760 or 62.4% of youth reported physical activity in the past week (source: AFLP Scope of Work Report).

CDPH/MCAH co-coordinated for California and participated with ASPHN and several national and state partners in a Pediatric Obesity Nutrition Mini CoIIN: An Obesity Prevention and Treatment Quality Improvement State Collaborative. The aim of the California mini CoIIN was to promote policies and practices that support behaviors to increase the proportion of children ages 0-5 years that fall within a healthy weight range by ensuring policies and practices affecting early care and education (ECE) facilities promote improved nutrition, physical activity, and reduced screen time. Through the mini-CoIIN, partners worked with the Emergency Medical Services Authority (EMSA) to post new professionally vetted nutrition, physical activity and breastfeeding resources to the EMSA licensed childcare curriculum website: <https://emsa.ca.gov/childcare-nutrition/>.

In November 2017, CDPH/MCAH became part of the Children's Healthy Weight CoIIN and addressed lactation accommodation in 2017-2018. The CoIIN offered a Lactating Employees workplace right webinar. There were 105 attendees and an additional 115 views of the recording. 71% of the attendees reported the webinar helped clarify Lactation Accommodation Laws. Attendees asked to be kept updated on changing laws. 92% of attendees reported feeling better prepared to access and explain lactation

accommodation laws.

Within CDPH, MCAH promoted national guidelines on weight, nutrition and physical activity for young children by collaborating with NEOP's Early Childhood Education initiative (funded by CDC 1305 grant).

CDPH/MCAH supports and maintains a relationship with the national and California ASPHN Nutritionists, especially their MCAH nutrition and their obesity councils. MCAH will identify or develop and disseminate information and tools through key partners (NEOP, WIC CDE, Systems of Care, EMSA) to help low-income children meet the dietary guidelines for Americans. MCAH will continue to promote national guidelines on weight, nutrition and physical activity for young children by collaborating with NEOP's Early Childhood Education initiative. A MCAH staff will continue to participate at bimonthly meetings held by NEOP.

Within CDPH, MCAH promoted national guidelines on weight, nutrition and physical activity for young children by collaborating with NEOP's Early Childhood Education initiative.

Examples of Local MCAH health jurisdictions use of Title V funds included:

- Alpine: Local MCAH coordinator established a walking group for adolescents and women of reproductive age that will meet bi-weekly from April 1st thru October 31st. These participants also received cookbooks, pamphlets, brochures from SNAP Ed program help identify some nutritional facts and information.
- Imperial: Local MCAH observed childcare providers and found that many childcare sites have taken advantage of the provision of the stenciling on their sidewalks and/or cemented areas, all sites are providing water that is available and accessible to children playing both inside and outside, many sites have a garden on site, scheduled playtime is made available to children, additional activities are available at sites to provide special physical activity inside when the weather is too hot and/or humid, to provide a consistent message to the children- at one site, providers are only allowed to drink from clear water bottle and to drink only water while at work, and numerous sites had a "no screen time" policy – verbal or written.
- San Francisco: Developed the Healthy Apple Program. In this program, childcare programs who participated, created program nutrition and physical activity policies and implemented these policies. CCHP had 18/23 overall sites achieve Healthy Apple Award levels this year.

Challenges for this strategy

While 22.6 percent of children ages 12-17 reported physically active at least 60 minutes everyday, 15.6 percent of children ages 10-17 were obese (BMI at or above 95th percentile)

Objective 1: Strategy 4:

Promote culturally congruent best practices to promote folic acid intake among women of reproductive age among MCAH programs by providing education, resources and technical assistance.

The MIHA team released 2013-2015 MIHA Data Snapshots for County and Regional Subgroups by Maternal Characteristics. These snapshots included data on daily folic acid use during the month before pregnancy for each of the top 35 birthing counties and all MIHA regions (which include all CA counties) by maternal race/ethnicity, age, education, income, prenatal health insurance, geographical area (urban vs. rural/frontier), level of neighborhood poverty, and total live births. The May 2018 release supported the Title V Local Needs Assessments and highlighted disparities to promote health equity for all mothers and infants in California.

CDPH/MCAH promoted daily preconception intake of 400 mcg folic acid through multiple partners, such as MCAH programs, WIC and nutrition email distribution lists. MCAH promoted the January 2018 National folic acid week to encourage use of state and national resources. MCAH distributed English and Spanish folic acid posters and pamphlets to local agencies. BIH distributed Folic Acid information to all potential and enrolled participants. MCAH updated the Folic Acid web page, a central location to disseminate folic acid information.

Challenges for this strategy

In 2016 the “Your Future Together,” a preconception booklet was discontinued and replaced by a sheet of paper with only the messages required by law. It had been given to couples when obtaining their marriage licenses. This booklet was a unique California opportunity to provide folic acid messaging. MCAH surveyed providers and families of reproductive age to see if the discontinued “Your Future Together” booklet should be reintroduced or if an alternative should be considered and make recommendation to Center for Family Health.

Objective 2:

By June 30, 2020, reduce the proportion of WIC children aged 2-4 years who

are overweight or obese from 34.5% (WIC PC 2012) to 33.5%.

Objective 2: Strategy 1:

Improve capacity for nutrition and physical activity for children through collaboration and technical assistance, especially by sharing science-based resources such as new nationally recognized guidelines and initiatives as well as trainings and funding opportunities with LHJ MCAH directors and MCAH funded program contacts.

CDPH/MCAH maintained the Systems and Environmental Changes toolkit to support optimal nutrition, physical activity, and breastfeeding through fostering partnerships between LHJ's MCAH Programs and existing organizations to promote healthy environmental changes.

CDPH/MCAH co-coordinated for California and participated with ASPHN and several national partners in a Pediatric Obesity Nutrition Mini CoIN: An Obesity Prevention and Treatment Quality Improvement State Collaborative.

Within CDPH, State MCAH NUPA Coordinator promoted national guidelines on weight, nutrition and physical activity for young children by collaborating with NEOP's Early Childhood Education initiative.

Objective 3:

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%.

Objective 3: Strategy 1:

Provide review and technical assistance of all materials in state programs to ensure culturally congruent messaging and education regarding folic acid intake among women of reproductive age.

CDPH/MCAH NUPA Coordinator maintains the States MCAH Folic Acid web page as a central location to disseminate resources to promote daily preconception intake of 400 mcg folic acid. Additionally, CDPH/MCAH NUPA promoted folic acid through multiple partners and distributes English and Spanish folic acid posters and pamphlets to local agencies to promote daily preconception intake of 400 mcg folic acid.

CDPH/MCAH supports and promotes folic acid by partnering with the Inter-conception Care Project, Every Women of California and the Before, Between and Beyond website. CDPH/MCAH promoted the January 2017 National folic acid week to MCAH programs,

partners and contacts through emails encouraging use of state and national resources.

CDPH/MCAH Epi Branch monitored folic acid intake through the MIHA.

Challenges for this strategy

In 2016 the “Your Future Together,” a preconception booklet was discontinued and replaced by a sheet of paper with only the messages required by law. It had been given to couples when obtaining their marriage licenses. This booklet was a unique California opportunity to provide folic acid messaging. MCAH surveyed providers and families of reproductive age to see if the discontinued “Your Future Together” booklet should be reintroduced or if an alternative should be considered and make recommendation to Center for Family Health.

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F. TECHNICAL ASSISTANCE

Areas for Technical Assistance

Improving Child Health and CYSHCN Data at the State and County Level

California is a large state composed of 61 separate and diverse LHJs. Being able to access accurate state and local data is essential for planning and needs assessment. Although the National Survey of Children's Health provides data on National Performance measures and outcome measures for child health and children and youth with special health care needs, data quality is a substantial challenge. There is a need for expanded data availability and reliability, particularly in the areas of medical home, transition to adult health care, and being able to access stable estimates of various measures by race/ethnicity. At the local level, there is little standard data available on the child and CYSHCN populations. California is requesting technical assistance for improving our child health and CYSHCN data by identifying options to improve national level data and support in accessing other sources of state-level data (for example, Department of Education and Medi-Cal).

Building a California CYSHCN strategic plan with expert consultation from HRSA or Subject Matter Experts

As California focuses on building capacity to meet the needs of Children and Youth with Special Health Care Needs (CYSHCN), we are seeking technical assistance to support the development of a statewide strategic plan, which will be included as part of the 2021-2025 Needs Assessment. Specifically, we plan to engage our local MCAH programs and other stakeholders in identifying the greatest needs, highest priorities, and most effective use for Title V funding in serving CYSHCN across the state. California is already engaging with several federal technical assistance providers on this topic, including the MCH Workforce Development Center and National Center for Family-Professional Partnerships, as well as receiving HRSA funding for a national expert on CYSHCN to attend our second annual CYSHCN stakeholder meeting. California is further requesting consultation as needed from subject matter experts and potentially expertise and assistance with facilitation at future stakeholder meetings to develop and vet the strategic plan.

Recruitment of Public Health Nurses

Many small and rural LHJs have difficulty recruiting and retaining public health nurses due to low salaries, competition among local hospitals, clinic and the prison system, lack of jobs for significant others, change in lifestyle.

Health Equity

The formula for how to achieve health equity is cloudy and complex, yet Public Health must continue to embrace this topic as many ethnic and vulnerable populations suffer adverse birth and health outcomes due to disparities and inequities. The U.S. Department of Health and Human Services defines health equity as the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally, regardless of sex, gender, or race; and a dedication to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

CDPH/MCAH is interested in receiving technical assistance on how to best support and expand the capacity of Local Health Jurisdictions to achieve health equity through the reduction of health disparities in their communities. We recognize the need to design and implement strategies and/or interventions to ensure access to high-quality health care, measure the impact of evidence-based/evidence informed interventions, and to leverage multi-sectoral collaboration and community engagement through inclusive public health practices.

Results Based Accountability

The Center for Family Health, including MCAH, has committed to adopting and building out a Results-Based Accountability (RBA) framework for the work within the Center. MCAH has launched a pilot process with RBA and plans to expand the framework to include all of the efforts in the Title V Block Grant. As HRSA also works to adopt this framework, MCAH would like to request technical assistance specifically around aligning the Title V required measures as they currently are written in the guidance with the RBA framework. Technical support will be critical for effectively transitioning to the new accountability system while ensuring that all Title V requirements are met.